Columbia Gas of Pennsylvania, Inc.
2012 General Rate Case
Docket No. R-2012-2321748
Standard Data Request
GASRR No. 24-55 A
Volume 2 of 2

2-13-13 Hbg GR

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Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-24:

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

Response:

The following are provided as attachments:

NiSource Health & Welfare Benefits Handbook – Attachment A
- Consolidated Flex Medical Plan
- Dental Plan
- Vision Plan
- Flexible Benefits Plan
- Long Term Disability Plan
- Life Insurance Plan

NiSource Pensions
- Account Balance Pension Option I – Attachment B
- Account Balance Pension Option II – Attachment C
- Final Average Pay Pension – Attachment D

NiSource Retirement Savings Plan – Attachment E

NiSource Short Term Disability Plan – Attachment F

NiSource Holidays – Attachment G

NiSource Vacation Policy – Attachment H

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

For Full-Time Employees in the Columbia Energy Group Bargaining Unit

Distributed: 2011
Effective Jan. 1, 2011

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of Columbia Energy Group, an affiliate of NiSource Inc. ("NiSource" or "Company"), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

This handbook serves as the Summary Plan Descriptions ("SPDs") for the benefit plans as of January 1, 2011. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD and an official plan document. The NiSource Benefits Committee (the "Committee") reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The benefit information contained in this handbook applies to all eligible full-time bargaining unit employees of Columbia Energy Group covered under the Program.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate handbooks and not herein: full-time exempt employees hired before January 1, 2010; full-time exempt employees hired on or after January 1, 2010; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

The Company offers you the following coverages in accordance with the terms of the applicable benefit plan (identified below). *(Details of each benefit plan can be found in the individual sections of this handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Long-Term Disability Coverage (NiSource Long-Term Disability Plan – referred to as the "Long-Term Disability Plan")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

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

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

To access MySource for Human Resources, go to the NiSource Intranet (called MySource) and log on to the secure website at **www.mysourceforhr.com**. MySource can be accessed 24 hours a day, seven days a week. Customer service associates are also

available to answer questions at the MySource automated telephone system at **1-888-640-3320.**

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual section of this handbook)* will be eligible to elect to participate in the benefit plans when and to the extent provided under the applicable benefit plan.

Please Note: It is your responsibility to advise MySource when a person is no longer eligible for coverage as a dependent under a benefit plan. Any amounts paid by a benefit plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan.

Certain benefit plans are maintained pursuant to one or more collective bargaining agreements. Copies of such agreements can be obtained upon written request to the Company and copies also are available for examination at the Company's principal offices at 801 E. 86th Avenue, Merrillville, Indiana 46410, during regular business hours, and at other specified locations upon your request made in advance to your local HR representative.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental or Vision Plans if you are actively at work and you are a regular full-time employee who regularly works 40 or more hours per week.

Your eligible dependents include:

- Your lawful spouse, if he or she is treated as a spouse under the Internal Revenue Code, and provided you are not legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise terminate, (2) the child is dependent upon the employee for financial support and maintenance, (3) the employee continues to be covered by the Plan, (4) the child's disability continues, and (5) the child has not attained age 65;
- Your child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient, as having a right to participate in the Plan as a dependent.

Your child is a person who is either (1) your naturally born child; (2) your legally adopted child or a child placed with you for adoption; (3) your stepchild; (4) your foster child who is legally placed in your custody, for whom you are providing parental care, and for whom you are legally responsible to provide medical care; (5) a child for whom you are legal guardian and who is dependent upon you for at least 50% of his or her financial support and who may be claimed on your Federal income tax return as a dependent (without giving effect to the child's gross income for the year); or (6) any person deemed by court order to be a child for purposes of the Plan.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these

determinations, you may ignore your child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the MySource website at ***www.mysourceforhr.com****, or call the MySource automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Medical, Dental or Vision Plan.*

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a benefit plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must enroll for the medical, dental, flexible benefits, vision, supplemental and dependent life and AD&D and supplemental long-term disability coverages within 31 days following the date on which you become eligible for such coverage. **(This Benefits Program Overview or the individual sections of this handbook contain additional information about enrollment in each plan.)**

You are automatically enrolled for basic long-term disability, basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll, you must log on to the MySource website at **www.mysourceforhr.com** or call MySource for Human Resources at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual section of this handbook)**, if applicable, for the remainder of that calendar year.

Please Note:

Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day period.

Enrollment in the Medical, Dental and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled *"Eligibility under the Medical, Dental and Vision Plans"*, you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the PPO medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the *"Enrollment"* and the *"Changing and Continuing Your Elections"* section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll your newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (spouse and/or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource benefit plan of the same type (e.g., more than one medical plan). Also, for most benefit plans, a NiSource active or retired employee cannot be covered under the benefit plan both as a participant and as a dependent. Likewise, if you and your spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your child(ren) under the same plan (e.g., child life insurance). Double benefits are not available.

Coverage under the Program for retired employees or for active employees other than eligible full-time bargaining unit employees of Columbia Energy Group is described in separate handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your child (as well as participation in the Health Care Flexible Spending Account) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or participating employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, the employer may withhold from your wages any contributions required for such coverage.

You may obtain, without charge, a copy of the benefit plans' QMCSO procedures from the Company.

Special Rule for Rehired Employees

If you terminate employment and are rehired after your termination date, the benefit elections that were in effect on the date of your termination **will not be** automatically reinstated. You will need to re-elect coverages once you again become eligible upon your return.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the benefit plans. If you do not enroll within the annual enrollment period, your current coverages remain in effect for the upcoming Plan Year, if available, at the applicable rates. You will be advised of any new benefit plans, plans that require enrollment and the deadline date. **If you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to re-enroll each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

In the event your current plan coverage is not available and you fail to elect coverage under another plan that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the individual sections of this handbook for further details.

Opt-Out Credit

If you are a full-time employee and have coverage elsewhere and decline medical or dental coverage under the Medical or Dental Plans, you may be eligible for an opt-out credit, if available. Please refer to the enrollment material to see if this option is currently being offered. If you have declined coverage, but your spouse or parent is also an employee or retiree and is covering you *as a dependent, you are not entitled to an* opt-out credit.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the following benefit plans at your home address.

- Medical; and
- Prescription Drug.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below or the individual sections of this handbook for a complete description of when the coverage begins and ends with respect to each benefit plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death), coverage under the Medical Plan, the Dental Plan, the Vision Plan and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")and except as provided by the NiSource Military Leave of Absence Policy or any applicable collective bargaining agreement;
- The last date for which any required contribution was made;
- The date on which a leave of absence begins, except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 ("FMLA"); or
- The end of the month following the date an employee terminated employment; or

A dependent shall cease to participate in the Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends;
- The last date for which any required contributions for the dependent's coverage was made;

- The end of the month following the date a dependent no longer qualifies as a dependent, except in the case of the Medical Plan to the extent continuation coverage is required under Michelle's Law.

Changing and Continuing Elections

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, the Flexible Benefits Plan, the Life and AD&D Plan or the Long-Term Disability Plan. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at MySource for Human Resources at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event. In addition to satisfying any requirements established by the applicable benefit plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable benefit plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the benefit plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll your newborn child within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a benefit plan (this does not apply to the Health Care Flexible Spending Account).
- You qualify for special enrollment in the Medical Plan during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical Plan, under such a Medicaid plan or State child health plan. *Please note: If you lose coverage because of an event described in item (3), your special enrollment period will be 60 days, not 31 days.*
- The benefit plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You take leave under the Family and Medical Leave Act.

Coordination of Benefits (COB)

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

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable benefit plan is primary, the benefit plan pays the amount payable under such plan.

If your coverage under the applicable benefit plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the benefit plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

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

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

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

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

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. (If you become disabled, you may become Medicare-eligible before age 65.)

You should notify a MySource customer service associate if you start Medicare benefits. The way medical coverage under the benefit plans coordinates with Medicare depends on your age and whether you are an active or inactive employee.

How Coordination of Benefits Works for Active Employees

If you are an active employee or covered by another active employer plan, and you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

If you are an active employee and you and your spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your spouse may, if age 65 or older, make a separate Medicare election. However, your spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Inactive Employees

If you are covered under the Medical Plan but are no longer considered an active employee for purposes of Medicare, and you or your spouse is Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying a MySource customer service associate if you or your spouse becomes Medicare-eligible.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the *"General Program Information"* found at the end of each benefit plan section of this handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

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

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

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

For details regarding how to file a claim and the claim denial and appeal processes for each of the benefit plans, please see the individual sections of the handbook.

Legal Action

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

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if a participating employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan. Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends.*" For example, as of the date of this handbook, the personnel policy of participating employers is to terminate your employment if the claims fiduciary of the participating employer's long-term disability plan determines you no longer qualify for benefits under the long-term disability plan. The leaves referred to above are:

Sick Leave – Coverage under the Medical, Dental, Vision and FSA Plans for you and your eligible dependents continues if you are on sick leave and your employer under its personnel policies continues to treat you as an employee. Your contributions for this coverage will continue to be deducted from your check.

Long Term Disability Leave ("LTD") – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues if you are on LTD leave and your employer under its personnel policies continues to treat you as an employee. You must continue to make your required contribution.

You **cannot** continue to participate in the Health Care FSA and/or Dependent Care FSA (Flexible Spending Accounts available under the FSA Plan) while you are receiving LTD Plan benefits. You may, however, use the existing balance in your account to pay for any eligible expense you incur before you commence your LTD leave.

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). In the event you are on FMLA leave, you must continue to make your required contribution.

The Company and any participating employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy or any applicable collective bargaining agreement.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse (if he or she is treated as a spouse under the Internal Revenue Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 30 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such

Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, commencement of a proceeding in bankruptcy with respect to your employer (in the case of loss of retiree coverage), or you become entitled to Medicare benefits (under Part A, Part B, or both), your employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. This notice must be provided to MySource for Human Resources. If notice is not provided within 60 days, you will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

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

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes

a loss of coverage under the Health Care FSA, you may continue your current contributions to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year and during the grace period following the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) within 60 days of the disability determination by Social Security and before the end of the initial 18-month period, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period, you will not be entitled to a disability extension. The disability would have to have started at some time during the first 60 days of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to a extension on account of the second qualifying event. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to provide any group health plan or coverage to any employee.
- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).

- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the *"Coordination with HIPAA"* provisions set forth below for additional information.

Coordination with HIPAA

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. The Health Insurance Portability and Accountability Act ("HIPAA") limits the extent to which employers' group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

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

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

Notification of Address Changes

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

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

Certificates of Group Health Coverage

If you or a covered dependent are no longer eligible for coverage under the Medical Plan, you will automatically receive a certification of group health plan coverage. A certification of group health plan coverage can be obtained from a MySource customer service associate any time during your coverage and during the 24-month period after your coverage under the Medical Plan ends.

Additional Information

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;

- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable benefit plan in relation to the illness, sickness or bodily injury. When this happens, the applicable benefit plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable benefit plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable benefit plan may recover any sums paid under such benefit plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable benefit plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable benefit plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable benefit plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable benefit plan, provide all information and sign and return all documents necessary for the benefit plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information does not preclude the benefit plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the benefit plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable benefit plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable benefit plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable benefit plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable benefit plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable benefit plan to the extent of the benefit plan assets that are so held in trust.

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

The applicable benefit plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation or arbitration, that the covered person (or his or her legal representative) receives or is entitled to receive from any of the sources listed above. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable benefit plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable benefit plan that result from the illness, sickness or bodily injury. The applicable benefit plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable benefit plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable benefit plan for the amount of the benefits paid under that benefit plan; and
- The applicable benefit plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable benefit plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable benefit plan's attorney fees and court costs, are the responsibility of the covered person, not the benefit plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the benefit plan, and as a condition of participating in the benefit plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's minor covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable benefit plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the benefit plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable benefit plan if all or some of the expense:

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

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

Provider Networks

Certain of the benefit plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an in-network provider rather than an out-of-network provider. For those benefit plans that make use of provider networks, provider lists may be obtained, without charge, at **www.anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

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

Permitted Uses and Disclosures

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

Disclosures to Company

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

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

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

Employment Rights Not Guaranteed

Your participation in the Program or any benefit plan does not ensure you of continued (or renewed) employment with the Company or a participating employer. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the benefit plans at any time. The Committee reserves the right to

terminate any benefit plan at any time without the consent of or advance notice to you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each benefit plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the benefit plans.

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

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the benefit plans and construe the benefit plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Internal Revenue Code with respect to the benefit plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the benefit plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the benefit plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Administration Department and third party administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrator the discretionary authority to:

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

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

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

The Role of the Claims Administrator

With respect to the benefit plans that are self-insured, the Committee has retained a Claims Administrator to provide claim payment and other administrative services to such plans. Even though an employee may receive a benefit check from a Claims Administrator, the Company, a participating employer or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although the Claims Administrator may have insurance coverage as part of its business, the Claims Administrator is not an insurer in relation to the self-insured plans. The self-insured plans are funded from the general assets of the Company or a participating employer or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured benefit plans, the Claims Administrator is also the Plan's insurer.

Statement of ERISA Rights

As a participant in a benefit plan maintained by NiSource Inc., you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the benefit plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the benefit plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the benefit plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the benefit plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the benefit plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the benefit plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the benefit plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Questions

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

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither Dependent Care FSA nor the HSAs to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

Your Medical Plan Options

NiSource Inc. (the "Company") provides eligible employees and their dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield:

- The Preferred Provider Organization (PPO), which uses the BlueCross/BlueShield Network;
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan ("Plan") may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where an HMO option is available. *If this option is available to you, you will be provided with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

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

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

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

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to your HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

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

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered through *Walgreens Health Initiatives*, which offers you access to a network of participating retail pharmacies for most of your short-term medications. *(The pharmacies that participate in this network are not limited to Walgreens pharmacies.)* You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

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

To find a provider who participates in the PPO network, log on to **www.walgreenshealth.com** or contact a Walgreens customer service associate at the number on the back of your ID card to request assistance.

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

Mental Health/Substance Use Disorder Treatments

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

When you become covered under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also have access to EAP-Work/Life Services administered by Value Options. For additional details, see the section below entitled *"EAP-Work/Life Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources at **1-888-640-3320**.

ID Card

If you elect coverage, you will receive your Medical ID card and Prescription ID card in the mail shortly after you enroll. The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact MySource for Human Resources at **1-888-640-3320**.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

In addition, notwithstanding the foregoing, in the event of a covered employee's death on or after January 1, 2004, coverage will continue for such employee's dependents who are covered under the Plan on the date of that employee's death until the earlier of (i) the date the employee's spouse dies, (ii) the last day of the month in which the employee's spouse remarries, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, and (v) with respect to any dependent, the date such dependent reaches age 65. If such employee's spouse remarries within the first 36 months after a covered employee's death, he or she may continue coverage for himself or herself and any qualified beneficiaries under COBRA for the duration of the 36-month period. See the subsection below entitled "COBRA" for a discussion of COBRA continuation coverage.

Also notwithstanding the foregoing, in the event of a covered employee's death before January 1, 2004, coverage may continue for such employee's dependents who are covered under the Plan on the date of that employee's death in accordance with a written plan or procedure, if any, applicable to such employee that was adopted by the Company and that was in effect as of December 31, 2003, as such plan or procedure was thereafter, or may hereafter, be modified by the Company.

Medical Coverage for Retirees

You are eligible for medical benefits as a retired employee if you retire with at least ten years of eligible service and you are at least 55 years of age at the time of your retirement.

Certain eligible retirees and their spouses may be entitled to receive an annual defined dollar subsidy ("Defined Dollar Subsidy") toward the cost of retiree medical coverage.

The Defined Dollar Subsidy for an eligible retiree who has not become eligible for Medicare coverage is $170 *($180, effective November 1, 2011)* times Years of Service. The defined dollar subsidy for an eligible retiree's spouse who has not become eligible for Medicare coverage is $120 *($125, effective November 1, 2011)* times Years of Service.

The Defined Dollar Subsidy for an eligible retiree who has become Medicare-eligible is $60 times Years of Service. The defined dollar subsidy for an eligible retiree's spouse who has become eligible for Medicare coverage is $40 times Years of Service.

In addition to the Defined Dollar Subsidy, an eligible retiree may receive a monthly payment of $37.50 as a Medicare Part B reimbursement.

If an eligible retiree dies prior to his or her spouse, the surviving spouse may receive a Defined Dollar Subsidy in the same amount as the eligible retiree, as if the eligible retiree were the same age as the surviving spouse.

For purposes of the Defined Dollar Subsidy, "Years of Service" means the total number of Years of Service, rounded up to the nearest whole number, earned by the eligible retiree for purposes of benefit accrual (including all service prior to a distribution that causes any prior service to be disregarded) under each defined benefit pension plan maintained by the Company or an affiliate in which the eligible retiree accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan.

You must notify the Company of your planned retirement, at which time you will receive further information regarding your retiree benefits. Retiree benefits are not described in this handbook. Generally, if you are under age 65, you are eligible to elect the same Medical Plan options that are available to active employees. If you or your spouse is over age 65, there are different plans that may be available to you and your spouse, depending upon the terms of the collective bargaining agreement in place at the time you retire. For further information about your benefit or to notify the Company of your retirement, contact MySource at **1-888-640-3320**.

Subject to the provisions of any applicable collective bargaining agreement, the Committee reserves the right to terminate, change or modify any retiree benefits at any time without the consent of, or advance notice to, you or your covered dependents.

Utilization Review Program

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

The UR Program offers the following services:

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

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also

can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

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

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

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, coinsurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

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

FEATURE	PPO	
	IN-NETWORK (OR OUT-OF-AREA)	OUT-OF-NETWORK
Calendar Year Deductible	**You Pay**	**You Pay**
Covered Member	$300 per covered member	$600 per covered member
Covered Member + Spouse	$300 per covered person	$600 per covered person
Covered Member + child(ren)	$300 per covered person, up to a total of $600	$600 per covered person, up to a total of $1,200
Covered Member + Family (spouse + children)	$300 per covered person, up to a total of $900	$600 per covered person, up to a total of $1,800
Copay Requirement	$20	Not Applicable
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include deductible or co-pay)		
Covered Member	$1,000	$2,000
Covered Member + Spouse	$2,000	$4,000
Covered Member + Child(ren)	$2,000	$4,000
Covered Member + Family	$3,000	$6,000
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of –network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of –network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of –network)	
Chiropractic/Spinal Manipulation Services	26 visits per calendar year (combined in-network and out-of –network)	
Home Health Care	120 visits (combined in-network and out-of –network)	

FEATURE	PPO	
	IN-NETWORK (OR OUT-OF-AREA)	OUT-OF-NETWORK
Hospice Care	180 days (combined in-network and out-of –network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. *Please refer to the HMO SPD for further information regarding services provided under an HMO option.*

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	Plan Pays
Inpatient Services		
Room and Board and Ancillary Services	80% (no deductible)	60% (after deductible)
Surgery	80% (no deductible)	60% (after deductible)
Skilled Nursing Facility	80% (no deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (no deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (no deductible)	60% (after deductible)
Dental/Oral Surgery	80% (no deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after in-network deductible)
Second Surgical Opinions	100% (after $20 co-pay per office visit)	60% (after deductible)
Professional Services (Outpatient)		
	100%, (after $20 co-pay per office visit) (copay does not apply for allergy injections and serums)	60% (after deductible)

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	Plan Pays
Emergency Care Services		
Accident	100% (no copay or deductible)	100% (no copay or deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)
Urgent Care	100% (after copay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (no deductible)	60% (after deductible)
Outpatient Therapy	100% (after $20 co-pay per office visit)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (no deductible)	60% (after deductible)
Outpatient	80% (no deductible)	60% (after deductible)
Allergy Testing	100% (after office visit co-pay)	60% (after deductible)
Maternity and Infertility		
Pre-natal Office Visits	100% (after $20 copay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (no deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (no deductible)*	60% (after deductible)*
Preventive Health Services		
Recommended Preventive Health Services	100% (no copay or deductible)	60% (after deductible)
Additional Preventive Health Services	100% (no copay or deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)		
	80% (after deductible)	60% (after deductible

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

How Deductibles Work in the PPO Option

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

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for in-network providers, $600 for covered member + spouse or for covered member + child(ren), or $900 for covered member + family), additional covered members within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $300 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered member must satisfy the $300 in-network deductible requirement before the "family" deductible requirement is met.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, coinsurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

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

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

FEATURE	HDPPO 1		HDPPO 2	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible				
Covered Member Only	$1,500	$1,500	$2,500	$2,500
Covered Member + Spouse	$3,000	$3,000	$5,000	$5,000
Covered Member + Child(ren)	$3,000	$3,000	$5,000	$5,000
Covered Member + Family	$3,000	$3,000	$5,000	$5,000
Coinsurance				
	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum*				
Covered Member Only	$1,500	$3,000	$2,500	$5,000
Covered Member + Spouse	$3,000	$6,000	$5,000	$10,000
Covered Member + Child(ren)	$3,000	$6,000	$5,000	$10,000
Covered Member + Family	$3,000	$6,000	$5,000	$10,000
Office Visit				
	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket				
	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

**Excludes deductible*

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options.

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

TYPE OF SERVICE	HDPPO 1		HDPPO 2	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Infertility				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*
Other Covered Services (including durable medical equipment and prosthetics/orthotics)				
	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

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

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

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

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

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for medically necessary eligible expenses up to the maximum allowance. *For services covered under an HMO plan, please refer to the HMO SPD.*

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

Inpatient Services

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

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

  The Plan pays benefits for both day and nighttime care.
- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and
  - Prescribed medications (Outpatient prescription drug services are covered under the prescription drug program. See the sections of this handbook relating to Prescription Drugs for details).
- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

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

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 36 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

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

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam and one hearing aid per ear during a two calendar-year period.; and
- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

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

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

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to

safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services. In some instances, the Plan may extend the limits based on medical necessity.

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

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

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 visits per person per year;
- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

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

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

Preventive Health Services

The Plan pays benefits for certain preventive health services.

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

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

benefits will be considered as diagnostic services.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommend preventive health service or an additional preventive health service. Additional preventive health services furnished by in-network providers are covered by the Plan with no deductible, copayments or coinsurance. Additional preventive health services furnished by out-of-network providers are subject to deductibles and coinsurance.

Recommended preventive health services shall meet requirements as determined by federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, copayments or coinsurance when furnished by an in-network provider. Recommended preventive health services furnished by an out-of-network provider are subject to deductibles and coinsurance. Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer;
  - Cervical cancer;
  - Colorectal cancer;
  - High Blood Pressure;
  - Type 2 Diabetes Mellitus;
  - Cholesterol;
  - Child and Adult Obesity;
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins after the date the recommendations or guidelines are issued and will not remain covered services after the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services.

The frequency, method, treatment and setting of recommended protected health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion.

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 copayment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a copayment and/or deductible for the office visit, unless the office visit involves an out-of-network provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a copayment and/or deductible for the office visit.

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these services (or you may view the federal government's web sites, **http://www.healthcare.gov/center/regulations/prevention.html; http://www.ahrq.gov/clinic/uspstfix.htm**; or **http://www.cdc.gov/vaccines/recs/acip/**.)

Maternity and Infertility

The Plan pays benefits for the following pre-natal, maternity, and infertility-related services:

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

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to your newborn infant while the mother is hospitalized after childbirth (even if you initially have employee only coverage). However, if your newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage. To add your newborn to your coverage, you must call MySource for Human Resources at **1-888-640-3320**, or log on to the MySource for Human Resources website at **www.mysourceforhr.com** and add your newborn within 31 days of the actual birth. Provided you timely enroll your newborn, coverage for the newborn takes effect as of the date of birth. Please see the *"Enrollment"* and the *"Changing and Continuing Your Elections"* section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll your newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll your child.

- Services performed to diagnose infertility. The Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

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

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for

temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse;
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;
  - Medically necessary services, supplies, and medications.
- *Hospice care services.* For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:
  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

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

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

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

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

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

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

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay

covered expenses based upon a determination of the Maximum Allowable Amount and you will be responsible for any amount not paid by the Plan.

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

- Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
- Inpatient covered hospital services related to the transplant procedure.
- Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).
- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

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

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

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

Contact the Plan Administrator for detailed information.

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

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

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320.**

Medical Expenses Not Covered

The medical expenses **not** covered include, but may not be limited to the following:

- Any condition, disease, defect, ailment, or injury that arises out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive benefits in whole or in part. It also applies whether or not you claim the benefits or compensation, and regardless of whether you recover benefits from any third party.
- Expenses for which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if you had applied for Part A and/or Part B (except as specified elsewhere under the Plan or as otherwise prohibited by federal law).
- Charges related to cosmetic surgery or related hospital admissions, unless made necessary:
  - By an injury;
  - For correction of congenital deformity when necessary to perform a normal body function;
  - For reconstructive surgery as necessary for the prompt treatment of a diseased condition.
- Any service or supply that is related to weight loss or the treatment of obesity (except for the surgical treatment of morbid obesity).
- Services associated with the treatment of infertility, including: artificial insemination; fertilization (such as in-vitro or GIFT); procedures and tests related to fertilization; and infertility drugs and related services that follow the diagnosis of infertility.
- Care received in an emergency room that is not considered emergency care (except as specified under the plan).
- Services or supplies that you receive at a health spa or similar type of facility.
- Self-help training and other forms of non-medical self care (except as provided under the plan).
- Radial keratotomy or keratomileusis, or excimer laser photo refractive keratectomy.
- Speech therapy, unless the therapy is expected to restore speech to a person who has lost speech function as a result of a disease or injury.
- Surgical-related expenses associated with Norplant and IUDs, elective abortions, or reverse sterilization.
- Custodial care, or for services received in an uncertified skilled nursing facility.
- Pre-admission testing if you decide to postpone your surgery.
- Dental implants.
- The Plan limits benefits for home health care services.
- Professional services when related to Depo-Provera injections or routine vision exams.
- Hospice care benefits for:
  - Home-delivered meals or homemaker services;
  - Respite care;
  - Traditional medical services to treat the terminal illness, disease, or condition;
  - Transportation, including – but not limited to – ambulance transportation; and
  - Care provided by a family member or friend.
- Maternity benefits for your dependent children.
- Human organ transplant benefits for the following:
  - Cardiac rehabilitation services provided more than three days after the recipient is discharged from the hospital;
  - Transportation by air ambulance for the donor or the recipient;
  - Travel time (and related expenses) required by a provider; or
  - Drugs that are experimental or investigational in nature.

- Dental appliances (except for intra-oral devices used in connection with the temporomandibular joint dysfunction treatments) or the replacement of cataract lenses when a prescription change is not required.
- Orthotics when used for comfort only.
- Any cutting procedure in the mouth (except when performed in connection with the removal of non-impacted teeth, replacement of teeth, dentures or appliances, orthodontia or periodontia, alveoplasty, or the repair or preparation of the mouth to receive or maintain dentures).
- Charges that are not for the care or treatment of an injury or sickness, except as specifically provided for by the Plan.
- Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for oral surgery for repair of injury to natural teeth, or as provided herein.
- Charges for the non-surgical treatment of temporomandibular joint (TMJ) dysfunction except for the appliance.
- Charges for or related to some services, treatment, education testing or training related to learning disabilities or developmental delays.
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease.
- Charges related to services provided by the United States government, any state government, or any government outside the United States in which the participant or dependent is entitled to receive benefits. An exception to this exclusion applies for services provided by the United States government that can be billed to the Plan under COBRA.
- Charges that a covered person is not legally required to pay and charges that would not have been made if the Plan had not existed.
- Charges that exceed reasonable and customary charges or the Maximum Allowable Amount or are not medically necessary.
- Charges that are reimbursed, or that could be reimbursed, by any public program other than Medicaid, Medicare or TRICARE.
- Charges for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy.
- Charges for marriage, family, child, career, social adjustment, pastoral and financial counseling, except as provided by the EAP.
- Charges for acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery that is covered under the Plan.
- Charges for biofeedback services.
- Charges for examinations related to employment.
- Charge for examinations related to marriage.
- Charges for eye surgery performed primarily to correct refractive errors.
- *Charges for experimental or investigational* services. These include treatments, procedures, equipment, drugs, devices or supplies that in the judgment of the Claims Administrator are experimental or investigational for the diagnosis for which the person is being treated, and services not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator. They also include any services related to such treatments, procedures, equipment, drugs, devices or supplies, regardless of when incurred.
- Charges for chiropractic maintenance care.
- Charges for transportation to and from places of treatment and care, other than ambulance service when medically necessary.
- Charges related to any services or supplies for counseling related to sexual dysfunctions or inadequacies.

- Charges incurred prior to the effective date of coverage, or after the termination date of coverage.
- Charges for services rendered by a relative of the participant, or any other person who resides in the same household as the participant.
- Charges incurred for the treatment of a sickness or injury as a result of any act of war, declared or undeclared.
- Charges incurred as a result of any act of rioting or civil disobedience.
- Court-ordered testing or care.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Missed or cancelled appointments.
- Mileage costs or travel expenses unless authorized by the Plan.
- Charges for custodial care, domiciliary or convalescent care, except as otherwise provided in the Plan.
- Charges for eyeglasses or contact lenses, except for the first pair of eyeglasses or contact lenses prescribed following cataract surgery.
- Charges for sex transformation surgery and related services, or the reversal thereof.
- Charges for reversal of sterilization.
- Charges for elective sterilization procedures for someone other than the participant or his or her spouse.
- Personal hygiene and convenience items.
- Charges for examinations relating to research screenings.
- Stand-by charges of a physician.

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

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

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through Walgreens Health Initiatives. HMOs will provide separate prescription drug coverage.

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

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

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

The PPO coverage option also utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Walgreens Health Initiatives before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Walgreens Health Initiatives toll-free at 1-877-665-6609.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a prescribed brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you request that the brand-name drug be dispensed, you will be responsible for the applicable co-pay plus the difference in cost between the brand-name drug and the generic substitute, unless your prescribing physician indicates that the brand-name drug is to be "dispensed as written."

You can fill your prescription at any participating pharmacy, which includes Walgreens and other chains and independent pharmacies.

Retail

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

If you fill your prescription at a nonparticipating pharmacy, the Plan pays the cost of the drug less the co-pay. The copay requirement applies to each original prescription or refill. If your physician authorizes a prescription refill, you must bring the prescription bottle or package to the participating pharmacy.

Advantage 90 Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Advantage 90 Program. The prescription must be filled at a WHI network pharmacy participating in the Advantage 90 Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

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

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery.
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Walgreens Health Initiatives*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Prescription Order Form and your check to:

  Walgreens Health Initiatives
  PO Box 628001
  Orlando FL 32862

- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
- One for an immediate supply (you can then take this to your local participating pharmacy)
- A second one for the extended supply (you can then submit this one to the mail order service)

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

To find out if your pharmacy is in the Walgreens Network, contact Walgreens at the number on the back of your ID card. Or you can log on to the Walgreens Health Initiatives website at **www.walgreenshealth.com**.

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

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY		MAIL ORDER		WALGREENS ADVANTAGE 90
	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay*
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$10 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $10 and maximum co-pay of $30
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$30 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180

Out-of-Pocket Maximum	
The maximum amount you have to pay out of your pocket each year	$1,500 per person per year

Day Supply Limit	Retail Pharmacy	Mail Order
The maximum amount you can receive per prescribed order	30-day supply	90-day supply

Refill Limit	Retail Pharmacy	Mail Order
The maximum amount you can receive per refill order	Up to a 30-day supply	Up to a 90-day supply
Use For:	Short-term medications or immediate prescription drug needs	Long-term, maintenance, and injectable medications

You either pay a percentage of the drug's cost (coinsurance), or a set copay amount (not both). If your percentage of the cost results in an amount that is **less than the "minimum copay," you pay the minimum copay amount. If your percentage of the cost results in an amount that is **greater than** the "maximum copay," you pay up to the maximum copay amount. For the PPO Coverage Option, if you request that a brand-name drug be dispensed instead of its generic substitute, you may be responsible for paying the difference between the cost of the brand-name drug and the generic substitute, in addition to the applicable co-pay.*

How Your Prescription Drug Coverage Works in the High Deductible Options

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

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

Retail Service

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

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

Mail Order Service

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

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

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

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

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

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

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

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

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

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

Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible.

Prescription Drug Coverage Expenses Covered

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

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Immunosuppressants;
- Injectables, other than insulin;
- Pre-natal vitamins;
- Retin-A, up to age 25;
- Diabetic diagnostics;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

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

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

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

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

- Drugs prescribed for cosmetic reasons;
- Vitamins (unless prescribed);
- Oral contraceptives, unless medically necessary;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications;
- Smoking cessation materials.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

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

If you participate in the PPO coverage option, you are also provided with the following: 1) Mental Health and Substance Use Disorder Coverage, and 2) Employee Assistance Program (EAP)/Work Life Services benefits. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life Services benefits are administered by Value Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option"* and the *"EAP-Work/Life Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

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

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

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

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

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

MENTAL HEALTH AND SUBSTANCE USE DISORDER	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS*
Mental Health Inpatient	85%	65% (after deductible)
Mental Health Outpatient	100% (after $15 copay)	65% (after deductible)
Substance Use Disorder (Detox Inpatient)	85%	65% (after deductible)
Substance Use Disorder (Detox Outpatient)	100% (after $15 copay)	65% (after deductible)
Substance Use Disorder (Rehab Inpatient)	85%	65% (after deductible)
Substance Use Disorder (Rehab Outpatient)	100% (after $15 copay)	65% (after deductible)

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

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

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

MENTAL HEALTH AND SUBSTANCE ABUSE	IN-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Mental Health Inpatient	80%	60%
Mental Health Outpatient	80%	60%
Alternative Levels of Care	80%	60%
Substance Abuse (Rehab Inpatient)	80%	60%
Substance Abuse (Rehab Outpatient)	80%	60%

For out-of-network providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowable Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowable Amount. As a result you are responsible for any charges that exceed the Maximum Allowable Amount.

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

Mental Health and Substance Use Disorder Treatments Expenses Covered Under the PPO Option

The PPO medical plan option limits benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply. The covered mental health and substance use disorder expenses include, but may not be limited to the following:

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

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

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

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

Mental Health and Substance Abuse Treatment Expenses Covered Under the High Deductible Plan Options

The High Deductible medical plan options limit benefits for inpatient and outpatient mental health and substance abuse treatments. Please contact the Claims Administrator for details regarding the limits that apply. The covered mental health and substance abuse expenses include, but may not be limited to the following:

- Alternative levels of care for mental health and substance abuse, as follows:
  - Acute Partial Hospitalization: Treatment that includes daily nursing and active

treatment in a structured treatment program lasting 5-7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and/or weekend.

- Intensive Outpatient Treatment (IOP): A structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least 4 hours of treatment per week.
- Residential Treatment Center (RTC): A medically supervised, psychiatric residential treatment – a level of care that includes individualized and intensive treatment on a 24-hour basis in a residential setting.

- Acute inpatient hospitalization involving treatment that includes 24-hour nursing and daily, active treatment under the direction of a psychiatrist, or for children and adolescents, a board certified/eligible child and adolescent psychiatrist. Charges of a facility and/or professional provider related to or because of psychiatric illness are covered as follows:
  - Inpatient facility charges;
  - Individual Psychotherapy;
  - Group Psychotherapy;
  - Psychological Testing;
  - Family Counseling (counseling with family members to assist in the covered person's diagnosis and treatment);
  - Electro-Convulsive Therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider. (Does not count toward benefit limit; rather is a medical service that may be rendered in conjunction with a mental health diagnosis).
  - Substance abuse detoxification confinements are considered a medical admission and do not count toward otherwise applicable limits indicated for substance abuse rehabilitation.
- Outpatient mental health treatment involving the diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin. Care must be provided by a physician or licensed mental health/chemical dependency provider. Covered services include but are not limited to:
  - Assessment;
  - Diagnosis;
  - Individual, group, family or conjoint psychotherapy;
  - Medication management;
  - Psychological testing and assessment;
  - Electroconvulsive treatment (ECT);
  - Crisis intervention;
  - Rehabilitation (drug and alcohol related).

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

EAP-Work/Life Services

Value Options offers you and your family information, resources and referrals on certain life issues that you may be facing. Issues such as:

- Finding child care
- Depression and anxiety
- Marital and family concerns
- Adopting a child
- Workplace concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and Financial Issues

Value Options' professional staff is available 24 hours a day, seven days a week at **1-800-946-5360**. Counselors will help you define your needs and then carry out an

extensive search for information and services compatible with your family's preferences and finances. Their service is free and confidential.

You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If you need additional legal or financial assistance, your EAP counselor will refer you to an attorney or financial counselor in your community.

Counselors work hard to find resources that fit your budget requirements. However, you are responsible for the cost of the care selected.

Health Savings Account (HSA)

When you enroll in an HDPPO, you may be eligible to establish and contribute to a Health Savings Account ("HSA"). You may not contribute to an HSA if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Internal Revenue Code ("IRC Section 223"). An HSA is a deferred compensation approach to savings. It works a little like a flexible spending account. It lets you save money to use toward eligible health care expenses for either the present or future. Eligible health care expenses are expenses you pay for medical care (as defined in Section 213(d) of the Internal Revenue Code) for you, your spouse or your dependents described in IRC Section 223, to the extent such expenses are not reimbursed by insurance or otherwise.

The HDPPO Options and the HSA are two separate components that work together to save you money. You can contribute to an HSA on a before-tax basis in an amount up to the IRS statutory limit. In addition, provided you enroll in the HDPPO 1 Option and activate your HSA before the end of the calendar year in which you enroll, NiSource may make a monthly contribution to this account.

Other features of an HSA are:

- The money in your account can be used to pay for any eligible health care expenses that you incur such as prescriptions, office visit co-payments, deductibles, etc,
- The money comes out of this account without being taxed, if it is used to pay for eligible health care expenses.
- You can withdraw the money at any time, subject to a 20% penalty and the addition of the withdrawal to your gross income for federal tax purposes.
- You will have an HSA debit card and personal checks to help pay for eligible health care expenses.
- If you do not use the money in your account, you can rollover the balance to the next year.
- In the event of your death, your spouse will receive your HSA account balance, without tax penalty.

Please consult your tax advisor if you have questions about your eligibility to contribute to an HSA or about the tax treatment of HSAs.

For more information about the Health Savings Account, please refer to the **Flexible Benefits Plan** section of this handbook.

Coordination of Benefits (COB)

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

Please Note: If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payer of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

Filing a Claim

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

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

- Complete the appropriate claim form. Claim forms can be obtained from the Claims Administrator by phone via MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website **www.mysourceforhr.com**.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your benefit plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact MySource for Human Resources at **1-888-640-3320**.

Claim Determination and Appeal Process

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage. 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 failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit. Solely with respect to claims involving a determination of your eligibility under the Plan, the term "Claims Administrator" used below shall also refer to the Plan Administrator.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

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

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

circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim improperly, you will receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you then have 45 days to provide any needed information.

Post-Service Claims

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

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

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

Urgent Care Claims

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

You will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim improperly, you will receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

You will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the requested information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

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

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding your request to extend a course of treatment beyond what has been approved.

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

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after

it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

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

Full and Fair Review

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

If the Claims Administrator Denies the Initial Claim or Rescinds Your Coverage

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

- To the extent required by applicable regulations, include information sufficient to identify the claim involved;
- Explain the reasons for the adverse determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

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

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

Mandatory First-Level Internal Appeal to Claims Administrator

If your initial claim is denied in whole or in part or your coverage under the Plan is rescinded (as described above), you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Expedited Review for Urgent Care Claims

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

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

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

If the Claims Administrator Denies Your Claim on Your Mandatory First-Level Internal Appeal

If the Claims Administrator denies your claim on a mandatory first-level internal appeal (a

"final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

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

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

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

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Voluntary Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator denies all or any portion of your pre- or post-service claim on a mandatory first-level internal appeal, you or your duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for a voluntary second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal. You are not required to request a voluntary second-level internal appeal before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to request a voluntary second-level internal appeal will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address set forth below in the section entitled "General Program Information."

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your

written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

If the Claims Administrator Denies Your Claim on Your Voluntary Second-Level Internal Appeal

If the Claims Administrator denies your claim on your voluntary second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

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

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

If the Claims Administrator relied upon medical necessity or experimental treatment

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

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Voluntary External Review by Independent Review Organization

If the Claims Administrator denies all or any portion of your initial claim or your claim on your mandatory first-level internal appeal or voluntary second-level internal appeal, you may be entitled to obtain an independent external review pursuant to federal law. External review is not available in connection with a denial, reduction, termination or failure to provide payment for a benefit based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. Also, with respect to claims for which external review has not been initiated before September 20, 2011, 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). You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

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

If the Claims Administrator denies all or any portion of your initial claim or your claim on your mandatory first-level appeal or voluntary second-level appeal, you or your duly authorized representative may file a request for an external review under federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

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

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

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request

is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

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

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

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

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

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

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

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

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

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

Expedited External Review

If the Claims Administrator denies all or any portion of your initial claim or your claim on your mandatory first-level appeal, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

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

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

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

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

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

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

Limitation of Actions

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

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans.*"

Continuation Coverage for Dependent Students under Michelle's Law

Under a federal law known as "Michelle's Law," eligibility for Plan coverage for your dependent child who was covered under the Plan on the basis of being a full-time student at a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) immediately before the first day of a "medically necessary leave of absence" shall continue until the earlier of

- the date that is one (1) year after the first day of the medically necessary leave of absence, or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

For such right to continued coverage to apply, the Plan must receive timely written certification by your dependent child's treating physician which states that your child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.

Solely for purposes of Michelle's Law, a "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment at such institution, of your dependent child who, immediately before the leave of absence, was covered under the Plan on the basis of being a full-time student at such institution, if such leave of absence or change in enrollment (a) commences while your child is suffering from a serious illness or injury, (b) is medically necessary, and (c) causes your child to lose full-time student status for purposes of coverage under the Plan.

If you have questions about your dependent child's rights to continued Plan coverage under Michelle's Law, contact My Source at **1-888-640-3320.**

Additional Information

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

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

Women's Health and Cancer Rights Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the participating employers, through participant contributions and other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the benefit plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of benefit plan coverage cost will be paid by the participating employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. Benefits will be paid under a benefit plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator For Medical and Mental Health and Substance Use Disorders:	Anthem Insurance Companies, Inc. P.O. Box 37010 Louisville, KY 40233 **www.anthem.com** 1-800-228-2891

Claims Administrator for EAP:	Value Options P.O. Box 1347 Latham, NY 12110-8847 **www.valueoptions.com** 1-800-946-5360
Claims Administrator for Prescription Drug Service:	Walgreens Health Initiatives (PPO) 7357 Greenbriar Pkwy Orlando, FL 32819-8917 **www.walgreenshealth.com** 1-800-999-2655 (mail order) 1-800-749-0009 (mail order refill) The Anthem Prescription Drug Program (HDPP0 1 and HDPPO 2) P.O. Box 746000 Cincinnati, OH 45274-6000 **www.anthem.com** 1-800-228-2891 (mail order) 1-800-228-2891 (customer service)
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571

Service of legal process may be made upon the Plan Administrator.

Dental Plan

Your Dental Plan Options

NiSource Inc. (the "Company") offers the NiSource Dental Plan (the "Plan") to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See *"Highlights of the Dental Plan Coverage"* for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge". You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Allowable Amount, contact the Claims Administrator.

To find a provider in your area, log on to the MySource for Human Resource website at **www.mysourceforhr.com** or call the MySource automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Dental Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Dental Plan, please see subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Dental Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (IN OR OUT OF NETWORK)		DENTAL PLAN (IN OR OUT-OF-NETWORK)		DENTAL PLUS (IN OR OUT OF NETWORK)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	
Orthodontia Lifetime Maximum	No Coverage		No Coverage		Up to $1,500 per person	

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture
  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus

coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  — Porcelain fused to high noble metal

  — Full cast, high noble metal

  — Three-fourths cast, metallic

- Removable Appliances

  — Complete (full) dentures, upper or lower

  — Partial dentures

  — Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)

  — Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)

- Fixed Appliances

  — Bridge pontics - cast high noble metal

  — Bridge pontics - porcelain fused to high noble metal

  — Bridge pontics - resin with high noble metal

  — Retainer crowns - resin with high noble metal

  — Retainer crowns - porcelain fused to high noble metal

  — Retainer crowns - full cast high noble metal

- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the

lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example	
Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*
*Subject to Lifetime Maximum	

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;

- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person's parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by June 15 following the Plan Year in which you incur the expense.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the *"Coordination of Benefits"* section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the MySource for Human Resources website **www.mysourceforhr.com**.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:
  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

Claim Determination and Appeal Process

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage. 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 failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit. Solely with respect to claims involving a determination of your eligibility under the Plan, the term "Claims Administrator" used below shall also refer to the Plan Administrator.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

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

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

If you file a pre-service claim improperly, you will receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you then have 45 days to provide any needed information.

Post-Service Claims

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

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

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

Urgent Care Claims

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

You will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim improperly, you will receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

You will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the requested information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

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

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding your request to extend a course of treatment beyond what has been approved.

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

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

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

to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

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

If the Claims Administrator Denies the Initial Claim or Rescinds Your Coverage

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

- To the extent required by applicable regulations, include information sufficient to identify the claim involved;
- Explain the reasons for the adverse determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

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

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

Mandatory First-Level Internal Appeal to Claims Administrator

If your initial claim is denied in whole or in part or your coverage under the Plan is rescinded (as described above), you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review. If more time or information is needed to make the determination, the Claims Administrator will notify you in writing prior to the expiration of the initial 30-day period of a 15-day extension of this period and will specify any additional information needed to complete its review.

Expedited Review for Urgent Care Claims

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

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

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

If the Claims Administrator Denies Your Claim on Your Mandatory First-Level Internal Appeal

If the Claims Administrator denies your claim on a mandatory first-level internal appeal (a "final adverse benefit determination"), it will

notify you of the following, in a manner to be understood by you:

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

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

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

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Mandatory Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator denies all or any portion of your pre- or post-service claim on a mandatory first-level internal appeal, you or your duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

Your request for review should be sent to the Claims Administrator at the address set forth below in the section entitled "General Program Information."

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

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

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the

individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

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

Pre-Service Claims

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

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review. If more time or information is needed to make the determination, the Claims Administrator will notify you in writing prior to the expiration of the initial 30-day period of a 15-day extension of this period and will specify any additional information needed to complete its review.

If the Claims Administrator Denies Your Claim on Your Mandatory Second-Level Internal Appeal

If the Claims Administrator denies your claim on your voluntary second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

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

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

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

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Voluntary External Review by Independent Review Organization

If the Claims Administrator denies all or any portion of your initial claim or your claim on your mandatory first-level internal appeal or your mandatory second-level internal appeal, you may be entitled to obtain an independent external review. External review is not available in connection with a denial, reduction, termination or failure to provide payment for a benefit based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. Also, with respect to claims for which external review has not been initiated before September 20, 2011, 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). You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

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

If the Claims Administrator denies all or any portion of your initial claim or your claim on your mandatory second-level appeal, you or your duly authorized representative may file a request for an external review within four months of the date you received notice of such adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

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

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

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

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

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

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

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

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

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

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

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator denies all or any portion of your initial claim or your claim on your mandatory first-level appeal, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

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

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

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

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

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

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

Limitation of Actions

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

Continuation of Coverage

For information regarding continuation of coverage under the Dental Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans.*"

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of participating employers, through participant contributions and other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the benefit plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of benefit plan coverage cost will be paid by the participating employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the benefit plan and the Claims Administrator. Benefits will be paid under a benefit plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 **www.cigna.com**
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571

Service of legal process may be made upon the Plan Administrator.

Vision Plan

Your Vision Plan Options

NiSource Inc. (the "Company") offers the NiSource Vision Plan (the "Plan") to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan.*

The Plan utilizes a network of VSP doctors. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP network doctor or a non-VSP provider. However, if you go to a VSP network provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Network Doctor** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care and eyewear from a VSP network provider, you are responsible for the amount in excess of the Plan's allowance, or the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the network. If you do, you must pay the provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a doctor who participates in the VSP Network, log on to the MySource for Human Resources website at **www.mysourceforhr.com** or call MySource at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources at **1-888-640-3320** or log on to the MySource for Human Resources website at **www.mysourceforhr.com**.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	FREQUENCY	VSP NETWORK PROVIDER	NON-VSP PROVIDER
Exam			
	Once every calendar year	100%	Up to a $35 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $25 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $40 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $55 allowance
Lenticular	Once every calendar year	100%	Up to a $80 allowance
Frame			
	One every two consecutive calendar years	100%, Up to a $180 frame allowance	Up to a $45 allowance
Contacts			
Visually necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $150 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts and contact lens exam (fitting and evaluation). The contact lens exam is in addition to your vision exam to ensure proper fit of contacts.

Basic Vision Option

COVERED SERVICES	FREQUENCY	VSP NETWORK PROVIDER	NON-VSP PROVIDER
Exam			
	Once every calendar year	100%	Up to a $35 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the *"Highlights of Your Vision Plan Coverage."*

The services and materials that the Plan covers include, but are not limited to, the following:

- One vision exam in every calendar year.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame, one pair in every two consecutive calendar year period (up to the frame allowance).
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the cost of your eye exam, contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of lenses.

Extra Discounts and Savings

When visiting a VSP network provider, you may receive:

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives;
- 20% off additional prescription glasses and sunglasses;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent children;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee. Visit the Claims Administrator's website at **www.vsp.com** or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

Vision Expenses Not Covered

The Plan pays benefits for many vision care services and eyewear. However, some limits and exclusions do apply. If you want to know if a service or eyewear will be covered under the Plan, or if you have questions regarding your coverage, please ask your VSP provider or call the Claims Administrator.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the covered member will pay the additional costs for the options.

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Progressive multifocal lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care.

Not Covered

There are no benefits for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses;
- Two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under the Plan that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- Services and/or eyewear not indicated as covered Plan benefits.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care services (i.e., any amounts that exceed the Plan's specified allowances). You must incur eligible expenses no later than March 15 following the end of the Plan Year and submit them to the Health Care Flexible Spending Account no later than June 15 following the end of the Plan Year. Please see the "Flexible Benefits Plan" section of this handbook for additional details about the Health Care Flexible Spending Account.

Coordination of Benefits (COB)

If you or your dependents have vision coverage under another plan, the primary plan is the one under which you are covered as an employee. Eligible dependent children *receive primary coverage under their* father's plan.

If your secondary plan pays the out-of-pocket expenses you incur under your primary plan, the following rules apply:

- The deductible (if any) under the secondary plan is waived;
- Payment under the secondary plan is made directly to you (according to the secondary plan's non-network provider schedule); and
- Any payment made toward a service or material that is covered under the secondary plan exhausts the secondary plan's coverage for that service for the entire benefit period.

If the primary plan already pays for a service or eyewear within the allowed period and you use a VSP network provider (in-network) under the secondary plan for that same service, the service is provided based on the secondary plan's preferred care provider schedule. In this case, deductible amounts (if any) toward that service apply under the secondary plan.

If you have primary coverage under another carrier, the Plan provides secondary coverage based on the coordination of benefits rules outlined in the *"Coordination of Benefits"* section of the **Benefits Program Overview**.

If you do not use the secondary plan to recover out-of-pocket expenses incurred under the primary plan, you can use the secondary plan for another claim (provided such services have been exhausted under the primary plan).

How to Access the Vision Benefits

Selecting a VSP Network Provider

- Log on to the MySource for Human Resources website at **www.mysourceforhr.com** to find the link to VSP's website that houses the most up-to-date list of VSP network providers; or call MySource for Human Resources at **1-888-640-3320** to locate a VSP network provider near you. Call the VSP network provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a claim form. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete your portion of the claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the MySource for Human Resources website **www.mysourceforhr.com** and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bill should include:
  - Name of patient;
  - Patient's relationship to you;
  - Patient's date of birth;
  - Name and Social Security number of employee;
  - Provider's bill; and
  - Copy of your itemized paid receipt (you can forward this to the Claims Administrator without a completed claim form as long as you include your name and social security number, the patient's name and relationship to you, and the patient's date of birth).

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Be sure to submit your completed claim to the Claims Administrator within six months of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP network provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

Claim Determination and Appeal Process

The Claims Administrator may establish a claim denial and appeal process. In the event the Claims Administrator does not do so, or if such process fails to comply with applicable law, the procedures set forth below will apply.

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

The Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide

payment for a benefit. Solely with respect to claims involving a determination of your eligibility under the Plan, the term "Claims Administrator" used below shall also refer to the Plan Administrator.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

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

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

If you file a "pre-service claim" improperly, you will receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you then have 45 days to provide any needed information.

Post-Service Claims

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

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

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

Urgent Care Claims

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

You will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow–up with a written or electronic confirmation within three days.

If you file an urgent care claim improperly, you will receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information. You will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the requested information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

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

Concurrent Care Claims

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

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

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

If the Claims Administrator Denies the Initial Claim

If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse 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 *will be provided free of charge to you, or you* will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

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

Appeal to Claims Administrator

If your initial claim is denied in whole or in part (as described above), you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

Your request for review should be sent to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

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

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

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

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

Pre-Service Claims

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

Post-Service Claims

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

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Denies Your Claim on Appeal

If the Claims Administrator denies your claim on appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to 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 will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

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

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second Appeal to the Claims Administrator for Pre-and Post-Service Claims

If the Claims Administrator denies all or any portion of your pre- or post-service claim on appeal, you or your 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 your receipt of the Claims Administrator's notice of claim denial.

Your request for review should be sent to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

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

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

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

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

Pre-Service Claims

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

Post-Service Claims

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

If the Claims Administrator Denies Your Claim on Appeal

If the Claims Administrator denies your claim on appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the *adverse determination;*
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to 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 will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

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

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Continuation of Coverage

For information regarding continuation of *coverage under the Plan, including COBRA* continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans.*"

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Inc. Vision Plan (a component of the NiSource Welfare Benefits Program
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the benefit plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of benefit plan coverage cost will be paid by the participating employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 **www.vsp.com**
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 997105 Sacramento, CA 95899-7105
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571

Service of legal process may be made upon the Plan Administrator.

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

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

Flexible Benefits Plan

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible regular full-time employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the FSA accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $5,000 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Internal Revenue Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

You can elect to participate in the FSA Plan provided you are a regular full-time employee and your collective bargaining agreement provides for your eligibility in the FSA Plan.

For purposes of the Dependent Care FSA, eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home;
- Other dependents of any age who are incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-

law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section of the FSA Plan, you can participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" section and the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA FEATURES	ELIGIBLE DEPENDENTS	ELIGIBLE EXPENSES
Health Care		
Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, copayments and coinsurance amounts. The expense must be considered a "Medical Expense" as defined in the Internal Revenue Code. A non-exhaustive list of eligible expenses can be found later in this section.
Dependent Care		
Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home. • Your dependents of any age who are incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). A non-exhaustive list of eligible expenses can be found later in this section.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or copayment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;
  - Services for chromosome or fertility studies;
  - Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
  - Services related to sexual dysfunctions or inadequacies;
  - Ace bandages, support hose, or other pressure garments prescribed by a physician;
  - Charges for medical expenses in excess of reasonable and customary expenses;
  - Acupuncture for pain relief as performed by a licensed practitioner;
  - Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
  - Insulin;
  - Orthodontic services not covered by a health care plan;
  - Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
  - Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
  - Hypnosis for treatment of an illness;
  - "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
  - Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
  - Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
  - Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
  - Special car controls for the handicapped; and
  - Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- *Over the counter medications (other than* insulin) obtained without a prescription;
- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform *physical housework);*
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;
- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health-related expenses until December 31. If you do not incur enough expenses to use all of the funds in your Health Care FSA by the end of the year, you may use an additional "grace period" (from January 1 until March 15) to incur expenses for the previous year's balance. You then have until June 15 to submit claims for expenses you incur between January 1 and December 31 plus the grace period.

Example: To show how you might use your Health Care FSA, assume that you elect to put $1,200 in your Health Care FSA for 2011. By December 31 you have incurred only $1,000 in eligible expenses. You have until March 15, 2012 (the end of the grace period) to incur *additional expenses, and must submit all* claims for your 2011 Health Care FSA by June 15, 2012.

Any health care expense incurred after March 15 will not be considered eligible for reimbursement from the prior year's funding. In addition, all expenses incurred between the previous January 1 and December 31 or during the grace period that follows must be submitted for payment no later than June 15.

Please note: *If you maintain a Health Care FSA during the current Plan Year and you want to participate in a high deductible health plan and contribute to a health savings account (HSA) during the next Plan Year, you must reduce the balance in your Health Care FSA (determined on a cash basis) to zero on or before December 31 of the current Plan Year. Pending claims, claims submitted, claims received, or claims under review that have not been paid as of December 31 are not taken into account in determining whether your Health Care FSA has a zero balance. If you fail to reduce the balance in your Health Care FSA to zero on or before December 31 of the current Plan Year, you may not contribute to an HSA until April 1 of the following year.*

Reimbursement Claims

A form can be obtained online via the MySource for Human Resources website **www.mysourceforhr.com**, or call the Claims Administrator via the MySource for Human Resources toll-free number **1-888-640-3320** to request a form.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may not use your debit card to obtain reimbursement for over the counter medications, even if you have a prescription for such medications.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be

substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or

— You and your spouse are not working (such as weekend or evening babysitting fees);

- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

To obtain reimbursement for an expense, complete and submit a dependent care reimbursement form. A form can be obtained online via the MySource for Human Resources website **www.mysourceforhr.com**, or by calling the Claims Administrator via the MySource for Human Resources toll-free number **1-888-640-3320** to request a form.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

The deadlines for your Health Care FSA and Dependent Care FSA are different.

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until June 15 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31), plus the grace period (January 1 through March 15 of the following year). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after June 15 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until April 1 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). **The "grace period" does not apply to the Dependent Care FSA.** Expenses are

considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after April 1 will be forfeited.

Claim Determination and Appeal Process for the Health Care FSA

The type of claim that is made determines the time frame under which the Claims Administrator makes a determination regarding a claim. The Company delegates the authority to decide claims and appeals under the Health Care FSA to the Claims Administrator. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

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

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

If you file a pre-service claim improperly, you will receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you will then have a designated amount of time (at least 45 days) to provide any needed information.

Post-Service Claims

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

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

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you will then have a designated amount of time (at least 45 days) to provide any needed information.

Urgent Care Claims

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

You will receive a notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim improperly, you will receive a notice of the improper filing and how to correct it within 24 hours

after the Claims Administrator receives your urgent care claim. Once you receive this notice, you will then have 48 hours to provide the requested information.

You will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the requested information; or
- The end of the period that you have to provide the specified additional information.

Concurrent Care Claims

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

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

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

If the Claims Administrator Denies the Initial Claim

If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse 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 will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

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

Appeal to Claims Administrator

If your initial claim is denied in whole or in part (as described above), you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

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

Your written request should state why you think your claim should not have been denied. Your request must include the name

of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

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

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

Pre-Service Claims

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

Post-Service Claims

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

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Denies Your Claim on Appeal

If the Claims Administrator denies your claim on appeal, it will provide the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to 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 will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the

determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your pre- or post-service claim on appeal, you or your 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 your receipt of the Claims Administrator's notice of claim denial.

Your request for review should be sent to:

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

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

If the Plan Administrator Denies Your Claim on Appeal

If the Plan Administrator denies your claim on appeal, it will provide the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to 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 will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.
- If the 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 your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

If, after completing all the steps of the claims procedure process, you decide to take legal action, you must do so within three years of the day the charge or claim is incurred.

Claim Determination and Appeal Process for the Dependent Care FSA

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to

120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

If, after completing all the steps of the claims procedure process, you decide to take legal action, you must do so within three years of the day the charge or claim is incurred.

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled *"Continuation of Coverage under the Medical, Dental, Vision and FSA Plans."*

Additional Information

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

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

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Aon Hewitt. The participating employers have no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other eligible health care expenses not covered by the plans. Eligible health care expenses are expenses you pay for medical care (as defined in Section 213(d) of the Internal Revenue Code) for you, your spouse or dependents (as defined in Section 223 of the Internal Revenue Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1, your Employer may make a monthly contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA each year is governed by federal law. Please call MySource for Human Resources at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current eligible health care expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for eligible health care expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for most retiree medical insurance or other eligible health care expenses on a tax-free basis, or you can take a distribution, subject to income tax.

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax purposes. Please consult your tax advisor for more information.*

Eligibility

You can elect to contribute to an HSA if you are a regular full-time employee who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Internal Revenue Code.

Please note: *You may not contribute to the HSA and the Health Care FSA at the same time.*

Enrollment

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.

- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

Please note: *If you had a Health Care FSA (or any other health flexible spending account with a grace period feature) during the previous Plan Year and the balance in your account was not reduced to zero by December 31 of that Plan Year, you may not contribute to an HSA until April 1 of the following year.*

When Coverage Begins and Ends

Coverage Begins

You may enroll in the Health Savings Account (HSA) at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Internal Revenue Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay tax on the account distribution as well as a 20% penalty. If a distribution is made after age 65, after disability, or after death, the distribution will be subject to tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at **www.irs.gov**.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, Aon Hewitt will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by Aon Hewitt. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Please note: *You may not use your HSA debit card to pay for over-the-counter medications, even though you may have a prescription for such medications.*

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit MySource for Human Resources website **www.mysourceforhr.com** or call MySource for Human Resources at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the benefit plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the benefit plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Aon Hewitt, who administers the HSAs. Benefits will be paid under a benefit plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Aon Hewitt 2300 Discovery Drive Orlando, FL 32826 **www.mysourceforhr.com**

Claims Administrator for Health Savings Accounts:	Aon Hewitt 2300 Discovery Drive Orlando, FL 32826 **www.mysourceforhr.com**
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571

Service of legal process may be made upon the Plan Administrator.

Long-Term Disability Plan

Your Long-Term Disability Options

NiSource Inc. (the "Company") offers the NiSource Long-Term Disability Plan (the "Plan") to eligible employees with the following coverage options:

- Basic LTD Coverage Option; and
- Supplemental LTD Coverage Option.

Benefits are provided under a group insurance contract (the "Group Contract") and a group insurance certificate (the "Group Insurance Certificate") issued by The Prudential Insurance Company of America ("Prudential"), who is the Claims Administrator and is wholly responsible for the payment of benefits.

You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description. *You may obtain a copy of the Group Insurance Certificate by contacting MySource for Human Resources at* ***1-888-640-3320****.*

The Plan provides financial protection for you by paying a portion of your income while you have a long period of disability. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits start after the elimination period. The elimination period is the period of continuous disability that must be satisfied before you are eligible to receive benefits and is the later of (i) 180 days or (ii) the date that you are absent from work for 1040 hours due to your disability.

If you are determined to be disabled, the Basic LTD Coverage Option provides monthly benefits of the lesser of (i) 50% of your monthly earnings, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $8,333.00.

If you are determined to be disabled, the Supplemental LTD Coverage Option provides monthly benefits of the lesser of (i) 60% of your monthly earnings, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $10,000.00. You pay a portion of the cost of the Supplemental LTD Coverage Option.

Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under the Plan. Refer to the Group Insurance Certificate for further details.

See *"Highlights of the Long-Term Disability Plan Coverage"* below for examples illustrating the payment of monthly benefits.

Eligibility

You are eligible to participate in the Plan if you are a regular full-time employee of a participating employer who regularly works 40 or more hours per week. Your eligibility for optional, contributory coverage may be subject to your providing evidence of insurability and satisfying other requirements established by Prudential. Refer to the Group Insurance Certificate for more details.

Information regarding eligibility can be accessed through the MySource website at **www.mysourceforhr.com** or by calling the MySource automated telephone system at **1-888-640-3320** to speak to a service representative.

Enrollment

Provided eligibility requirements are met, as described in the *"Eligibility"* section immediately above, you will be automatically enrolled in the Basic LTD Coverage Option, unless you choose to enroll in the Supplemental LTD Coverage Option. Newly eligible employees must enroll in the Supplemental LTD Coverage Option within 31 days of their date of hire or, if later, the date they first become eligible for coverage. If you fail to enroll, you will automatically be covered under the Basic LTD Coverage Option. In general, once you enroll in (or decline) the Supplemental LTD Coverage Option, your elections stay in effect for the entire Plan

Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the *"Enrollment"* and the *"Changing and Continuing Elections"* section of the **Benefits Program Overview** for further details.)

Contributions

The Basic LTD Coverage Option is provided at no cost to you. If you elect the Supplemental LTD Coverage Option, you and your employer will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. *If you have questions regarding the amount of your required contributions, please contact MySource for Human Resources at* ***1-888-640-3320****.*

When Coverage Begins and Ends

Coverage Begins

Coverage under the Basic LTD Coverage Option of the Plan generally may become effective on (1) your first day of active employment, for regular new hires, (2) the day you become a member of a class eligible for coverage under the Plan, (3) the first day of the following Plan Year, for eligible employees who choose not to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period, or (4) the date the Plan approves such enrollment, for employees who disenroll from the Supplemental LTD Coverage Option due to a qualified life event.

Coverage under the Supplemental LTD Coverage Option generally may become effective on the later of (1) your first day of active employment for regular new hires, if you apply within 31 days of such date, (2) the first day of the following Plan Year, for eligible employees who choose to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period, (3) the date the Plan approves such enrollment due to a qualified life event, or (4) the date Prudential approves your application, if evidence of insurability is required.

Evidence of insurability is required if you (1) apply for coverage more than 31 days after the date you are first eligible for coverage, (2) voluntarily canceled your coverage and are reapplying, (3) apply after any of your coverage ended because you did not pay a required contribution, or (4) have not met a previous evidence requirement to become insured under any plan a participating employer has with Prudential.

Notwithstanding the foregoing, all employees must be in active employment in order for any coverage initially to become effective and for any subsequent Plan changes to take effect.

Coverage Ends

The coverage will end on the date you lose eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the Group Contract is canceled;
- The date that the Plan is amended to terminate your coverage;
- The date you terminate employment or are no longer eligible for coverage under the Plan;
- The date you are no longer in active employment due to a disability that is not covered under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy or any applicable collective bargaining agreement;
- The last date for which any required contribution was made; or
- The date you are no longer in active employment, except as provided below and except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 ("FMLA").

If you are on a temporary layoff or are working reduced hours for reasons other than disability and the premium is paid, you will be covered to the end of the month following the month in which your temporary layoff or reduced hours begin. If you are on a leave of absence and the premium is paid, you will be covered to the end of the month in which your leave begins. Neither temporary layoff nor leave of absence includes normal vacation time or any period of disability or absence in connection with any severance or termination agreement. Your FMLA leave also is not considered a temporary layoff.

Highlights of the Long-Term Disability Plan Coverage

The following charts provide examples illustrating how the Plan pays benefits if a participant becomes disabled and is unable to work and when a participant becomes disabled, but continues working. The following are provided for illustrative purposes only and shall be construed in manner consistent with the terms of the Group Contract and your Group Insurance Certificate. In the event of a conflict between the following and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

If you are Disabled and Not Working

To show how your Monthly Benefit is calculated, let's assume that your monthly pre-disability earnings ("Monthly Earnings") equal $3,000, and that you qualify for a monthly Social Security Disability Benefit of $500. Here is how the Plan calculates your Monthly Benefit under both coverage options.

If you have the Basic LTD Coverage Option, your monthly payment is the lesser of:

- 50% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $8,333.00 per month.

If you have elected the Supplemental LTD Coverage Option, your monthly payment is the lesser of:

- 60% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $10,000.00 per month

For example:

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Monthly Earnings*	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (Monthly Earnings times Percentage of Coverage) (A x B)	$1,500	$1,800
D	70% of your Monthly Earnings Less Deductible Sources of Income	$2,100 - 500 $1,600	$2,100 - 500 $1,600
E	**Monthly Benefit**** (Lesser of C or D)	**$1,500**	**$1,600**

**Your Monthly Earnings are indexed as provided in the Group Insurance Certificate.*

***The minimum monthly payment is the greater of (a) $100 or (b) 10% of your Gross Disability Payment. Prudential may apply this amount toward an outstanding overpayment.*

If You Are Disabled and Working

If your monthly disability earnings ("Disability Earnings") are less than 20% of your indexed monthly earnings ("Indexed Monthly Earnings"), your LTD benefit is the same as it would be if you were not working.

If your Disability Earnings are greater than 80% of your Indexed Monthly Earnings, no benefit is payable to you. If benefits have already commenced, Prudential will stop sending you payments and your claim will end.

If you are disabled and your monthly Disability earnings are at least 20%, but not more than 80%, of your Indexed Monthly Earnings, due to the same sickness or injury, Prudential will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as Disability Earnings plus the gross disability payment does not exceed 100% of Indexed Monthly Earnings.

1. Add your monthly Disability Earnings to your gross disability payment.
2. Compare the answer in item 1 to your Indexed Monthly Earnings.

If the answer from item 1 is less than or equal to 100% of your Indexed Monthly Earnings, Prudential will not further reduce your monthly payment.

If the answer from item 1 is more than 100% of your Indexed Monthly Earnings, Prudential will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your Disability.

1. Subtract your Disability Earnings from your Indexed Monthly Earnings.
2. Divide the answer in item 1 by your Indexed Monthly Earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

The following examples show how your Monthly Benefit is calculated if you are working while you are disabled and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings.

First 12 months

To show how your Monthly Benefits are calculated during the first 12 months you are disabled and working and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings, assume that your Indexed Monthly Earnings are $3,000. Assume further that your Disability Earnings are $1,000, and that you are not receiving any other deductible sources of income. Here is how the Plan calculates your benefits under both coverage options:

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Indexed Monthly Earnings	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (Monthly Earnings times Percentage of Coverage) (A x B)	$1,500	$1,800
D	Monthly Payment (Gross Disability Payment minus Deductible Sources of Income, if any)*	$1,500 - 0 $1,500	$1,800 - 0 $1,800
E	Add Disability Earnings and Gross Disability Payment to determine if the sum exceeds Indexed Monthly Earnings	$1,000 +1,500 $2,500 (does not exceed $3,000)	$1,000 +1,800 $2,800 (does not exceed $3,000)
F	Subtract the amount that Disability Earnings plus the Gross Disability Payment exceeds Monthly Earnings (E - A, if > 0) from the Monthly Payment in D to determine the Monthly Benefit	$1,500 - 0 $1,500	$1,800 - 0 $1,800
G	**Monthly Benefit**	**$1,500**	**$1,600**

**Deductible sources of income are subtracted only if the Percentage of Coverage is 70%*

After First 12 months

To show how your Monthly Benefit is calculated after the first 12 months you are disabled and working and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings, assume that your Indexed Monthly Earnings are $3,000 and your Disability Earnings are $2,000. Assume also that you do not qualify for Social Security Disability Benefits. Here is how the Plan calculates your Monthly Benefit under both coverage options.

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Indexed Monthly Earnings	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (A x B)	$1,500	$1,800
D	Your Indexed Monthly Earnings less your Disability Earnings	$3,000 - 2,000 $1,000	$3,000 - 2,000 $1,000
E	Lost earnings percentage calculation	$1,000 = .33 $3,000	$1,000 = .33 $3,000
F	Gross Disability Payment less any Deductible Sources of Income*	$1,500 - 0 $1,500	$1,800 - 0 $1,800
G	**Monthly Benefit *(E x F)***	**33% x $1,500 = $500**	**33% x $1,800 = $600**

**Deductible sources of income are subtracted only if the Percentage of Coverage is 70%*

Definition of "Disability"

You are "disabled" when Prudential determines that:

- you are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury;
- you have a 20% or more loss in your indexed monthly earnings due to that sickness or injury; and
- you are under the regular care of a doctor.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received by Prudential within 30 days of its request.

Prudential may require you to be examined by doctors, other medical practitioners or vocational experts of its choice. It will pay for these examinations. Prudential can require examinations as often as it is reasonable to do so. It may also require you to be interviewed by an authorized Prudential Representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Additional Definitions

Active employment means you are classified as working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least 40 hours per week. Your worksite must be: your Employer's usual place of business; an alternate worksite at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or a location to which your job requires you to travel. Normal vacation is considered active employment. Individuals who are on layoff or leave of absence or whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Deductible sources of income means income from deductible sources listed in the Group Insurance Certificate that you receive or are entitled to receive while you are disabled. This income may be subtracted from your gross disability payment. Examples of deductible sources of income include but are not limited to (a) amounts you receive or are entitled to receive as (i) loss of time benefits under a workers' compensation law, an occupational disease law or any other act or law with similar intent; (ii) loss of time disability income payments under any state compulsory benefit act or law, any insurance, health or welfare plan or other group insurance plan where the Employer, directly or indirectly, has paid all or part of the cost or made payroll deductions, or any governmental retirement system as a result of your job with your Employer, or (iii) any loss of time disability payments under the United States Social Security Act or any similar plan or act, (b) any retirement payments you receive under the United States Social Security Act or any similar plan or act, or (c) amounts you receive as disability payments, that you voluntarily elect to receive as retirement or early retirement payments, or that you receive as retirement payments when you reach normal retirement age, under your Employer's retirement plan. Refer to the Group Insurance Certificate for a complete list of these sources.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations: (i) during the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation, that is reasonably available; and (ii) beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience. Salary continuance will not be included as disability earnings since it is not payment for work performed.

Gainful occupation means an occupation, including self employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 50% of your monthly earnings, if you are not working. However, if you enrolled for the Supplemental LTD Coverage Option, it means an occupation, including self employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 60% of your monthly earnings, if you are not working.

Gross disability payment means the benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1, provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Injury means a bodily injury that is the direct result of an accident, that is not related to any other cause, and that results in immediate disability. Disability must begin while you are covered under the Plan.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week,

Prudential will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Monthly earnings includes your total annual income before taxes divided by 12. It is determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your employer. Commissions will be averaged for the lesser of: (a) the 24 full calendar month period of your employment with your participating employer just prior to the date disability begins; or (b) the period of actual employment with your employer.

Regular occupation means the occupation you are routinely performing when your disability occurs. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the Plan.

Maximum Period of Payments

The longest period of time the Plan will make payments to you for any one period of disability (your "maximum period of payment") is as follows:

YOUR AGE ON DATE DISABILITY BEGINS	YOUR MAXIMUM PERIOD OF PAYMENT
Less than 60	To age 65
Age 60 and over	60 months

Your maximum period of payment will end on the earliest of the following:

- During the first 24 months of payments, when you are able to work in your regular occupation on a "part-time basis" but you choose not to; after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to. "Part-time basis" means the ability to work and earn 20% or more of your indexed monthly earnings.
- The end of the maximum period of payment.
- The date you are no longer disabled under the terms of the Plan.
- The date you fail to submit proof of continuing disability satisfactory to Prudential.
- The date your disability earnings exceed the amount allowable under the Plan.
- The date you retire.
- The date you die.
- The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by your doctor.

Notwithstanding the above, disabilities due to a sickness or injury which, as determined by Prudential, are primarily based on self-reported symptoms have a limited pay period during your lifetime. "Self-reported symptoms" means the manifestations of your condition, which you tell your doctor, that are not verifiable using tests, procedures and clinical examinations standardly accepted in the practice of medicine. Examples include, without limitation, headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Also, disabilities which, as determined by Prudential, are due in whole or part to mental illness also have a limited pay period during your lifetime. "Mental illness" means a psychiatric or psychological condition regardless of cause and includes, without limitation, schizophrenia, depression, manic depressive, or bipolar illness, anxiety, somatization, substance related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods

of treatment as standardly accepted in the practice of medicine.

The limited pay period for self-reported symptoms and mental illness combined is 24 months during your lifetime. There are exceptions to the limited pay period rules. Refer to the Group Insurance Certificate for a detailed explanation of these exceptions.

Recurrent Disabilities

If you have a "recurrent disability," as determined by Prudential, your disability will be treated as part of your prior claim and you will not have to complete another elimination period if (a) you were continuously insured under the Plan for the period between your prior claim and your current disability; and (b) your recurrent disability occurs within 180 days of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the Plan as your prior claim. Any disability which occurs after 180 days from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the Plan provisions.

If you become covered under any other group long term disability plan, you will not be eligible for payments under the Plan.

A "recurrent disability" is a disability that is (a) caused by a worsening in your condition; and (b) due to the same cause(s) as your prior disability for which the Plan made a Long Term Disability payment.

Exclusions from Coverage

The Plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot; or
- commission of a crime for which you have been convicted under state or federal law.

The Plan does not cover a disability which is due to a pre-existing condition.

The plan does not cover a disability due to war, declared or undeclared, or any act of war.

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available; and
- Your disability begins within 12 months of the date your coverage under the Plan becomes effective.

Pre-existing conditions may also affect an increase in your benefits due to an amendment of the Plan or your enrollment in another Plan option. *For further details, refer to the Group Insurance Certificate. You may obtain a copy of the Group Insurance Certificate by contacting MySource for Human Resources at* ***1-888-640-3320****.*

Survivor Benefits

When Prudential receives proof that you have died, it will pay your spouse, if living; otherwise, your children under age 25 (your "eligible survivors"), a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. However, Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

Other Services Provided Under the Plan

As part of your coverage under the Plan, Prudential also provides certain benefits in the nature of a Social Security Claimant Assistance Program, a Rehabilitation Program and a program of reimbursing employers for the cost of certain worksite modifications that are identified by your employer and Prudential as being likely to help you remain at work or return to work. Refer to the Group Insurance Certificate for further details regarding these programs. With respect to

the Rehabilitation Program, if at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease paying your monthly benefit.

Filing A Claim

General

Written notice of a claim should be sent to Prudential within 30 days after the date your disability begins. However, you must send Prudential written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity. You must notify us immediately when you return to work in any capacity.

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

How to File Claims

You and your employer must fill out your own section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and send it directly to Prudential.

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a doctor.
- Appropriate documentation of your monthly earnings.
- The date your disability began.
- Appropriate documentation of the disabling disorder.
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation.
- The name and address of any hospital or institution where you received treatment, including all attending doctors.
- The name and address of any doctor you have seen.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by Prudential.

In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by Prudential. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.

Recovery of Overpayments

Prudential has the right to recover any overpayments due to fraud, any error it makes in processing a claim, and your receipt of deductible sources of income.

Claim Determination and Appeal Process

Consideration of Initial Claim

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of

time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the denial,
- references to the specific plan provisions on which the benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
- a description of the Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and
- if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

First Appeal to the Claims Administrator

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

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

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to and additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- the specific reason(s) for the adverse determination,
- references to the specific plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- a description of Prudential's review procedures and applicable time limits,
- a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA after completion of the appeals 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 you free of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request

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

Second Appeal to the Claims Administrator

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under the Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to the claimant within the time frames mentioned above, the claim shall be deemed denied upon appeal.

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

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

If, after completing all the steps of the appeals process, you decide to take legal action, you must do so within three years of the day proof of claim is required, unless otherwise provided under federal law.

Continuation of Other Coverages

Certain coverages provided to you under the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program

continue while you are Disabled and receiving Plan benefits, provided your employer under its personnel policies continues to treat you as an employee. Any contributions that you are required to make toward the cost of these coverages will be billed to you. For further information regarding the billing arrangement, contact MySource for Human Resources.

Medical, Prescription Drug, Vision and Dental

Medical, vision and dental coverages for you and your eligible dependents continue while you are receiving Plan benefits, provided your employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Life and AD&D

Life and AD&D coverages for you and your eligible dependents continue while you are receiving Plan benefits, provided your employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Flexible Spending Accounts (FSAs)

Health Care Flexible Spending Account

You cannot continue to make contributions to the Health Care FSA while you are receiving Plan benefits. You may use the existing balance in your account to pay for any eligible expense that you incurred prior to the commencement of your Plan benefits. If you return to work, your original contribution election is amortized over the remaining pay periods for the calendar year.

Dependent Care Flexible Spending Account

You cannot continue to make contributions to the Dependent Care FSA while you are receiving Plan benefits. You may use the existing balance in your account to pay for any eligible expense that you incurred prior to the commencement of your Plan benefits.

HSAs

While you are receiving Plan benefits, you are not entitled to receive any employer contributions to an HSA, nor may you contribute to an HSA by means of payroll deduction.

Retirement Plans

While you are receiving Plan benefits, you may continue to earn service under your retirement plans. However, your contributions to the Savings Plan automatically stop. You are eligible to receive the value of your Savings Plan Account due to your disability. Refer to the Savings Plan and your other retirement plans for further information.

Other Programs

The Adoption Assistance and the Tuition Reimbursement Programs are not available to you while you are receiving Plan benefits.

Important Information For Residents Of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and in this summary plan description. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this summary plan description. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 93191.

*If you are unable to access this website, and if you want to receive a printed copy of these requirements or have any questions, call Prudential at **1-866-439-9026**.*

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Long-Term Disability Plan (a component of NiSource Welfare Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing disability benefits
Plan Number:	537
Contribution Source:	Basic LTD Coverage: Employer Supplemental LTD Coverage: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	The Prudential Insurance Company of America 51 Broad Street Newark, New Jersey 07102
Claims Administrator: (if you need to submit a claim)	The Prudential Insurance Company of America Prudential Disability Management Services P.O. Box 13480 Philadelphia, PA 19176
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571

Service of legal process may be made upon the Plan Administrator.

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. ***In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail***. The Group Insurance Certificate is available upon request by calling the MySource automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

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

Life Insurance Plan

Your Life Insurance and AD&D Options

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan (the "Plan") to eligible employees with the following coverage options (each a "Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Optional Employee Term Life Coverage Option;
- Dependents Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;
- Optional Employee AD&D Coverage Option; and
- Optional Dependents AD&D Coverage Option

Benefits are provided under a group insurance contract (the "Group Contract") and a group insurance certificate (the "Group Insurance Certificate") issued by The Prudential Insurance Company of America ("Prudential"), who is the Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting MySource for Human Resources at **1-888-640-3320**.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance") and, if elected, on the person of your "qualified dependents" ("Dependents Insurance"). See the individual sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

Employees

You are eligible to participate in the Plan if you are regular full-time employee of Columbia Energy Group who regularly works 40 or more hours per week and who is covered by a collective bargaining agreement between Columbia Energy Group and a union. Your eligibility for optional, contributory coverage may be subject to your providing evidence of insurability and satisfying other requirements established by Prudential. Refer to the Group Insurance Certificate for further details.

Qualified Dependents

If you are eligible to participate in the Plan, you may obtain certain coverage for your "qualified dependents." Your "qualified dependents" are:

- Your spouse; and
- Your unmarried children from live birth to the end of the month in which the unmarried child attains age 26; and

Your children include: (1) your legally adopted children and children placed with you for adoption prior to legal adoption; and (2) each of your stepchildren, foster children, children subject to legal guardianship, grandchildren, and other blood relatives who depends on you for more than fifty percent of the child's support and maintenance. A child placed with you for adoption prior to legal adoption is considered your qualified dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

Notwithstanding the foregoing,

1. Your spouse is not your "qualified dependent" while on active duty in the armed forces of any country; and
2. Your child is not your "qualified dependent" while (a) on active duty in the armed forces of any country; or (b) insured under any Employee Term Life Coverage.

A child will not be considered the "qualified dependent" of more than one employee. If this would otherwise be the case, the child will be considered the "qualified dependent" of the employee named in a written agreement of all such employees filed with the Company. If there is no written agreement, the child will be considered the "qualified dependent" of:

1. the employee who became insured under the Plan with respect to the child while the child was a "qualified dependent" of only that employee; and otherwise
2. the employee who has the longest continuous service with a participating employer, based on the Company's records.

Please Note: It is your responsibility to advise MySource when a person is no longer eligible for coverage as a qualified dependent under the Plan. Any amounts paid on behalf of a person who is no longer a qualified dependent will be required to be repaid to the Plan.

Information regarding eligibility can be accessed through the MySource website at ***www.mysourceforhr.com*** *or by calling the MySource automated telephone system at* ***1-888-640-3320*** *to speak to a service representative.*

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option. If they desire coverage, newly eligible employees must enroll in the Optional Employee Term Life Coverage Option, the Dependents Term Life Coverage Option, the Optional Employee AD&D Coverage Option and the Optional Dependents AD&D Coverage Option (collectively the "Optional Coverages") within 31 days of their date of hire or the date they become newly eligible. If you do not enroll in an Optional Coverage during this initial 31-day period, you may need to provide evidence of insurability if you decide to enroll at a later date. You must enroll using forms approved by Prudential. *You may obtain enrollment forms by contacting MySource for Human Resources at* ***1-888-640-3320***

In general, once you enroll in (or decline) any of the Optional Coverages, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage election will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. If any change in coverage is subject to evidence of insurability, Prudential must decide that such evidence is satisfactory. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.) *To obtain the necessary forms for enrolling in, or changing, your Optional Coverages, please contact MySource for Human Resources at* ***1-888-640-3320.***

Contributions

The Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option are provided at no cost to you. If you elect any of the Optional Coverages, you will pay for the cost of such coverage. *If you have questions regarding the amount of your required contributions, please contact MySource for Human Resources at* ***1-888-640-3320.***

When Coverage Begins and Ends

Coverage Begins

Provided you have satisfied the eligibility requirements described above, coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day. If you are not actively at work on the day you become eligible or newly eligible for coverage, your coverage will begin on the first day you are actively at work.

Provided you have satisfied the eligibility requirements described above, coverage under the Employee Optional Coverages may generally become effective on the first day on which each of the following conditions are met: (1) you have enrolled for coverage, (2) you have met any evidence requirement and (3) you are actively at work.

Provided you have satisfied the eligibility requirements described above, coverage of your "qualified dependents" under the Dependents Term Life Coverage Option and the Optional Dependents AD&D Coverage Option ("Dependents Insurance") generally may become effective on the first day on which each of the following conditions are met: (1) you have enrolled for coverage, (2) the person to be covered is your "qualified dependent", (3) you are insured for employee coverage under the particular coverage sought (e.g., for Dependents Term Life Coverage, you are covered under Employee Term Life Coverage, and for Dependents AD&D Coverage, you are coverage under Optional Employee AD&D Coverage), (4) for Dependents Term Life Coverage, you have met any evidence requirement for the "qualified dependent," and (5) your "qualified dependent" is not confined for medical care or treatment, at home or elsewhere (this condition does not apply to your child if the child is born to you, becomes your qualified dependent at birth and either is your first qualified dependent or becomes a qualified dependent while you are insured for Dependents Insurance for any other qualified dependent)..

Evidence of your insurability is required if you (1) apply for coverage more than 31 days after the date you are first eligible for coverage, (2) desire life insurance coverage and have an individual life insurance contract you obtained by converting your coverage under the Plan, (3) apply after any of your coverage ended because you did not pay a required contribution, or (4) have not met a previous evidence requirement to become insured under any plan a participating employer has with Prudential.

Evidence of insurability for your spouse who is a "qualified dependent" is required if (1) you enroll for Dependents Insurance more than 31 days after you are first eligible for such coverage, (2) you enroll for Dependents Insurance after any coverage under the Plan ends because you did not pay a required contribution, (3) your spouse previously did not meet a requirement for evidence of insurability under any Prudential group contract for the participating employer, or (4) you elect $50,000 spousal coverage.

Coverage Ends

Your Employee Insurance or Dependents Insurance under a Coverage Option will end when the first of these occurs:

- The date as of which the Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Coverage Option, the date a Coverage Option is terminated;
- The date that the Plan is amended to terminate coverage for you;
- The date you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular full-time employee or as a member of another eligible class;
- For Coverage Options that are contributory, the last date for which any required contribution was made, provided that failure to contribute for Dependents Insurance will not cause your Employee Insurance to end;

- For Dependents Term Life Coverage, the date your Employee Term Life Coverage ends;
- For Dependents AD&D Coverage, the date your Optional Employee AD&D Coverage ends;
- For Dependents Insurance, the date your "qualified dependent" ceases to be a "qualified dependent" for the coverage.

If you make a written request to the Company to end the Dependents Insurance for a "qualified dependent" under the Optional Dependents AD&D Coverage, coverage for that person will end.

For purposes of life insurance coverage, your employment will not be considered to end while you (1) are absent from work for your employer on account of your disability; and (2) have been so absent for less than six months; and (3) are not working at any other job for wage or profit.

For Dependents Term Life Coverage, coverage for a child will not end upon his or her attainment of the age limit described above if (1) the child is then mentally or physically incapable of earning a living and Prudential receives proof of this within the next 31 days; and (2) the child otherwise meets the definition of "qualified dependent." This will apply as long as the child remains so incapacitated.

If you stop active full-time work for any reason, you should contact the Company at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or whether you belong to another class of employees that may be eligible for coverage under the Plan.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Coverage Option. You can obtain a beneficiary form by calling MySource at **1-888-640-3320**. The Group Insurance Certificate also contains details regarding arranging for payment of life insurance benefits other than in one sum (referred to as "modes of settlement"). Prudential has prepared information about the modes of settlement that are available. For further information, contact MySource at **1-888-640-3320**.

The Group Insurance Certificate also contains detailed rules regarding the assignment of your insurance under a Coverage Option, including rules governing gift assignments. Refer to the Group Insurance Certificate for the terms and conditions under which such assignments may be made.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in an amount up to 200% of your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The minimum benefit is $1,000 and the maximum benefit (for Basic and Optional Employee Term Life Coverage combined) is $1,500,000. Amounts

otherwise payable as benefits will be reduced by the amount of any "Terminal Illness Proceeds" paid under the Option to Accelerate Payment of Death Benefits.

Optional Employee Term Life Coverage

You may enroll in one of the options below for optional term life coverage.

BENEFIT CLASSES	AMOUNT OF INSURANCE
Option 1	100% of your annual Earnings
Option 2	200% of your annual Earnings
Option 3	300% of your annual Earnings
Option 4	400% of your annual Earnings

If the amount of insurance is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit is $1,500,000 minus the amount of your insurance under the Basic Employee Term Life Coverage Option. Amounts otherwise payable as benefits will be reduced by the amount of any "Terminal Illness Proceeds" paid under the Option to Accelerate Payment of Death Benefits.

Notwithstanding the foregoing, the amount of your coverage may not exceed the "Non-medical Limit" unless you submit evidence of insurability that is satisfactory to Prudential and you are actively at work. The "Non-medical Limit" is the lesser of (1) 300% of your annual Earnings, and (2) $500,000.

Any requested change in coverage (increase or decrease) must be made within 31 days of a qualified life event. If you request an increase in coverage due to a qualified life event, you must also provide evidence of insurability to Prudential. Any requested change will become effective when Prudential decides the evidence is satisfactory and you are actively at work. If you enroll in Optional Employee Term Life Coverage or change the amount of insurance during open enrollment, you must submit evidence of insurability to Prudential, unless you are requesting an increase of only one option, the amount is not over the Non-medical Limit and you do not enroll more than 31 days after you first could have been covered. A new enrollment or requested increase subject to evidence will be effective on the later of (1) the following January 1, and (2) the date Prudential decides the evidence is satisfactory and you are actively at work.

Option to Accelerate Payment of Death Benefits

If you become a Terminally Ill Employee while insured under the Basic Employee Term Coverage Option or the Optional Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have Terminal Illness Proceeds paid to you in one sum or in six equal monthly installments when Prudential receives proof that you are a Terminally Ill Employee.

Benefits otherwise payable under the Employee Term Life Insurance upon your death and any amount you could otherwise have converted to an individual contract will be reduced by the Terminal Illness Proceeds. If you elect monthly installments and you die before all payments have been made, Prudential will pay the total remaining payments to your beneficiary or beneficiaries in one sum.

Your right to be paid under this option is subject to the following terms: (1) You must choose this option in writing in a form that satisfies Prudential; (2) You must furnish proof that satisfies Prudential that your life expectancy is 6 months or less, including certification by a doctor; (3) Your Employee Term Life Insurance must not be assigned; (4) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit; and (5) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this benefit.

You are a "Terminally Ill Employee" if your life expectancy is 6 months or less. "Terminal Illness Proceeds" means the amount of

Employee Term Life Insurance that you may elect to place under this option. The Terminal Illness Proceeds are equal to 75% of the amount in force on your life on the date Prudential receives the proof that you are a Terminally Ill Employee, but not more than $50,000. This amount may be reduced if, within 6 months after the date Prudential receives such proof, a reduction on account of age would have applied to the amount of your Employee Term Life Insurance. In that case, the amount of the Terminal Illness Proceeds may not exceed the amount of such Insurance after applying the reduction.

Please note that any payment made under this option may be taxable. You should consult your tax advisor for assistance with any questions you may have.

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

Dependents Term Life Coverage

Under the Dependents Term Life Coverage Option, you may enroll your "qualified dependents" for coverage in the amounts shown below.

YOUR SPOUSE WHO IS A "QUALIFIED DEPENDENT"	
Benefit Classes	**Amount of Insurance**
Option 1	$10,000
Option 2	$25,000
Option 3	$50,000

YOUR CHILDREN WHO ARE "QUALIFIED DEPENDENTS"	
Benefit Classes	**Amount of Insurance**
Option 1	$5,000
Option 2	$10,000

The amount of insurance on a dependent will not exceed 50% of the amount for which you are insured under the Basic and Optional Employee Term Life Coverages. In addition, you must give evidence of insurability if you choose Option 3 spousal coverage. Option 3 spousal coverage will become effective on the date Prudential decides the evidence is satisfactory. No enrollment or increases in coverage may become effective so long as your "qualified dependents" are confined for medical care or treatment, whether at home or elsewhere.

Payment of Death Benefits under Life Coverage

If you or your "qualified dependent" dies while covered under the Plan, the amount of insurance on you or your "qualified dependent" is payable when Prudential receives written proof of death. If you or a "qualified dependent" die within 31 days after ceasing to be covered under the Plan, but while you or your "qualified dependent," as the case may be, are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Prudential receives written proof of death.

Death Benefits under the Employee Term Life Coverage are payable according to Prudential's beneficiary and mode of settlement rules. Death benefits under the Dependents Term Life Coverage are payable to you, if you are living. If you are not living, benefits are payable to the dependent's estate or, at Prudential's option, to certain surviving relatives of the dependent.

Conversion Privilege for Life Coverage

If you cease to be insured for Employee Term Life Coverage because (1) your employment ends or you transfer out of a class eligible for coverage, or (2) all term life insurance for your class ends by amendment of the Plan or otherwise and you have been insured under that insurance for five years, you may convert

all or a part of your Employee Term Life Coverage to an individual life insurance contract.

Similarly, if you cease to be insured for Dependents Term Life Coverage with respect to a "qualified dependent," your "qualified dependent" may have your insurance on the dependent converted to an individual life insurance contract. However, conversion is not available for a dependent if the insurance ends because (1) you fail to make any required contribution, or (2) all Dependents Term Life Coverage for your class ends by amendment of the Plan or otherwise and you have not been insured with respect to the dependent for five years for that insurance.

The amount of any conversion coverage will not exceed the amount of coverage in effect when the insurance ceases under the Plan. However, if insurance under the Plan ceases because all Employee Term Life Coverage or Dependents Term Life Coverage (as the case may be) for your class ends, the total amount of individual insurance that you or your "qualified dependent" may obtain will not exceed the lesser of (1) the total amount of life insurance then ending under the Plan reduced by the amount of group life insurance from any carrier for which you are or become eligible within the next 31 days (on your life or the life of your "qualified dependent," as the case may be), or (2) $10,000.

Minnesota Residents: Refer to the Group Insurance Certificate for different provisions that apply to conversion of life insurance coverage.

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

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in an amount up to 200% of your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit is $500,000.

Optional Employee AD&D Coverage Option

You may enroll for optional employee AD&D coverage in any multiple of $10,000 up to the lesser of (1) ten times your annual Earnings, and (2) $1,500,000 minus the amount of your insurance under the Basic Employee AD&D Coverage Option).

Optional Dependents AD&D Coverage Option

You may enroll for optional AD&D coverage on each of your "qualified dependents" in an amount equal to a percentage of your Optional Employee AD&D Coverage, as set forth below:

QUALIFIED DEPENDENTS	AMOUNT OF INSURANCE ON EACH QUALIFIED DEPENDENT (AS % OF EMPLOYEE AD&D COVERAGE)
Spouse only	60% on spouse
Child(ren) only	10% on each child
Spouse and child(ren)	50% on spouse; 10% on each child

Additional AD&D Coverage

The Plan provides additional benefits under Basic and Optional Employee and Dependents AD&D Coverage for a person's loss of life as a result of an accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of the "amount of insurance coverage" on the person, and (2) $10,000. The "amount of insurance coverage" is determined without regard to the additional benefits. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for an accidental Loss that results from an accident that happens to you while you are engaged in or the victim of a "Hazard" (a "Covered Accident"). A "Loss," for purposes of AD&D coverage, means a person's (1) loss of life; (2) total and permanent loss of sight; (3) loss of hand or foot by severance at or above the wrist or ankle; (4) total and permanent loss of speech; (5) total and permanent loss of hearing in both ears; (6) loss of thumb and index finger of the same hand by severance at or above the point at which they are attached to the hand; or (7) loss due to Quadriplegia, Paraplegia, or Hemiplegia.

Benefits for an accidental Loss are payable only if the Loss is otherwise covered and all of the following conditions are met and the Loss is otherwise covered: (1) the person sustains an accidental bodily injury while covered under the Plan; (2) The Loss results directly from that injury and from no other cause; (3) the person suffers the Loss within 365 days after the accident; and (4) the Loss is due to a Covered Accident.

"Hazard" means (1) 24 Hour All Risk Hazard: you are engaged in or the victim of a risk; (2) Specified Aircraft Hazard: During an authorized business trip for your employer, you are boarding, leaving, riding as a passenger or crew member in, or struck by, a specified aircraft (described in the Group Certificate) that is owned, operated, controlled or leased by or on behalf of NiSource Inc. or any of its subsidiaries or affiliates or its customers, if such aircraft is certified, and operated by a pilot who has a certificate of competency and who has logged the applicable minimum number of hours of flying time in aircraft of similar design, but excluding any aircraft used for firefighting.

All benefits are subject to the limitation per accident described below:

LOSS OF OR BY REASON OF	PERCENT OF PERSON'S AMOUNT OF INSURANCE
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing in both ears; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing hemiplegia	50%
Thumb and index finger of same hand	25%

No more than the amount of insurance on a person at the time of the accident will be paid for all Losses resulting from injuries sustained in that accident. Benefits for accidental Loss that results from a Covered Accident will be paid only once, even if more than one Hazard provision applies.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the Loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any bacterial or viral infection (this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including Reserve or National Guard active duty for training); (8) travel or flight in any vehicle used for aerial navigation (including getting in, out, on or off any such vehicle), except as

provided by a Hazard provision [this (8) applies only if: (a) the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; (b) the person is performing as a pilot or a crew member of any aircraft; or (c) the person is riding as a passenger in an aircraft owned, leased or operated by the Company or any of its subsidiaries or affiliates]; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.

Portability of Life and AD&D Coverage

If coverage under any of the Coverage Options ceases, you may have the right to apply for coverage for yourself or for your "qualified dependent," as the case may be, under a Portability Plan maintained by Prudential. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

In addition to the requirements described below and in the Group Insurance Certificate, you must provide evidence of insurability if you want to port *life insurance* coverage for you or your spouse under any Coverage Option other than the Optional Employee Term Life Coverage Option. If you would like to port Optional Employee Term Life Coverage and you submit evidence of insurability, you may pay lower premiums for such coverage if Prudential decides the evidence is satisfactory.

Minnesota Residents: Refer to the Group Insurance Certificate for different provisions that apply to the continuation of life insurance coverage. See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Coverage and Dependents Term Life Coverage, except that (1) you or your "qualified dependent," as the case may be, may convert the amount of insurance under the Employee Term Life Coverage or Dependents Term Life Coverage that exceeds the maximum amount of coverage that may be obtained under the Portability Plan, and (2) you or your "qualified dependent," as the case may be, may convert insurance if Portability Plan coverage is elected, but Prudential decides that evidence of insurability is not satisfactory.

Your Application for Portability Coverage

To have the right to apply for term life or AD&D coverage under the Portability Plan based upon your Employee Term Life Coverage (for term life coverage) or Employee AD&D Coverage (for AD&D coverage), (1) your Employee Term Life Coverage or Employee AD&D Coverage must have ended for reasons other than your failure to pay required contributions, your retirement, or the end of coverage for all employees when coverage is replaced by group insurance coverage from any carrier for which you are or become eligible within 31 days after the end of coverage, (2) you must be actively at work on the day your insurance ends; (3) you must be less than 80; (4) your amount of insurance for the particular Coverage Option must be at least $20,000 on the day your insurance ends; and (5) with respect to AD&D coverage, you must have applied for term life coverage under the Portability Plan.

To have the right to apply for term life or AD&D coverage for a "qualified dependent" under the Portability Plan based upon your Dependents Term Life Coverage (for term life coverage) or Optional Dependents AD&D Coverage (for AD&D coverage), (1) your coverage must have ended for reasons other than your failure to pay required contributions, your retirement, or the end of

Basic Employee Term Life Coverage or Employee AD&D Coverage, as the case may be, for all employees when that coverage is replaced by group insurance coverage from any carrier for which you are or become eligible within 31 days after the original coverage ends; (2) you must apply and become covered for corresponding term life coverage and/or AD&D coverage, as the case may be, under the Portability Plan; (3) with respect to a dependent spouse, the spouse must be less than 80; (4) with respect to a dependent child, the child must be (a) less than 19, or (b) less than 23, enrolled as a full-time student in a school, and wholly dependent upon you for support and maintenance; (5) the dependent must have been covered for Dependents Term Life Coverage or Optional Dependents AD&D Coverage, as the case may be, on the day your corresponding Basic Employee Term Life Coverage or Employee AD&D Coverage ended; and (6) the dependent must not be confined for medical care or treatment, at home or elsewhere, on the day your Basic Employee Term Life Coverage and/or Employee AD&D Coverage, as the case may be, ended.

Your Spouse's Application for Portability Coverage

With respect to portability of Dependents Term Life Coverage and Optional Dependents AD&D Coverage, if you die, your spouse may apply for term life coverage or AD&D coverage, as the case may be, under the Portability Plan, if your spouse meets all of the conditions of items (3), (5) and (6) in the paragraph immediately above (and, with respect to AD&D coverage, your spouse applies and becomes covered for term life coverage under the Portability Plan). If you die, your spouse may also apply for term life (or AD&D) coverage under the Portability Plan for a "qualified dependent child" if your spouse also applies and becomes covered for term life (or AD&D) coverage and you child meets all of the conditions of items (4), (5), and (6) in the paragraph immediately above.

If you divorce, your spouse may have the right to apply for term life (or AD&D) coverage under the Portability Plan if (1) with respect to term life coverage, Dependents Term Life Coverage on your spouse ends due to divorce; (2) with respect to AD&D coverage, Optional Dependents AD&D Coverage on your spouse ends due to divorce and your spouse applies and becomes covered for term life coverage under the Portability Plan; (3) your spouse is less than 80; and (4) your spouse is not confined for medical care or treatment, at home or elsewhere, on the day Dependents Term Life Coverage or Optional Dependents AD&D Coverage, as the case may be, on your spouse ends.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that may be ported under the Portability Plan with respect to Basic Employee Term Life Coverage, Dependents Term Life Coverage, Employee AD&D Coverage and Optional Dependents AD&D Coverage is the lesser of (1) the amount of insurance under the Coverage Option when that insurance ends, and (2) the lesser of 5 times your annual Earnings, and $1,000,000. The maximum amount of insurance that may be ported under the Portability Plan with respect to Optional Employee Term Life Coverage is the lesser of (1) the amount of insurance under the Coverage Option when that insurance ends, and (2) (a) the lesser of 5 times your annual Earnings, and $1,000,000, minus (b) the amount ported under Basic Employee Term Life Coverage. In addition, the amount of your (or your "qualified dependent's") AD&D insurance under the Portability Plan may not exceed your (or your "qualified dependent's") term life insurance under the Portability Plan.

The minimum amount of insurance that may be ported with respect to any Coverage Option (other than Optional Employee Term Life Coverage) under the Portability Plan is $20,000. The minimum amount of insurance that may be ported with respect to Optional Employee Term Life Coverage under the Portability Plan is $20,000 less the amount ported under Basic Employee Term Life Coverage.

Highlights of Conversion and Portability Features

	CONVERSION	PORTABILITY
Can Basic Life, Optional Life, Dependent Life, Dependent Child Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Can a retiree convert or port coverages?	Yes	No
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No	Yes, for basic employee and optional dependent life coverage (spouses only). No for AD&D. Submission of evidence satisfactory to Prudential may lower premiums for optional employee life coverage.
Application Deadline	Application and first month premium due the later of (i) 31 days after your coverage termination, or (ii) 15 days after receipt of written notice of the conversion privilege, but no later than 92 days after your coverage termination.	For life coverage, application due the later of (i) 31 days after your coverage termination, or (ii) the conversion deadline. Prudential will bill the participant directly. For AD&D coverage, the later of (i) 31 days after your coverage termination, (ii) for employee coverage, the number of days during which you have the right to apply for term life coverage under the Portability Plan, or (iii) for dependent coverage, the number of days during which you have the right to apply for AD&D coverage under the Portability Plan, or in case of your death or divorce, the number o f days during which your spouse has the right to apply for term life coverage under the Portability Plan.
Prudential Contacts	Prudential Group Life Conversion P.O. Box 70180 Philadelphia, PA 19176 (P) 877-889-2070 (F) 888-634-1118	The Prudential Insurance Company of America Group Life Record Keeping P.O. Box 13676 Philadelphia, PA 19176 (P) 800-778-3827

Important Information For Residents Of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and in this summary plan description. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this summary plan description. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 93191.

*If you are unable to access this website, and if you want to receive a printed copy of these requirements or have any questions, call Prudential at **1-866-439-9026**.*

Particular State-Specific Plan Provisions

Without limiting the generality of any of the foregoing, the following information applies to residents of Minnesota.

Different conversion and continuation of coverage provisions for life insurance benefits apply for Minnesota residents. Minnesota residents should refer to the Group Insurance Certificate for a description of these provisions and for the requirements for applying for such benefits.

*You may obtain a copy of the Group Insurance Certificate by contacting MySource for Human Resources at **1-888-640-3320**.*

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Prudential must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Coverage provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

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

Claim Determination and Appeal Process

Consideration of Initial Claim

Prudential shall notify you of the claim determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized

representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

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

First Appeal to the Claims Administrator

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or from when the claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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

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

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- the specific reason(s) for the adverse determination,
- references to the specific plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- a description of Prudential's voluntary appeal procedures and your right to obtain certain information about those procedures,
- a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

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

Second Appeal to the Claims Administrator

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or from when the claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter.

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

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

Prudential has the right to recover any overpayments for whatever reason. You must reimburse Prudential in full. Prudential will determine the method by which the repayment is to be made. Prudential will not recover more money than the amount it paid you.

If, after completing all the steps of the appeals process, you decide to take legal action, you must do so within three years after the end of the time within which proof of loss is required.

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	The Prudential Insurance Company of America Prudential Plaza Newark, New Jersey 07102

Claims Administrator: (if you need to submit a claim)	(Life/AD&D)	(Conversions)
	Prudential Group Life Claims Division P.O. Box 8517 Philadelphia, PA 19176 1-800-524-0542	Prudential Group Life Conversions P.O. Box 70180 Philadelphia, PA 19176 1-877-889-2070

Agent for Service of Legal Process:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5571

Service of legal process may be made upon the Plan Administrator.

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the MySource automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

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

NiSource®

SUMMARY PLAN DESCRIPTION FOR THE

Columbia Energy Group Pension Plan

A DESCRIPTION OF YOUR RETIREMENT PENSION BENEFITS

For Employees in the AB1 Benefit

June 2011

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INTRODUCTION

Retirement can be the most exciting time of your life. Of course, you must work hard and save during your career to achieve the kind of financial security needed to enjoy those years to the fullest. Early on, you will need to ask yourself: "What sources of income will I have for my retirement?" You will likely be relying on (1) your pension benefit from the **Columbia Energy Group Pension Plan** (previously known as the Retirement Plan of Columbia Energy Group Companies, hereinafter referred to as the "**Plan**"), (2) a retirement benefit from Social Security, (3) your own personal savings, and (4) if applicable, savings under the NiSource Inc. Retirement Savings Plan or any other employer-sponsored retirement plan. Your employer, Columbia Energy Group, offers the Plan for the benefit of its employees and their beneficiaries in order to help provide for retirement.

Overview of the Plan

An innovative retirement plan that helps you prepare more effectively for your future, the Plan is a defined benefit pension plan funded entirely by contributions from NiSource Inc. or its affiliates. Its purpose is to provide you with retirement income that is in addition to any other retirement income you have or may be eligible to receive.

As an employee of Columbia Energy Group or any affiliate that adopts the Plan for its employees (collectively, the "**Company**") satisfying the criteria described in the "Eligibility and Enrollment" section, you are eligible for the **AB I Benefit** of the Plan. Note that if you are a union employee of the Company, you will not participate in the AB I Benefit unless the collective bargaining agreement that covers you provides for your participation.

Introduction to the AB I Benefit

You are covered under the **AB I Benefit** of the Plan. The AB I Benefit (formerly the "Account Balance Option Benefit") is a "cash balance" option that makes it easy to understand your retirement benefit under the Plan. This option is unique because it offers you both a visible and a portable benefit.

Once you become a participant in the Plan, the Company sets up a bookkeeping account in your name. Each year, the Company adds *pay credits* equal to a percentage of your pay to your account. Your account also grows with interest in the form of annual *interest credits* throughout your career. The total of these pay credits and interest credits, plus, if applicable, any "opening balance" reflecting the benefit you earned prior to becoming an AB I Benefit participant make up your account balance. Periodically (in general, annually), you will receive personalized statements showing your current account balance. Because you will always see your account balance, you can easily monitor the growth of your retirement benefit – so your benefit is *visible*. When you retire, you can choose to receive your account balance in one of several payment methods (also explained in more detail later in this Summary). What's more, you are entitled to receive the "vested" portion of your account balance if you leave the Company prior to retirement, so your benefit is also *portable*.

Again, it costs you nothing to participate because the Company makes all contributions necessary to fund your AB I Benefit under the Plan on your behalf.

About this Plan Summary and Plan Administration

This handbook serves as a Summary Plan Description ("SPD" or "Summary") of the Plan, prepared in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. This SPD does not extend or change the Plan in any way.

The NiSource Benefits Committee (the "Committee") serves as business manager and administrator for the Plan (the "Plan Administrator"). The Plan Administrator utilizes the NiSource Human Resources Department and other specified individuals to carry out a number of administrative tasks for the Plan. See "Administrative Information" found later in this Summary. A trust fund has been established for the purpose of holding funds contributed to the Plan. The trust fund is administered by a trustee (the "Trustee") appointed by the Committee.

While the Committee intends to continue the Plan described in this handbook, the Committee reserves the right to change, modify, or discontinue the Plan and any of its terms at its discretion, subject to any applicable collective bargaining agreement.

HIGHLIGHTS: AB I BENEFIT

ARE THERE EMPLOYEE CONTRIBUTIONS?	No, all contributions are made by the Company
ARE THERE COMPANY CONTRIBUTIONS?	Yes; the Company makes contributions to fund your AB I Benefit, which is based on: • Your age • Your years of service • Your Eligible Pay, taking into consideration the Social Security Taxable Wage Base; and • The Plan's interest credit rate (currently the greater of the 30-year Treasury Securities, but no less than 4%)
WHEN AM I VESTED IN MY BENEFIT?	You are fully vested after 3 years of service (if you terminated prior to January 1, 2008, you generally were vested after 5 years of service).
WHAT IS ELIGIBLE PAY FOR PURPOSES OF DETERMINING MY BENEFIT?	In order to calculate your pay credits under the Plan, Eligible Pay includes your base salary and commissions, plus your performance based pay (e.g., annual incentives) paid in or prior to the month of your termination of service, any salary reduction contributions made for a Company cafeteria or 401(k) plan, any "banked" vacation paid under the NiSource Vacation Policy, and effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (i.e., lump-sum merit pay). However, the Plan does not consider certain items to be Eligible Pay. These excluded items include, but are not limited to, overtime, shift differential pay, amounts deferred to a nonqualified plan, and other special forms of pay such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income. In addition, the Plan also excludes from Eligible Pay any unused and accrued vacation paid on or after your termination of service. Note again, Eligible Pay excludes any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance based pay) when paid in any month following your termination of service.
WHEN IS MY BENEFIT PAID?	Provided you are vested, you can be paid: • When you terminate employment; • When you retire; • When you reach age 70-1/2 (provided you have already terminated employment or are considered a 5% owner of the Company); or • In the event of your death
HOW CAN I RECEIVE MY BENEFIT?	You may elect to receive your benefit in the form of: • One of several Monthly Annuity Options • A Lump Sum • A Rollover

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be an "Eligible Employee" of the Company to actively participate in the Plan. Generally, you are eligible to participate in the AB I Benefit of the Plan (*i.e.*, you are an "AB I Participant") if you are a regular full-time or part-time "non-exempt employee" (as classified by the Company) and fall within one of the categories described in the box below. You are not eligible to participate if you are an intern, an independent contractor or a leased employee of the Company, or if you are a union employee whose collective bargaining agreement does not provide for Plan participation. In addition, you are not eligible to participate in the Plan as an AB I Participant if you are an "exempt employee" (as classified by the Company) either because you transitioned to the AB II Benefit effective January 1, 2011 (see the Summary applicable to the AB II Benefit) or because you were hired or rehired on or after January 1, 2010 and are not eligible to participate in the Plan.

More specifically, an AB I Participant is:

- Any non-exempt (union or non-union) employee newly hired or rehired on or after January 1, 2000 but before January 1, 2008.
- Any non-exempt eligible employee who elected to participate in the AB I Benefit effective January 1, 2000 or effective January 1, 2004, i.e., the 2000 Choice or 2004 Choice described below.*
- Any non-exempt eligible employee on long-term disability as of the 2000 Choice or 2004 Choice dates who returned to active employment prior to January 1, 2009 and who elected to participate in the AB I Benefit effective upon return to employment.
- Certain other persons who are allowed to elect to participate in the AB I Benefit pursuant to terms of the Plan or an applicable collective bargaining agreement.

Note that effective January 1, 2013, all non-exempt employees will be governed by the AB II Benefit provisions of the Plan (i.e., the Summary applicable to the AB II Benefit will apply on or after that date).

***Note:** Each eligible employee who participated in the FAP Benefit of the Plan as of December 31, 1999 had the opportunity to make an irrevocable Plan choice by April 30, 2000 to stay in FAP Benefit or switch to the AB I Benefit effective January 1, 2000 ("2000 Choice"). If no 2000 Choice was made, the employee remained in the FAP Benefit under the Plan. Subsequently, each participant in the FAP Benefit as of December 31, 2003 who was not eligible to make an election under the 2000 Choice period had the opportunity to make an irrevocable choice by May 31, 2004 to switch to the AB I Benefit effective January 1, 2004 ("2004 Choice"). Again, if no 2004 Choice was made, the employee remained in the FAP Benefit. Both the 2000 Choice and the 2004 Choice elections were made and documented in a manner specified by the Plan Administrator.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts on your first day of work with the Company. Once you start to participate in the Plan, you will continue to participate as long as you are an Eligible Employee of the Company. If you terminate employment after becoming a Plan

participant and later return to employment as an Eligible Employee, you will participate in the Plan under the AB II Benefit provisions of the Plan (a different Summary applies). Upon rehire as an Eligible Employee, your participation as an AB II Benefit participant will begin immediately; however, the "Break in Service" rules may impact your service crediting under Plan. See the "Break in Service" section later in this Summary for an explanation of this rule and how it might affect you if you terminate employment and later become reemployed by the Company. Note again that if you terminate employment and later return as an "exempt employee", you are no longer eligible to participate in the Plan (*i.e.*, "exempt employees" hired or rehired on or after January 1, 2010 are not eligible to participate in the Plan).

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an Eligible Employee (*i.e.*, you terminate employment or your employment status changes to one that is not eligible to participate in the Plan);*
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

* Note that once you are no longer an Eligible Employee, you will remain an inactive Plan participant (continuing to earn interest credits on your vested account) until you take a full distribution of your vested benefit from the Plan.

Service

Your Service with the Company, and also any breaks in your Service, have an effect on your participation in and benefits under the Plan. As explained in the following paragraphs, your Service with the Company is used as a component to calculate your benefit under the Plan. Also, the Plan uses Service to determine when you are entitled to (or "vested" in) your benefit under the Plan. Note that if you terminate and return to work as an ineligible employee (*e.g.*, an exempt employee hired or rehired on or after January 1, 2010), you no longer earn Point Service under the Plan. However, you will earn additional Vesting Service as described below.

Point Service

"Point Service" is the number of your years and partial years (*i.e.*, months) of Service as an employee of the Company (or any affiliate of the Company) from the first day of the month in which your employment began through the last day of the year in which your termination of employment, for any reason, occurs. Notwithstanding the foregoing, if you were a FAP Participant who voluntarily elected to become an AB I Participant, your Point Service for the period prior to your conversion to the AB I Benefit is equal to the amount of credited service you earned prior to your conversion. Point Service is used to determine, in part, the amount of pay credits that are added to your Account. Please see the "How the Plan Works" section later in this Summary for a complete explanation of how your pay credits are calculated.

Vesting Service

"Vesting Service" is the number of your years of Service as an employee of the Company (or any affiliate) from your date of employment through the date of your termination of employment for any reason. To be "vested" means you have a non-forfeitable right to your Plan benefit. You are fully vested in your pension benefit after completing three years of Vesting Service with the

Company and/or an affiliate. Note that if you terminated prior to January 1, 2008, you generally had to complete five years of Vesting Service before becoming fully vested in your benefit (unless you terminated at a time when an even higher vesting requirement applied, in which case the terms of the Plan in effect at your termination will control).

Special rules may apply if you experience a break in service, become disabled, or if you were previously a leased employee of the Company or an affiliate.

Break in Service

A break in employment (called a "Break in Service") may affect how you are credited with Service under the Plan. A Break in Service occurs if you terminate employment with the Company and are not employed for a period of 12 consecutive months. If you incur a Break in Service, the effect on your Vesting Service and Point Service will depend on the following: (1) the length of your Break in Service; (2) whether you were vested in your pension benefit prior to the Break in Service; and (3) whether you received a distribution of your benefit under the Plan. Note again that regardless of whether you have a Break in Service (or regardless of its length), if you terminate employment and are rehired as an Eligible Employee, you begin participation in the Plan under the AB II Benefit provisions. If you experience a transfer of employment within the Company or from/to an affiliate of the Company, see the section entitled "Changes in Employment Status" later in this Summary for an explanation of the impact on your benefit and Service crediting under the Plan.

Break in Service Less Than 1 Year

If you terminate employment and are reemployed by the Company within 12 consecutive months, you are not considered to have a Break in Service. In this case, the Plan will consider your period of absence as part of your Vesting Service and Point Service under the Plan. However, as noted below, if you receive a distribution of your benefit, then your Point Service will start at zero upon your return to employment.

Break in Service of 1 to 5 Years

If you terminate employment and your Break in Service lasts more than 1 year but less than 5 years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. If you are re-employed, the period of your absence will not count as part of your Service for any purpose.

Break in Service More Than 5 Years

If you are not vested in your pension benefit prior to your Break in Service, and your Break in Service lasts for 5 or more years, you will lose credit for all of your prior Service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you are vested when you terminate employment and you are later re-employed after a Break in Service of 5 or more years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. However, the Company does not count the period of your absence as part of your Service.

If You Received a Distribution

If you experience a Break in Service *and* receive or begin to receive a distribution of your vested benefit under the Plan before your return to work, you will receive credit for your Service prior to the break for purposes of counting Vesting Service only. For purposes of earning pay credits and interest credits (explained later in the "How the Plan Works" section), you will be treated as a new participant (*i.e.* your Point Service will start at zero upon your return to employment).

Effect of Leaves on Break in Service

If you are on an "Authorized Leave of Absence" as discussed below, the Break in Service rules do not apply to the extent you continue to earn Service during the authorized leave. If the authorized leave provisions don't apply and you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement, then different rules apply when determining if a Break in Service has occurred. In general, if you are

absent from work for one of the foregoing reasons beyond the first anniversary of the first date of your absence, you will not be considered to have a severance from Service until the second anniversary of the first date of your absence. In addition, you will not have a Break in Service if you are on an Authorized Leave of Absence pursuant to the Family and Medical Leave Act, or if you are absent from employment due to service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")) and if you return to work at the end of your Authorized Leave of Absence.

Other Circumstances Impacting Service

Authorized Leaves of Absence—If you are on a leave of absence that is approved by the Company in accordance with its procedures and the Plan (an "Authorized Leave of Absence"), you will continue to earn Vesting Service and Point Service while the authorized leave continues for a period of up to 12 months. Service crediting will cease as of the expiration of this 12 month period or, if earlier, the date the Authorized Leave of Absence ends (unless you return to work at that time).

Disability—Vesting Service and Point Service are also impacted if you become Disabled (as defined in the Plan). To learn how a Disability affects your benefit and the Service you earn under the Plan, see "If You Become Disabled" found later in this Summary.

HOW THE PLAN WORKS

As explained at the beginning of this Summary, the AB I Benefit of the Plan is a "cash balance" pension plan. A cash balance pension plan is just like other pension plans in that it can provide you with a guaranteed monthly pension benefit for life after you retire. A cash balance plan is different from other pension plans in how it defines what your benefit will be. "Traditional" pension plans use a formula, often based on your years of service and average pay leading up to retirement, to define how much your monthly pension will be. Under this kind of plan, it is hard to know the value of what you will ultimately receive when you retire until you near or reach retirement.

A cash balance plan is designed to help you better understand the value of your benefit. Instead of using a formula to define your monthly retirement pension, a cash balance plan provides an accounting of the value of your benefit (the value of your **AB I Benefit**, also known as your "**Account**"). Your benefit is based on the value of the Account kept for you. As you work, credits are made to your Account. When you retire, you will receive the value of your Account in one of the payment forms available under the Plan (these are explained in detail later in this Summary).

Also, while most traditional pension plans only let you receive your benefit as a monthly payment (*i.e.*, an annuity), the AB I Benefit gives you the option of receiving a single lump sum cash payment. In addition, while many traditional defined benefit plans provide your benefit as a monthly annuity that ends at your death or your surviving spouse's death, with the AB I Benefit you can name any beneficiary to receive your benefit in the event of your death, such as a child or unrelated beneficiary, provided the consent requirements explained later in this Summary are satisfied.

Your Account

The Company sets up an account in your name (your "Account") once you become a participant in the Plan. Your Account is a bookkeeping account maintained for plan administration to keep track of your pay credits and interest credits and any distributions made to you from the Plan. *The dollar amount in your Account tells you the current cash value of the benefits payable to you at your retirement.*

Opening Balance

Transition from the FAP Benefit to the AB I Benefit— If you participated in the Final Average Pay Benefit ("FAP Benefit") under the Plan before becoming an AB I Benefit participant, your accrued FAP Benefit was converted to a lump sum "Opening Balance" and credited to your Account as of the date you converted to the AB I Benefit (your "Conversion Date"). The Opening Balance is calculated by following these steps:

1. The value of your accrued FAP Benefit is determined as of your Conversion Date;
2. If an annuity was purchased on your behalf, the value of your accrued FAP Benefit is reduced by the amount of such annuity, which is expressed as a single life annuity commencing at your Normal Retirement Date;
3. If you became an AB I Benefit participant *on or after* the first day of the month following (or coincident with) your "Calculation Date" (defined below), or if your Calculation Date is on or before January 1, 2000, then your Opening Balance will not be reduced further;
4. If you became an AB I Benefit participant *before* the first day of the month following (or coincident with) your Calculation Date, and your Calculation Date is after January 1, 2000, then an early retirement reduction factor (0.25% per month) is applied based on the number of months between your Calculation Date and the later of (a) the Conversion Date or (b) the first day of the month following the date you reach age 60; and

5. The present value of the lump sum benefit is calculated using standard mortality and interest rate assumptions as provided in the Plan.

   For purposes of the above Opening Balance calculation, your "*Calculation Date*" is generally the date that is three years before the first day of the month following the date you reach your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born). (Note that if you first became a participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Calculation Date is modified as follows: (1) if you first became a participant between January 1, 1976 and January 1, 1989, your Calculation Date is the first day of the month coincident with or next following your 62nd birthday; (2) if you first became a participant prior to January 1, 1976, your Calculation Date is the first day of the month coincident with or next following your 65th birthday.)

Determining Your Eligible Pay

As described below, your Pay Credits are based upon your **Eligible Pay**, which is a technical term under the Plan referring to the compensation on which your Pay Credits are calculated. Your Eligible Pay generally equals:

- Your annual base pay received from the Company, including
- Salary reduction contributions made for you under a cafeteria plan or a 401(k) plan, plus
- Commissions, if you are compensated in whole or in part on a commission basis, plus
- Performance based pay such as bonuses or annual incentive payments (provided such amounts are paid in or prior to the month of your termination of service), plus
- Any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay) (included effective September 1, 2009), plus
- Any amounts attributable to "banked" vacation and paid to you under the NiSource Vacation Policy.

However, Eligible Pay does not include all types of compensation you might receive from the Company. Specifically, items excluded from Eligible Pay include, but are not limited to the following:

- Overtime pay,
- Shift differential pay,
- Amounts deferred to a nonqualified plan,
- Any unused and accrued vacation paid on or after termination of service,
- Any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance based pay) when paid in any month following your termination of service, and
- Other special forms of compensation, such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

In general, Eligible Pay shall be determined on a monthly basis. If you are a full-time employee paid on a monthly, semi-monthly, biweekly, or weekly basis, your monthly Eligible Pay equals one-twelfth of your annual base rate of pay last in effect for the month, plus pay inclusions described above such as actual commissions paid in the month. If you are a part-time employee, your monthly Eligible Pay equals the sum of your actual Eligible Pay, plus pay inclusions described above (such as commissions) paid to you for each pay period during the month. For purposes of determining your Pay-Based Credits (described below), Eligible Pay means the sum of the monthly Eligible Pay for

each month during the Plan Year in which you are an AB I Participant, including actual bonuses received by the Employee while actively employed in the month.

The IRS imposes a limit on the amount of Eligible Pay that may be taken into account by the Plan. As a result, Eligible Pay above $245,000 for 2011 (as adjusted annually by the IRS for cost-of-living increases) does not count for purposes of determining Pay Credits under the Plan.

Impact of Disability Leave, an Authorized Leave of Absence, or Other Absence on Your Eligible Pay—If you are participating in the Plan, and you are on a leave due to Disability (as defined in the Plan and as further described later in this Summary) or on an Authorized Leave of Absence or other absence approved by the Company, you will be deemed to receive Eligible Pay for purposes of calculating your Plan benefit during your period of leave. However, similar to service crediting described earlier, if on an Authorized Leave of Absence or other approved (non-Disability) leave, you will only receive Eligible Pay crediting for up to 12 months. Your Eligible Pay for each month during this period generally shall equal one-twelfth of your annual base rate of pay last in effect for the month in which the employment absence occurred. For more specific information on how Eligible Pay is calculated during any of the above-described absences from employment, please contact the NiSource Human Resource Department.

Pay Credits

The Plan provides for two types of Pay Credits: Basic Pay Credits and Excess Pay Credits. You are eligible to receive Basic Pay Credits and, if applicable, Excess Pay Credits effective as of the date you become an AB I Participant and up until the time you terminate service or otherwise stop accruing a benefit under the AB I Benefit provisions of the Plan.

The Company allocates Basic Pay Credits to your Account as of December 31 of each year. These Basic Pay Credits are equal to a percentage of your annual Eligible Pay. The total age and years of Point Service you accumulate each year, as measured on December 31, determines the annual Basic Pay Credit percentage. If you leave the Company mid-year, you will receive prorated Basic Pay Credits through your termination date.

The Company also allocates Excess Pay Credits as of December 31 of each year to qualifying participants' Accounts. Excess Pay Credits are available if you earn more than one-half of the Social Security Wage Base for that year. If you qualify, the Excess Pay Credit is 2% of your Eligible Pay that exceeds one-half of the Social Security Wage Base.

The table below shows how Basic Pay Credits and Excess Pay Credits are calculated:

AB I PAY CREDITS				
If your age plus years of Point Service at the end of the year total...	Less than 45	45-59	60-74	75+
Your Basic Pay Credit for that year will be equal to this percentage of your Eligible Pay...	5 %	6.5 %	8 %	10 %
Your Excess Pay Credit will be equal to an additional percentage of your Eligible Pay over one-half of the Social Security Wage Base* in effect that year...	2 %			

**The Social Security Wage Base (SSWB) is the maximum amount of eligible pay on which you and the Company pay Social Security (or OASDI) taxes each year. For 2011, the SSWB is $106,800. Because you do not pay Social Security taxes on eligible pay in excess of the SSWB, you also do not earn Social Security benefits on eligible pay in excess of the SSWB. To help compensate affected employees, the AB I Benefit provides additional credit on pay over one-half the SSWB, which is $53,400 in 2011 ($106,800 divided by two).*

Example

Assume that on December 31, 2011, a participant has attained age 40 years and 6 months and has earned Point Service of 8 years and 10 months. Because the participant will have a total age plus Point Service of 49 years and 4 months, he/she will be eligible for a Basic Pay Credit of 6.5%. Let's assume the participant earns $40,000 for the year. The participant would receive a Basic Pay Credit to his Account of $2,600 for 2011 (6.5% of $40,000). The participant would not be eligible for the Excess Pay Credit because his Eligible Pay is not in excess of one-half of the SSWB for the year. However, if the same participant's Eligible Pay were $60,000 for 2011, he would receive a Basic Pay Credit of $3,900 (6.5% of $60,000), plus an Excess Pay Credit of $132 (2% of $6,600, which is the excess of Eligible Pay over one-half of the SSWB).

Interest Credits

Interest is credited to your Account each Plan Year effective as of December 31 up until the time you commence retirement benefits. Interest Credits are based on the 30-year Treasury Securities Rate for September of the preceding year (but not less than 4%) and are applied to your Account based on the value of your Account as of the last day of the prior Plan Year.

Your Account will continue to receive Interest Credits until you commence your retirement benefit payments under the Plan, regardless of whether you have stopped working for the Company as an Eligible Employee. However, if you terminate employment with the Company before you are vested in your benefit, you will not receive Interest Credits after your termination. If you are subsequently reemployed, you will receive Interest Credits effective as of the date of your reemployment. In the year you begin receiving benefits, you will receive prorated Interest Credits for the portion of the year before the benefit starts. If you become a participant in the Plan mid-year, you will receive prorated Interest Credits from the date your participation began.

Example

Assume that on January 1, 2011, your Account is $50,000, and that the Interest Credit rate for the Plan Year is 4% (*i.e.*, the greater of the 30-year Treasury Securities rate for September 2010 or 4%). On December 31, 2011, your Account would receive an Interest Credit of $2,000 (or $50,000 × 4%).

Summing it Up: How Your Account Grows

Altogether, taking into account the Pay Credit (both Basic and Excess) and Interest Credit components, your Account is thus the sum of:

- **Your Opening Balance**, if any, under the Plan as of the beginning of the year; plus
- **Pay Credits** allocated to your Account as an annual percentage of eligible pay based on age plus Point Service as outlined in the table above; plus
- **Interest Credits** allocated to your Account based on the annual interest rate on 30-year Treasury Securities for the September immediately preceding the first day of the Plan Year (but no less than 4%).

Example

With the addition of both Interest and Pay Credits each year, you can see your Account balance grow. Here is an example of how your Account can grow in one year, using the assumptions set forth below.

First, calculate the Basic and Excess Pay Credit:

If you are 49 years old, have eligible earnings of $60,000 and have completed 17 years of Point Service at the end of 2011, your 2011 Pay Credit would be calculated as follows:

Basic Pay Credit

Your 2011 Eligible Pay	$60,000
Your Basic Pay Credit % (49 + 17 = 66 points = 8%)	x 8%
Your Basic Pay Credit amount on December 31, 2011	**$4,800**

Excess Pay Credit

Your 2011 Eligible Pay over ½ SSWB ($60,000 – $53,400)	$6,600
Your Excess Pay Credit %	x 2%
Your Excess Pay Credit amount on December 31, 2011	**$132**

Your total Pay Credit on December 31, 2011 is the sum of $4,800 + $132 or a total of $4,932 for the year.

Second, add the Interest Credit:

If the interest rate is at 4% for the Plan Year, your Interest Credit would be 4% of your Account balance as of the beginning of the Plan Year. Assuming your Account balance as of January 1, 2011 was $50,000, then you received an Interest Credit effective as of December 31, 2011 equal to $2,000.

Finally, total the Pay Credits and Interest Credit, and add to the Account balance at the beginning of the year:

January 1 Account Balance (includes your "Opening Balance," if any)	$50,000
	+
December 31 Interest Credit (4%)	$2,000
	+
December 31 Basic Pay Credit (8%)	$4,800
	+
December 31 Excess Pay Credit (2%)	$132
December 31 Account Balance	**$56,932**

Remember, how your Account grows over time depends on the actual base pay increases and performance-based pay you receive and the Interest Credits allocated to your Account.

Monitoring the Growth of Your Account

To help you track the growth of your Account, you will receive personalized statements (generally on an annual basis) that will keep you up-to-date on your Account activity. These statements show your:

- Account;
- Pay Credits since the last statement;
- Any applicable Interest Credits since the last statement.

You can also obtain information on the value of your Account any time by contacting MySource for Human Resources at **1-888-640-3320** or by visiting the Web site **www.mysourceforhr.com**.

Benefits From Your Account

Although your Account is communicated to you as a lump-sum amount, when you leave the Company and commence benefits, as previously mentioned, your Account can provide a monthly annuity based on prevailing interest rates at the time you commence benefits. See the "Payment Options Under the Plan" section later in this Summary for details on how you may receive your benefit, and see the "Designation of Beneficiary" section for details on how you may designate your spouse or another individual to receive your benefit in the event of your death.

For example, if your Account balance on the date you commence benefits is $200,000 and the annuity factor (to convert your Account to an annual benefit) at that time is 11, you would receive either a lump sum of $200,000 (minus applicable withholding taxes) or a monthly benefit for life of approximately $1,515, as follows:

Calculating Annuity Example:	
Account Balance:	$200,000
Annuity Factor:	÷ 11
Annual Benefit:	$ 18,182
	÷ 12
Monthly Benefit:	**$ 1,515**

Protected Benefit

In addition to your Account, the Plan may also consider a "Protected Benefit" in calculating your retirement benefit. If you previously participated in the FAP Benefit of the Plan, your Plan benefit under the AB I Benefit is guaranteed to be no less than the lump sum actuarial equivalent of your accrued benefit under the FAP Benefit (which does not include any supplemental benefit) using eligible pay and Service through your Conversion Date (your **"Protected Benefit"**).

If you are eligible for this Protected Benefit, your benefit could be reduced if you elect to receive it prior to your "Normal Retirement Date" to reflect early commencement of payment. Because your Protected Benefit is derived from a traditional pension plan formula, you would generally not be able to receive your benefit until you retired. As noted earlier though, one benefit of the Plan's cash balance status is that you may receive your benefits anytime after your termination of employment. However, for purposes of valuing *only* the Protected Benefit portion of your Plan benefit, the Plan will consider whether you begin to receive benefits before your "Normal Retirement Date." The following subsections describe how the calculation of your Protected Benefit may be affected by when you choose to receive your benefit.

As a reminder, your AB I Benefit is calculated as described in the preceding portions of the "How the Plan Works" section. The following subsections apply *only* for any Protected Benefit portion of your Plan benefit and *do not* apply to the calculation of your AB I Benefit.

Normal Retirement

If you retire on or after your "Normal Retirement Date," your Protected Benefit will be not be impacted. Your "**Normal Retirement Date**" is the first day of the month following the later of (1) your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born) (your

"**Normal Retirement Age**"); or (2) the fifth anniversary of the date you began participation in the Plan. (Note that if you first became a participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Normal Retirement Date is the first day of the month following your 65th birthday.) If you retire on or after your Normal Retirement Date, the amount of your Protected Benefit will be based on the full amount of your Protected Benefit up to your Conversion Date (*i.e.*, your benefit will not be reduced for early commencement of payment.)

Early Retirement

If you retire on or after your "Early Retirement Date" but before your Normal Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. Your "**Early Retirement Date**" is the first day of the month on or after the date that you have (1) both attained age 60 or older and completed at least five years of Service; or (2) both attained age 55 (or older) and completed 10 years of Service. If you reach your Early Retirement Date, you may elect to retire and receive your benefits immediately or defer the commencement of your benefits until you reach your Normal Retirement Age. If you retire and elect to receive benefits at or after your Early Retirement Date, the amount of your Protected Benefit would be reduced by ¼% for each month by which your Early Retirement Date precedes the date that is three years prior to your Social Security Retirement Age.

If you defer the receipt of your benefits until your Normal Retirement Date, the amount of your Protected Benefit will be unreduced.

Distribution Prior to Early Retirement

If you terminate prior to your Early Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. If you elect to receive your benefit prior to your Early Retirement Date, the amount of your Protected Benefit will be reduced actuarially using the interest rate and mortality factors specified in the Plan.

Calculating Your Benefit

The calculation of your benefit under the Plan depends on how and when you wish to receive your benefit. Of course, if you terminate employment and elect to begin receiving your Plan benefit right away, your Account will have a smaller balance than if you had worked longer or waited to receive your benefits until a later date. Remember, you stop accruing Pay Credits when you terminate employment, and you no longer earn Interest Credits once you begin receiving your benefit. In addition, if you begin payment of your benefits prior to your Normal Retirement Age, your Protected Benefit (if applicable) would be reduced as explained above.

Your total benefit under the Plan is your Accrued Benefit. Your "**Accrued Benefit**" is the value of your benefit under the Plan as of any date before you reach your Normal Retirement Date. Your Accrued Benefit is generally the current value of your entire Account. However, if you have a Protected Benefit as described above, your Accrued Benefit is generally equal to the greater of:

1. Your entire Account (reflecting all Pay Credits, Interest Credits, and any Opening Balance); **or**

2. Your Protected Benefit, reduced by the appropriate early commencement factor (if necessary).

In other words, if your Protected Benefit is greater than your Account, you will receive your Protected Benefit. Thus, for a period of time after you become an AB I Participant, even though your Account reflects an Opening Balance and earns Pay Credits and Interest Credits, your Accrued Benefit may not appear to grow to the extent that your Protected Benefit exceeds the value of your Account.

If you are interested in finding out your benefit under the Plan, you may have your benefit calculated by visiting the Web site **www.mysourceforhr.com**.

Funding: Who Pays For Your Benefit

The Plan is funded with contributions made by the Company. On an annual basis, the Plan Administrator actuarially determines the amount that the Company must contribute in order to fund the pension benefits for you and your fellow co-workers that participate in the Plan.

Vesting: When Do You Own Your Benefit

As discussed earlier in this Summary, to be vested means you have a permanent right to your Plan benefit and are entitled to receive that benefit whenever you stop working for the Company. You become fully vested in your Plan benefit once you have completed 3 years of Vesting Service (5 years of Vesting Service for employees terminating prior to January 1, 2008) (see "Service" section described earlier in this Summary). There is no partial vesting in your Plan benefit. You are not vested until you reach 3 years of Vesting Service, and you become fully vested once you reach 3 years of Vesting Service (5 years for employees terminating prior to January 1, 2008).

Thus, for example, if you terminate employment with only 2 years of Vesting Service, then you will receive no benefit under the Plan. That is, you are not vested in your benefit because you have less than 3 years of Vesting Service. If you terminate employment with 3 or more years of Vesting Service, you are fully vested in your benefit.

RECEIVING YOUR BENEFIT

When Is Your Benefit Paid?

Provided you are vested in your benefit as described above, you (or your beneficiary) may receive or begin to receive your benefit under the Plan as soon as possible following: (1) your termination of Service with the Company or an affiliate; or (2) your death (see "Death Benefits" found later in this Summary).

If you are vested in your benefit and terminate employment with the Company, you may receive your benefit at any time after your termination. If your benefit is $5,000 or less, you will automatically be paid a single lump sum as soon as practicable after your termination. Alternatively, if your vested benefit amount is more than $5,000, you may defer receipt of your benefit until a later time, such as the date you would have reached Early Retirement or Normal Retirement. By law, you must begin to receive payment of your Plan benefit by April 1 of the calendar year following the later of either (1) the year you turn age 70½, or (2) the year in which you retire.

The amount you would be eligible to receive would be the amount of your Account (subject also to any Protected Benefit provisions). Remember, if you leave the Company before you are vested in your benefit, you are not entitled to a benefit under the Plan.

How Is Your Account Paid?

Regardless of *when* you receive your benefits, generally you will need to elect the *form* of your benefit. You can elect to receive your Plan benefit in an immediate single lump-sum payment or in an annuity form. Once you terminate employment, you can request a distribution of your benefit at any time in any of the forms available under the Plan (described below).

A Note on "Actuarially Equivalent" Benefits

The various benefit form options are considered to be *"actuarially equivalent"* meaning that, statistically, they should produce the same total benefit amount even though they provide very different monthly benefit payments or the benefit may be paid in a lump sum. To calculate actuarial equivalence, the Plan uses specified interest rate and mortality factors for various purposes. For instance, to calculate the lump sum present value for your Protected Benefit (if applicable), the Plan uses as its interest rate the rate for 30-year Treasury Securities for September of the prior year (or a minimum interest rate prescribed by the IRS if it produces a larger benefit).

Note that to receive the current year's interest rate for certain calculations, such as calculating the Protected Benefit, the last day worked must be November 30 (*i.e.*, a December 1 benefits commencement date). A December 1 benefits commencement date requires a retirement date of December 1 and filing proper paperwork (described below) with MySource for Human Resources on or before November 30 requesting commencement of pension distribution.

Applying for Benefits

If you are retiring, you must call MySource for Human Resources at **1-888-640-3320** or visit the Web site **www.mysourceforhr.com** to request a pension benefit commencement kit. If you contact by phone, please ask to speak with a Retirement Specialist.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to

commence your pension benefit. You may change your payment option at any time before your first payment is processed. However, once your payments begin, you may not change the form of payment you have elected. Generally, all forms must be returned by the 10th of the month preceding the date your benefits are calculated to commence (your "**Benefit Commencement Date**"). The actual payment(s) will be made as soon as practicable following your Benefit Commencement Date.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively practicable after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Payment Options Under the Plan

When you retire or leave the Company, you may elect to receive your vested benefit under the Plan in any of the payment forms outlined below. As previously stated, various benefit forms are "actuarially equivalent." If you do not make a payment election, your benefit will be paid in the form of a "Single Life Annuity" if you are not married, or as a "50% Pop-Up Annuity" if you are married. If you are married, you may elect a different form of payment only with your spouse's notarized consent.

Lump-Sum Payment

You may receive your Account balance in a single lump-sum payment. If you select this distribution option, no further benefits would be payable from the Plan. If you are married at the time you want your pension benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less. Again, if your vested Plan benefit is $5,000 or less, the Plan automatically pays this amount as a lump sum distribution (*i.e.*, annuity payments are not available).

Rollovers—If you receive your Account balance under the Plan in the form of a single lump sum, you may elect to roll over all or a portion of the distribution into an individual retirement account annuity ("IRA") or to another eligible retirement plan that accepts rollovers. Note that if you do not make a payment election (direct payment vs. rollover) and your benefit is greater than $1,000 but less than or equal to $5,000, then the Plan Administrator will roll over your benefit to an IRA designated by the Plan Administrator. If your benefit is $1,000 or less when you leave the Company, and you do not elect whether to receive this benefit directly or to roll it over, then the Plan automatically pays this single lump-sum amount directly to you.

Annuity Payment Forms

If the value of your Account is over $5,000, you may choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan. If you elect this option, the value of your Account is converted to an annuity. To determine your monthly benefit, your Account balance is divided by an actuarial factor based on your age when benefits start. In calculating your benefit amount, the Plan considers the type of annuity you elect and, if applicable, your beneficiary's age. The following annuity options are available to you:

- **Single Life Annuity**—As stated above, if you are single, the single life annuity option is the automatic form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it as a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may not elect this form of payment without your spouse's notarized consent.
- **50% Pop-Up Annuity**—As stated above, if you are married, the 50% Pop-Up Annuity (with no reduction for the value of the pop-up feature), with your spouse as the contingent annuitant, is the automatic form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form.

If you are married, you may choose the 50% Pop-Up Annuity distribution option, naming a beneficiary other than your spouse (and with a reduction for the value of the pop-up feature), provided your spouse consents to the alternate beneficiary. Your spouse's consent must be notarized.

If you are single, you may choose the 50% Pop-Up Annuity distribution option (also reduced for the value of the pop-up feature) naming a beneficiary of your choice.

Under the 50% Pop-Up Annuity distribution option, you receive reduced benefits monthly for your lifetime. If you die before your beneficiary, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime.

If your beneficiary dies within 60 months after your Benefit Commencement Date and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death.

If your beneficiary dies more than 60 months after your Benefit Commencement Date and before you die, your monthly payment will remain the same as when your beneficiary was living and all payments will stop at your death.

- **33-1/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 33-1/3% of your benefit for his or her lifetime. If you are married, you may not elect this form of payment without your spouse's notarized consent.
- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.
- **75% Annuity** — Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 75% of your benefits for his or her lifetime. This option is available effective January 1, 2008. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.
- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.

Payments under any of these options will be based on your Account (as well as any Protected Benefit, if applicable). Subject to the spousal consent requirements noted above, you may choose any form of distribution as well as choose any beneficiary as your joint annuitant. If you die before an elected form of distribution begins, your (or your beneficiary's) benefit will be determined as provided in the "Death Benefits" section of this Summary.

A Comparison of Payment Options

If you choose to receive your benefit as a lump sum, you will receive the total vested value of your Account (or if greater, the benefit calculated under the Protected Benefit provisions described previously). If you choose to receive your benefit as an annuity, the total vested value of your benefit will be converted into an annuity form of payment. To determine how much any annuity option would pay, your benefit is first defined as a single life annuity. If you choose a different annuity payment option providing benefits for a beneficiary after your death, your actual payment will be reduced to reflect the cost or value of guaranteeing payments over the lives of two people.

For example, assume you are married and retiring when both you and your spouse are age 55. Assume also that your Account is valued at $200,000 and the applicable interest rate is 3.77% at the time you retire (note that the applicable interest rate fluctuates from year to year). See below for examples of estimated monthly amounts under some of the payment options that you could choose, and the amounts your surviving spouse could receive if you die after payments begin. Note that these examples do not incorporate any Protected Benefit you may have.

PAYMENT OPTIONS	YOUR MONTHLY BENEFIT FOR LIFE	YOUR SPOUSE'S MONTHLY BENEFIT FOR LIFE AFTER YOUR DEATH
Lump Sum Payment *($200,000)*	None	None
Single life annuity	$996.36	$0.00
50% Pop-Up Annuity (unreduced for pop-up feature with spouse as beneficiary)	$952.52	$476.26
33-1/3 % Annuity	$967.46	$322.16
66-2/3% Annuity	$939.56	$626.69
75% Annuity	$932.59	$699.44
100% Annuity	$912.66	$912.66

Situations Affecting Your Plan Benefit

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed three years of vesting service (five years of vesting service if you terminated prior to January 1, 2008) you will not be entitled to a pension benefit and your pension benefit is forfeited.
- If you do not make the proper application for benefits, do not provide necessary information, or do not provide your current address, your pension benefits could be delayed.
- If you die before your pension benefits begin and are unmarried, your pension benefit is payable to your beneficiary, estate, or trust. See "Death Benefits" below.
- If required by a qualified domestic relations order, all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony, or marital property rights. See "In the Event of Divorce or Dissolution" below.
- If there is a mistake or misstatement about eligibility, participation, or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan Administrator has the authority to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made. In addition, in the event that an overpayment is made from the Plan and no additional payments are due to be paid, the Plan Administrator has the authority to seek

reimbursement of such overpaid amounts from the Participant (plus interest calculated in accordance with IRS guidance).

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

A Note on Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. The Social Security office can advise you on the documents you will need in order to apply for this benefit.

DEATH BENEFITS

Death After Pension Payments Begin

If you die after you have begun receiving your pension benefit, additional payments to a named beneficiary will depend on the form of benefit payment you selected (see "Payment Options Under the Plan" above).

Death Before Pension Payments Begin

If you die before you begin receiving your pension benefit and you were vested under the Plan at the time of your death (see "Vesting: When Do You Own Your Benefit" above), the Plan will provide pre-retirement death benefits to your spouse or other beneficiary.

The death benefit payable will equal the full value of your vested Account. If you were married on the date of your death, your surviving spouse will be entitled to a Pre-retirement Survivor Annuity equal to the value of your vested Account (or if greater, equal to the survivor annuity portion of a joint and 50% survivor annuity calculated as if you terminated employment on the date of your death and considering any Protected Benefit calculation). Generally, a "**Pre-retirement Survivor Annuity**" provides your surviving spouse with a single life annuity benefit for his or her remaining lifetime. If you do not wish for your surviving spouse to receive a Pre-retirement Survivor Annuity in the event of your death, or if you wish to name a beneficiary other than your surviving spouse to receive benefits at your death, you may, with your spouse's written consent, waive the Pre-retirement Survivor Annuity and/or elect another beneficiary.

Even if you do not elect a different form of payment, your surviving spouse may elect to receive the death benefit as follows:

- **Single Life Annuity**—A monthly benefit payable for the life of your spouse, commencing as of the first day of the month following your death. Alternatively, your spouse can elect to delay beginning payment of this annuity up to the date you would have attained age 65, but no later.
- **Single Lump Sum**—Payment in the form of a single lump sum payable as soon as practicable after your death.

If your beneficiary is someone other than your spouse, your Account will be paid out as a lump sum. Note that if the present value of the death benefit payable to your spouse or other beneficiary is $5,000 or less, the Trustee will automatically distribute your death benefit to your surviving spouse or other beneficiary in a single lump sum payment.

Death Benefit Rollovers

Your beneficiary (whether spouse or non-spouse) may elect to rollover a lump sum death benefit to an individual retirement account/annuity (IRA) or, for a spouse beneficiary, to some other qualifying retirement plan. Note that non-spouse beneficiaries must request that the Plan make a "direct rollover" to the applicable IRA (*i.e.*, the Plan pays the lump sum death benefit directly to the IRA). A non-spouse beneficiary may not receive a distribution and then try to deposit it into an IRA as a rollover. For further information, see "Rollovers" below.

Designation of Beneficiary

When you first join the Plan, you will need to name a beneficiary of your AB I Benefit. A beneficiary designation form will be sent to you when you become eligible to join the Plan. On your beneficiary designation form, you indicate the person(s) who will receive the remaining payments of your Plan benefit, if any, in the event of your death. You may change your beneficiary at any time prior to commencing benefit payment(s) by completing and returning a new form. Contact MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com** to change your beneficiary.

If you are married—By law, you must name your spouse as your beneficiary. If you wish to designate someone other than your spouse, your spouse must consent to your election in writing. The consent must be witnessed by a Notary Public and returned to MySource for Human Resources.

If you are single—You may name anyone as your beneficiary.

Some points on naming a beneficiary:

- If you marry, **your spouse automatically becomes your beneficiary** regardless of your previous designation, unless your new spouse consents in writing to another designation. You should notify MySource for Human Resources of any changes in your marital status. See "In the Event of Divorce or Dissolution" (the following section) for an explanation of how a divorce may affect your beneficiary designation under the Plan.
- If you designate more than one beneficiary, payment of your Plan benefit will be divided evenly among your beneficiaries unless you designate otherwise.

Failure of Beneficiary Designation

If you do not designate a beneficiary, or if your beneficiary designation is for any reason illegal or ineffective, or if none of the beneficiaries that you have designated survives you, your Plan benefit will be paid in the following order of priority:

- your surviving spouse;
- your descendants, per stirpes; or
- to the legal representative of your estate.

Duty to Report Participant's Death

If you die while receiving pension payments, the Plan Administrator must be notified of your death so that appropriate action may be taken concerning your benefits (*e.g.*, beginning payments to a designated beneficiary; stopping payments; etc.). It is illegal for any person or entity to continue to receive after your death benefit payments that are supposed to be made only for the duration of your life. Accordingly, please advise those persons who may ultimately represent your estate, or who may be in a position to receive your benefit payments, of this legal duty to contact the Plan Administrator upon your death.

IN THE EVENT OF DIVORCE OR DISSOLUTION

If you are married and you go through a divorce or dissolution, such proceedings may affect your Plan benefit or your beneficiary designation under the Plan, as explained below. You must inform the Plan Administrator if you are divorced by contacting MySource for Human Resource at **1-888-640-3320.**

Beneficiary Designations After Divorce/Dissolution

If you are married and your marriage terminates by reason of divorce, dissolution or other similar operation of domestic relations law, any beneficiary designation you have previously made will remain unchanged. Note that while some state laws may invalidate a spousal beneficiary designation upon divorce, that is not the case under the Plan. Upon divorce, if you had named your former spouse as your beneficiary under the Plan, your beneficiary designation will not change unless you make a new beneficiary designation that revokes your prior beneficiary designation, or you remarry.

If you subsequently re-marry a different spouse, your previous beneficiary designation is *automatically* revoked and your new spouse becomes your beneficiary, unless a valid "qualified domestic relations order" provides otherwise. As explained below, a qualified domestic relations order may limit your ability to name another beneficiary in the event of a divorce or dissolution.

Qualified Domestic Relations Order (QDRO)

If you become divorced or legally separated, a specific type of court order could require that part of your benefit be paid to someone else – your former spouse, for example. This is known as a "qualified domestic relations order" ("QDRO"). By federal law, the Plan must comply with a QDRO. A QDRO is a legal judgment or decree that recognizes the rights of or support obligation toward a spouse, former spouse, child, or other dependent. A domestic relations order must satisfy specific requirements to be "qualified," and it must be recognized by the Plan Administrator.

If required by a QDRO, all or a portion of your benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony, or marital property rights. A QDRO may require that your former spouse be treated as your surviving spouse for all or any part of the survivor benefits payable after your death. This means that if you re-marry, your subsequent spouse may not be treated as your surviving spouse for the portion of your benefit assigned to your former spouse if a valid QDRO so provides.

You and your beneficiaries may obtain, free of charge, a copy of the procedures used to determine the "qualified" status of a domestic relations order from MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com**. You or your spouse should submit a draft version of a domestic relations order to the Plan Administrator for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any court proceedings that may affect your Account, contact MySource for Human Resources at **1-888-640-3320**. When the Plan Administrator receives notice of a pending QDRO, a hold will be placed on your Account that will prevent you from making any withdrawals until the QDRO is processed.

CHANGES IN EMPLOYMENT STATUS*

Rehired Employees

If you terminate employment after becoming a Plan participant and later return to employment as an Eligible Employee (*i.e.*, you are NOT an "exempt employee" rehired after January 1, 2010 or an otherwise ineligible employee), you will generally begin participation in the Plan under the AB II Benefit provisions. As an Eligible Employee, you will begin participation immediately once you are rehired; however, the Break in Service rules (described earlier in this Summary) may impact your Service crediting under the Plan.

If you are participating under the AB I Benefit and you terminate employment but do not receive a distribution, then when you are reemployed, the Plan will convert your AB I Benefit to an AB II Benefit. If you terminate employment and receive a lump sum distribution of your AB I Benefit, then when you are reemployed, you will begin participating in the Plan as a new AB II Benefit employee (*i.e.*, with a $0 opening balance and 0 years of Point Service, though your prior Service will count for vesting purposes).

If you are receiving your benefits in the form of an annuity at the time of your return to employment, your annuity payments will be suspended and the unpaid portion of your prior benefit will be converted to an AB II Benefit opening balance as of the date of your reemployment. On your subsequent Benefit Commencement Date, your Protected Benefit (if any) will be reduced by the amount of annuity benefits you received. For purposes of calculating your AB II pay credits (described in the AB II Benefit Summary), you will be credited with Point Service both before and after your absence from employment. Further, your prior Service (as well as your Service earned after your reemployment) will count for vesting purposes. Note that the suspension of benefits and conversion to an AB II opening balance may be impacted if you return to work after your Normal Retirement Age. In such instances, contact the Plan Administrator for additional details regarding the effect of reemployment on your retirement benefit.

NOTE: If you are rehired by the Company on or after January 1, 2010 as an exempt employee, you will not participate in the Plan under any benefit option. Any prior benefit you had accrued during your previous employment with the Company that had not been paid out to you prior to your rehire date will remain in the Plan and any service you accrue after rehire will count for purposes of vesting in your prior benefit. However, you will accrue no new benefit under the Plan.

Transfers Within the Plan

Change from Non-Exempt to Exempt Status

Subject to the exception described in the next paragraph, if you transfer *from* a *non-exempt* position with the Company *to* an *exempt* position with the Company, your benefit will be determined under the AB II Benefit. Your AB I Benefit will be converted to an AB II Benefit opening balance in the Plan. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer.

* Note the rehire provisions of this section are applicable to any participant rehired on or after January 1, 2008. Note the transfer provisions of this section are applicable to transfers occurring on or after January 1, 2009.

Exempt Employee Transfers When Hired or Rehired On or After January 1, 2010—If you transfer to an *exempt* position and were hired or rehired on or after January 1, 2010 (regardless of whether first hired as an exempt or non-exempt employee), then once you transfer to an exempt position, you are no longer eligible to participate in the Plan and your benefit accruals will cease upon your transfer.

If You Have a Prior Frozen FAP Benefit—If you have a FAP Benefit that was never previously converted to an AB I Opening Balance and you transfer to become an exempt Eligible Employee, then in addition to your current AB I Benefit, your previously accrued FAP Benefit will be converted to an AB II opening balance. The conversion will be effective as of the date you become an active exempt employee accruing a benefit under the Plan. The following conditions shall apply to this opening balance:

- Your opening balance shall earn interest credits in accordance with the AB II Benefit provisions of the plan in which the frozen benefit was accrued.
- If your converted frozen benefit was not earned under the Plan, the benefit will remain in the plan in which it was earned and will be tracked separately from any benefit earned under the Plan.
- If your converted frozen benefit was earned under the Plan, the Plan Administrator may elect to track your previously accrued frozen benefit separately from your ongoing AB II Benefit under the Plan.
- You will never receive less than the previously accrued FAP Benefit earned prior to the conversion.

Changes between Union and Non-Union Status

If you transfer *from* a *union* position with the Company *to* a *non-union* position with the Company, or if you transfer *from* a *non-union* position with the Company *to* a *union* position with the Company, your benefit will be determined under the AB II Benefit. Your AB I benefit under the Plan will be converted to an AB II Benefit opening balance in the Plan. You will receive credit for Point Service for your Service both before and after the transfer.

Transfers to/from Affiliates

From An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under an affiliate's pension plan *to* an employment position with the Company otherwise providing coverage under the Plan. Unless specific provisions in the Plan or an affiliate's plan provides otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources Department for further information.

Note that as described below, transferring from a Company affiliate means that you either stay in the affiliate's plan or you become an AB II Benefit participant in the Plan. Either way, this Summary (applicable to the AB I Benefit) will not apply. The chart below is provided for informational purposes. If you transfer from an affiliate, please see the Summary applicable to you.

IF YOU TRANSFER FROM AN AFFILIATE IN THE FOLLOWING POSITION:	TO THE COMPANY IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Non-union (exempt or non-exempt)	Non-union (exempt or non-exempt)	You will remain in the affiliate's plan and will accrue no benefit under the Plan. In accordance with the terms of the affiliate's plan, you will remain subject to your plan benefit terms in effect prior to your transfer, except that any non-union non-exempt employee that becomes an exempt Eligible Employee (hired or rehired prior to January 1, 2010) shall become an AB II participant under such plan and shall have his/her benefit converted to an AB II Benefit opening balance under such plan.
Union	Non-union (exempt or non-exempt)	Your benefit under the affiliate's plan will be frozen as of your transfer date and you will begin to participate in the AB II Benefit of the Plan. Your prior benefit will remain in the affiliate's plan and you will begin participation in this Plan with a $0 opening balance. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer. With respect to your benefit under the affiliate's plan, you will cease to earn service for benefit accrual as of the date of transfer, except that service following transfer shall be counted solely for purposes of determining eligibility for an early retirement benefit under such plan. Note, however that if you transfer to an exempt employee position, you must be an "Eligible Employee" (*i.e.*, you were hired or rehired prior to January 1, 2010) in order to begin to accrue a benefit under the Plan.
Non-union (exempt or non-exempt)	Union	
Union	Union	

To An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under the Plan *to* an employment position with an affiliate that does not sponsor the Plan (because the affiliate offers a different plan or no plan). Unless specific provisions in the Plan or an affiliate's plan provide otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources Department for further information.

IF YOU TRANSFER FROM THE COMPANY IN THE FOLLOWING POSITION:	TO AN AFFILIATE IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Non-union (non-exempt)	Non-union (non-exempt)	You will remain in the AB I Benefit of the Plan and will continue to earn Vesting Service and Point Service under the Plan after the transfer.
Non-union (non-exempt)	Non-union (exempt)	*Hired or Rehired by the Company Prior to January 1, 2010.* If you were hired or rehired prior to January 1, 2010, your benefit in the Plan will be converted to an AB II Benefit opening balance and you will participate in the Plan under the AB II Benefit after your transfer. You will remain in the Plan and will continue to earn Vesting Service and Point Service under the Plan after the transfer.

IF YOU TRANSFER FROM THE COMPANY IN THE FOLLOWING POSITION:	TO AN AFFILIATE IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
		Hired or Rehired by the Company On or After January 1, 2010. If you were hired or rehired on or after January 1, 2010, you will no longer earn a benefit under either the Plan or under the affiliate's plan. Your AB I Benefit Account in the Plan will be *frozen as of the date of your transfer, but will continue to earn* Interest Credits until you commence distribution of your benefit. You will continue to earn Vesting Service under the Plan after the transfer.
Union	Non-union (exempt or non-exempt)	Your AB I Benefit Account in the Plan will be frozen as of the date of your transfer but will continue to earn Interest Credits until you commence distribution of your benefit. With respect to your benefit under the Plan, you will cease to earn service for benefit accrual as of the date of transfer, except that service following transfer shall be counted solely for purposes of determining eligibility for an early retirement benefit under the Plan (*i.e.*, for your Protected Benefit, if applicable). You will begin participating in the affiliate's plan as a new participant (assuming you are an "Eligible Employee"). If the affiliate's plan provides for your participation in an AB I or AB II Benefit option, you shall begin participation in such option with a $0 opening balance, though you will receive credit for vesting service and point service both before and after the transfer. If the affiliate's plan provides for your participation in a FAP Benefit option, you shall begin participation in such option with zero credited service.
Non-union (non-exempt)	Union	
Union	Union	
Union	NiSource Corporate Services	Your benefit will remain in the Plan and will be determined under the AB II Benefit. Your AB I Benefit will be converted to an AB II Benefit opening balance in the Plan. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer. *Exception:* If you were hired or rehired on or after January 1, 2010, and then you transfer to an exempt position with NiSource Corporate Services, you will no longer earn a benefit under either the Plan or under any NiSource plan. Your AB I Benefit Account in the Plan will be frozen as of the date of your transfer, but will continue to earn Interest Credits until you commence distribution of your benefit. You will continue to earn Vesting Service under the Plan after the transfer.
Non-union (non-exempt)	NiSource Corporate Services	

If You Continue to Work After Normal Retirement Age

If you choose to work beyond your Normal Retirement Age, you will continue to earn Pay Credits and Interest Credits under the AB I provisions of the Plan until you retire. If you work 40 or more hours per month on and after reaching Normal Retirement Age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching Normal Retirement Age, you may begin receiving your pension benefit from the Plan.

If You Become Disabled

If you become Disabled while working for the Company, the calculation of your Plan benefit will be impacted as described in this section. In general, "**Disability**" or "**Disabled**" under the Plan means any physical or mental condition that constitutes a disability under the long-term disability plan (the "LTD Plan") maintained by the Company. A Disability commences when you first qualify for benefits under the Company's LTD Plan and ceases when you no longer qualify for benefits under such LTD Plan.

If you are considered Disabled under the Plan and later return to active employment as an Eligible Employee (*i.e.*, you are NOT an "exempt employee" that was originally hired or rehired after January 1, 2010 or an otherwise ineligible employee), you will be covered under the AB II Benefit once you return to active work. The Plan will convert your AB I Benefit to an AB II Benefit.

Service Crediting—If you are considered Disabled under the Plan, you will continue to earn Vesting Service and Point Service while the Disability continues without regard to whether the Disability lasts beyond one year and could thus constitute a "Severance from Service" (as defined in the Plan). Point Service under the Disability provision shall cease to be credited as of the earliest of (1) the date on which your Disability ends pursuant to the Company LTD Plan (which shall be deemed your "Termination of Service" (as defined in the Plan) unless you return to employment with the Company or unless the Company determines a different "Termination of Service" date), (2) the date on which you return to employment, or (3) the date your benefit under the Plan commences. Note that if your Disability under the Company LTD Plan commenced prior to January 1, 2000, you earned Point Service during the period of your Disability prior to January 1, 2000 only if you were both Disabled under the Plan and eligible for disability benefits under the Social Security Act.

Your Account—You will continue to receive Pay Credits and Interest Credits to your Account while you are Disabled. For these purposes, you will be deemed to receive Eligible Pay at the same level of Eligible Pay in effect for the month when you became Disabled (but excluding any performance-based components of Eligible Pay). See the "How the Plan Works" section earlier this summary for an explanation of what compensation counts as Eligible Pay.

You may elect to start your Plan benefit payments at any time once you are considered to have terminated employment by the Company. You may receive your benefit under any of the payment options described in "Payment Options Under the Plan" above. Note that if you elect to begin benefit payments, you will stop earning Pay Credits and Interest Credits. In addition, commencing your Plan benefit might mean that your LTD benefits would no longer be payable. For more information about electing payment of your Plan benefit and whether such an election would impact your LTD payments, contact MySource for Human Resources and consult your LTD Plan.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

As stated above, to request your Plan benefits you must obtain a pension benefit commencement kit from MySource for Human Resources (1-888-640-3320; www.mysourceforhr.com).

Claim Denial and Appeal Process

If you disagree with any decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the administrative review procedure you must follow. If you think benefits owed to you are not paid, or are too low, or are paid at a time other than when you think they should be, you can make a "claim" for benefits to the Plan Administrator.

If your claim for a pension benefit is denied in whole or in part, you have the right to request a review of the denial. You (or your beneficiary) will be notified of a denial of your claim in writing by the Plan Administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice of the denial will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan Administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the NiSource Benefits Committee at the following address:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. If your appeal is denied, you will be told why and which Plan provisions support that decision. If the final determination is made in your favor, the determination shall be binding and conclusive. If the final determination is not made in your favor, the determination shall be binding and conclusive unless you notify the NiSource Benefits Committee within 90 days after the mailing or delivery of the determination that you intend to institute legal proceedings under Section 502(a) of ERISA challenging the determination, and you actually institute such legal proceedings within 180 days after such mailing or delivery. All questions arising with respect to the Plan during any such legal proceedings shall be governed by Indiana law, except to the extent superseded by federal law.

TAX CONSEQUENCES

How and When Your Plan Benefits are Taxed

Generally, federal and state income tax laws do not require you to pay tax on your Plan benefits until you actually receive distributions under the Plan. Once you begin to receive benefit payments, you will have taxable income on these payments in the year that your receive them. In the year(s) of any distribution from the Plan, you will receive a tax form that will provide you with the information you need to file your taxes. You may be able to defer federal income taxes and avoid any penalty taxes if you transfer or "roll over" your distribution (see the Rollover section below). You should consult your tax advisor concerning any distribution you receive from the Plan.

Withholding Requirements

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA, including a Roth IRA (see the Rollover section below). You should consult with your personal tax adviser regarding this matter.

Rollovers

If you receive your benefit under the plan in the form of a single lump-sum, you may elect to roll over all or a portion of the distribution to an Individual Retirement Account/Annuity (an "IRA") or into another retirement plan that accepts rollovers from qualified plans. If you directly roll over your distribution from the Plan into a traditional IRA or another retirement plan, no income tax will be due on the amount rolled over and earnings thereon until you begin withdrawing the funds from the traditional IRA or retirement plan. If you roll over your distribution to a Roth IRA, the amount rolled over *is* subject to income tax in the year of the rollover. Under certain circumstances, all or a portion of a distribution may not qualify for rollover treatment.

As stated above, if you elect to have your benefit paid directly to you in a lump-sum payment, rather than rolled over, 20% of your distribution will be withheld and paid to the IRS. Even if you elect to have your benefit paid directly to you, you may still decide to roll over all or a portion of your distribution to an IRA or another retirement plan. If you decide to roll over your distribution, you must make the rollover within 60 days after your receive the distribution. If you choose to roll over 100% of your distribution, you must replace the 20% that has been withheld with other money available to you within the 60-day period. If you do not replace the 20% that has been withheld and you roll over only the 80% that you actually received, you will be taxed on the 20% that was withheld.

Note that in contrast to a single lump-sum payment, you cannot roll over monthly benefit payments into an IRA or another retirement plan.

Distributions Prior to Age 59 ½

In addition to being taxed as ordinary income, the taxable portion of a distribution taken prior to age 59 ½ (an early distribution) may be subject to a nondeductible federal penalty tax of 10%. Additional penalties may exist under state tax law. Early distributions are exempt from federal penalty taxes if the distribution was made for one of the following reasons:

- Distribution to your named beneficiary due to your death;
- Distribution that is made in the form of annuity payments over your life expectancy or over the life expectancy of you and your beneficiary;
- Distribution is made after termination of employment if you terminate after you reach age 55;
- Distribution that is made because you are totally and permanently disabled;
- For deductible medical expenses;
- Payment to an alternate payee under a qualified domestic relations order upon dissolution of a marriage; or
- To roll over to an IRA or other retirement plan within 60 days of receipt.

Please contact your Plan Administrator to receive a copy of the Special Tax Notice regarding payments from the Plan. This notice contains important information that you need to know before making a payment/withholding election.

AMENDMENT OR PLAN TERMINATION

The Committee expects to continue the Plan, but reserves the right to suspend, amend, modify, or terminate the Plan in whole or in part at any time. If the Plan is amended, the amendments will not decrease your Accrued Benefit as of the time an amendment is adopted.

The Committee may only amend the Plan in writing. Any amendments shall be duly authorized if approved or ratified by the Committee. Thus, the Plan may not be modified or amended simply by representations, oral or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or human resources representative, for instance. If you believe you have received information that is contrary to the terms of the Plan or this Summary, please contact the Plan Administrator for clarification or confirmation.

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be fully vested as of the date of the termination. Benefits will be paid, according to law, as described in the following paragraph. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan assets would be used to pay benefits to retirees, beneficiaries, and active participants, up to the total amount of assets in the Plan's trust. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made in the following order of priority: (1) benefits that are being paid or that will begin to be paid within three years; (2) benefits guaranteed by the Pension Benefit Guaranty Corporation; (3) benefits that were already vested before the Plan's termination; and (4) all other benefits.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Your Benefits are Insured

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;

- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact MySource for Human Resources at **1-888-640-3320** or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

ADMINISTRATIVE / LEGAL OVERVIEW

Administrative Information

Plan Sponsor

The Plan Sponsor is Columbia Energy Group.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee (the "Committee"). In its discretion, the Committee may designate members of the NiSource Human Resources Department or other individuals to act on its behalf with respect to the administration of the Plan. The Committee has the sole authority to interpret the terms of the Plan. You may contact the Committee/Plan Administrator at:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for Columbia Energy Group is 13-1594808.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 001. The AB I Benefit is a cash balance plan. The official Plan name is the Columbia Energy Group Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan Trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Committee's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the Plan Trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Legal Information/Issues

Employment Rights

The Plan is neither a contract for employment nor consideration for employment. Participation in the Plan is not a guarantee of or contract for new or continued employment. All employees remain subject to termination, layoff, or discipline as if the Plan had never been put into effect.

If the Plan Becomes "Top-Heavy"; A Legal Limitation

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $160,000

(indexed for 2011), and employees who are 1 percent owners of the Company with annual compensation of more than $150,000 (not indexed), 5 percent owners of the Company, and beneficiaries of the above. You will be notified if this affects you.

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Senior Vice President of Human Resources
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan Administrator or the Plan Trustee.

State Law

Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

Collective Bargaining Agreements

As stated earlier in this SPD, employees who are covered by a collective bargaining agreement are not eligible for the Plan unless the applicable collective bargaining agreement provides for participation in the Plan. For those employees who are covered by a collective bargaining agreement providing for participation in the Plan, the Plan is maintained pursuant to a collective bargaining agreement.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged, or garnished, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend, or a court-appointed guardian.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including

insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (Social Security retirement age) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.
- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your

telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the "Publications Hotline" of the EBSA.

NiSource®

SUMMARY PLAN DESCRIPTION FOR THE

Columbia Energy Group Pension Plan

A DESCRIPTION OF YOUR RETIREMENT PENSION BENEFITS

For Employees in the AB II Benefit

March 2011

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INTRODUCTION

Retirement can be the most exciting time of your life. Of course, you must work hard and save during your career to achieve the kind of financial security needed to enjoy those years to the fullest. Early on, you will need to ask yourself: "What sources of income will I have for my retirement?" You will likely be relying on (1) your pension benefit from the **Columbia Energy Group Pension Plan** (previously known as the Retirement Plan of Columbia Energy Group Companies, hereinafter referred to as the "**Plan**"), (2) a retirement benefit from Social Security, (3) your own personal savings, and (4) if applicable, savings under the NiSource Inc. Retirement Savings Plan or any other employer-sponsored retirement plan. Your employer, Columbia Energy Group, offers the Plan for the benefit of its employees and their beneficiaries in order to help provide for retirement.

Overview of the Plan

An innovative retirement plan that helps you prepare more effectively for your future, the Plan is a defined benefit pension plan funded entirely by contributions from NiSource Inc. or its affiliates. Its purpose is to provide you with retirement income that is in addition to any other retirement income you have or may be eligible to receive.

As an employee of Columbia Energy Group or any affiliate that adopts the Plan for its employees (collectively, the "**Company**") satisfying the criteria described in the "Eligibility and Enrollment" section, you are eligible for the **AB II Benefit** of the Plan. Note that if you are a union employee of the Company, you will not participate in the AB II Benefit unless the collective bargaining agreement that covers you provides for your participation.

Introduction to the AB II Benefit

You are covered under the **AB II Benefit** of the Plan. The AB II Benefit (formerly the "Account Balance 2011 Option Benefit") is a "cash balance" option that makes it easy to understand your retirement benefit under the Plan. This option is unique because it offers you both a visible and a portable benefit.

Once you become a participant in the Plan, the Company sets up a bookkeeping account in your name. Each year, the Company adds *pay credits* equal to a percentage of your pay to your account. Your account also grows with interest in the form of annual *interest credits* throughout your career. The total of these pay credits and interest credits, plus, if applicable, any "opening balance" reflecting the benefit you earned prior to becoming an AB II Benefit participant make up your account balance. Periodically (in general, annually), you will receive personalized statements showing your current account balance. Because you will always see your account balance, you can easily monitor the growth of your retirement benefit – so your benefit is *visible*. When you retire, you can choose to receive your account balance in one of several payment methods (also explained in more detail later in this Summary). What's more, you are entitled to receive the "vested" portion of your account balance if you leave the Company prior to retirement, so your benefit is also *portable*.

Again, it costs you nothing to participate because the Company makes all contributions necessary to fund your AB II Benefit under the Plan on your behalf.

About this Plan Summary and Plan Administration

This handbook serves as a Summary Plan Description ("SPD") of the Plan, prepared in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. This SPD does not extend or change the Plan in any way.

The NiSource Benefits Committee (the "Committee") serves as business manager and administrator for the Plan (the "Plan Administrator"). The Plan Administrator utilizes the NiSource Human Resources Department and other specified individuals to carry out a number of administrative tasks for the Plan. See "Administrative Information" found later in this Summary. A trust fund has been established for the purpose of holding funds contributed to the Plan. The trust fund is administered by a trustee (the "Trustee") appointed by the Committee.

While the Committee intends to continue the Plan described in this handbook, the Committee reserves the right to change, modify, or discontinue the Plan and any of its terms at its discretion, subject to any applicable collective bargaining agreement.

HIGHLIGHTS: AB II BENEFIT

ARE THERE EMPLOYEE CONTRIBUTIONS?	No, all contributions are made by the Company
ARE THERE COMPANY CONTRIBUTIONS?	Yes; the Company makes contributions to fund your AB II Benefit, which is based on: • Your age • Your years of service • Your Eligible Pay, taking into consideration the Social Security Taxable Wage Base; and • The Plan's interest credit rate (currently the greater of the 30-year Treasury Securities, but no less than 4%)
WHEN AM I VESTED IN MY BENEFIT?	You are fully vested after 3 years of service (if you terminated prior to January 1, 2008, you generally were vested after 5 years of service).
WHAT IS ELIGIBLE PAY FOR PURPOSES OF DETERMINING MY BENEFIT?	In order to calculate your pay credits under the Plan, Eligible Pay includes your base salary and commissions, plus your performance based pay (*e.g.*, annual incentives) paid in or prior to the month of your termination of service, any salary reduction contributions made for a Company cafeteria or 401(k) plan, any "banked" vacation paid under the NiSource Vacation Policy, and effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay). However, the Plan does <u>not</u> consider certain items to be Eligible Pay. These excluded items include, but are not limited to, overtime, shift differential pay, amounts deferred to a nonqualified plan, and other special forms of pay such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income. In addition, the Plan also excludes from Eligible Pay any unused and accrued vacation paid on or after your termination of service. Note again, Eligible Pay excludes any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance based pay) when paid in any month following your termination of service.
WHEN IS MY BENEFIT PAID?	Provided you are vested, you can be paid: • When you terminate employment; • When you retire; • When you reach age 70-1/2; or • In the event of your death
HOW CAN I RECEIVE MY BENEFIT?	You may elect to receive your benefit in the form of: • One of several Monthly Annuity Options • A Lump Sum • A Rollover

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be an "Eligible Employee" of the Company to actively participate in the Plan. Generally, you are eligible to participate in the AB II Benefit of the Plan (*i.e.*, you are an "AB II Participant") if you are a regular full-time or part-time employee and fall within one of the categories described in the box below. You are not eligible to participate if you are an "exempt employee" (as classified by the Company) who is hired or rehired on or after January 1, 2010, an intern, an independent contractor or a leased employee of the Company, or if you are a union employee whose collective bargaining agreement does not provide for Plan participation.

More specifically, an AB II Participant is:

- All *exempt* employees (except exempt employees hired or rehired on or after January 1, 2010), including:
  - Any exempt employee newly hired or rehired on or after October 1, 2005 but before January 1, 2010;
  - Any exempt employee who elected to participate in the AB II Benefit effective January 1, 2006*;
  - Any exempt employee on long-term disability as of October 1, 2005 who returned to active employment and who elected to participate in the AB II Benefit or who automatically transitioned to the AB II Benefit effective upon return to employment; and
  - All other exempt employees who are participating in the Plan and transitioned to the AB II Benefit effective January 1, 2011.
- Any *non-exempt* (union or non-union) employee hired or rehired on or after January 1, 2008.
- Certain other persons who are allowed to elect to participate in the AB II Benefit pursuant to terms of the Plan.
- All other *non-exempt* (union and non-union) employees effective January 1, 2013.

***Note:** Each non-union exempt employee who participated in the FAP Benefit or the AB I Benefit of the Plan had the opportunity to make an irrevocable Plan choice in December 2005 to stay in his or her current option or switch to the AB II Benefit ("Choice"). If no Choice was made, the employee remained in his or her option under the Plan.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts on your first day of work with the Company. Once you start to participate in the Plan, you will continue to participate as long as you are an Eligible Employee of the Company. If you terminate employment after becoming a Plan participant and later return to employment as an Eligible Employee, you will participate again immediately once you are rehired unless the "Break in Service" rule applies. See the "Break in Service" section later in this Summary for an explanation of this rule and how it might affect your participation if you terminate employment and later become reemployed by the Company. Note again, that if you terminate employment and later return as an "exempt employee", you are no

longer eligible to participate in the Plan (*i.e.*, "exempt employees" hired or rehired on or after January 1, 2010 are not eligible to participate in the Plan).

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an Eligible Employee (*i.e.*, you terminate employment or your employment status changes to one that is not eligible to participate in the Plan);*
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

***Note:** Once you are no longer an Eligible Employee, you will remain an inactive Plan participant (continuing to earn interest credits on your vested account) until you take a full distribution of your vested benefit from the Plan.

Service

Your Service with the Company, and also any breaks in your Service, have an effect on your participation in and benefits under the Plan. As explained in the following paragraphs, your Service with the Company is used as a component to calculate your benefit under the Plan. Also, the Plan uses Service to determine when you are entitled to (or "vested" in) your benefit under the Plan. Note that if you terminate and return to work as an ineligible employee (*e.g.*, an exempt employee hired or rehired on or after January 1, 2010), you no longer earn Point Service under the Plan. However, you will earn additional Vesting Service as described below.

Point Service

"Point Service" is the number of your years and partial years (*i.e.*, months) of Service as an employee of the Company (or any affiliate of the Company) from the first day of the month in which your employment began through the last day of the year in which your termination of employment, for any reason, occurs. Notwithstanding the foregoing, if you were a FAP Participant who voluntarily elected to become an AB II Participant, your Point Service for the period prior to your conversion to the AB II Benefit is equal to the amount of credited service you earned prior to your conversion. Point Service is used to determine, in part, the amount of pay credits that are added to your Account. Please see the "How the Plan Works" section later in this Summary for a complete explanation of how your pay credits are calculated.

Vesting Service

"Vesting Service" is the number of your years of Service as an employee of the Company (or any affiliate) from your date of employment through the date of your termination of employment for any reason. To be "vested" means you have a non-forfeitable right to your Plan benefit. You are fully vested in your pension benefit after completing three years of Vesting Service with the Company and/or an affiliate. Note that if you terminated prior to January 1, 2008, you generally had to complete five years of Vesting Service before becoming fully vested in your benefit (unless you terminated at a time when an even higher vesting requirement applied, in which case the terms of the Plan in effect at your termination will control).

Special rules may apply if you experience a break in service, become disabled or if you were previously a leased employee of the Company or an affiliate.

Break in Service

A break in employment (called a "Break in Service") may affect how you are credited with Service under the Plan. A Break in Service occurs if you terminate employment with the Company and are not employed for a period of 12 consecutive months. If you incur a Break in Service, the effect on your Vesting Service and Point Service will depend on the following: (1) the length of your Break in Service; (2) whether you were vested in your pension benefit prior to the Break in Service; and (3) whether you received a distribution of your benefit under the Plan. If you experience a transfer of employment within the Company or from/to an affiliate of the Company, see the section entitled "Changes in Employment Status" later in this Summary for an explanation of the impact on your Service crediting under the Plan.

Break in Service Less Than 1 Year

If you terminate employment and are reemployed by the Company within 12 consecutive months, you are not considered to have a Break in Service. In this case, the Plan will consider your period of absence as part of your Vesting Service and Point Service under the Plan. However, as noted below, if you receive a distribution of your benefit, then your Point Service will start at zero upon your return to employment.

Break in Service of 1 to 5 Years

If you terminate employment and your Break in Service lasts more than 1 year but less than 5 years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. If you are re-employed, the period of your absence will not count as part of your Service for any purpose.

Break in Service More Than 5 Years

If you are not vested in your pension benefit prior to your Break in Service, and your Break in Service lasts for 5 or more years, you will lose credit for all of your prior Service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you are vested when you terminate employment and you are later re-employed after a Break in Service of 5 or more years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. However, the Company does not count the period of your absence as part of your Service.

If You Received a Distribution

If you experience a Break in Service *and* receive or begin to receive a distribution of your vested benefit under the Plan before your return to work, you will receive credit for your Service prior to the break for purposes of counting Vesting Service only. For purposes of earning pay credits and interest credits (explained later in the "How the Plan Works" section), you will be treated as a new participant (*i.e.* your Point Service will start at zero upon your return to employment).

Effect of Leaves on Break in Service

If you are on an "Authorized Leave of Absence" as discussed below, the Break in Service rules do not apply to the extent you continue to earn Service during the authorized leave. If the authorized leave provisions don't apply and you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement, then different rules apply when determining if a Break in Service has occurred. In general, if you are absent from work for one of the foregoing reasons beyond the first anniversary of the first date of your absence, you will not be considered to have a severance from Service until the second anniversary of the first date of your absence. In addition, you will not have a Break in Service if you are on an Authorized Leave of Absence pursuant to the Family and Medical Leave Act, or if you are absent from employment due to service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")) and if you return to work at the end of your Authorized Leave of Absence.

Other Circumstances Impacting Service

Authorized Leaves of Absence—If you are on a leave of absence that is approved by the Company in accordance with its procedures and the Plan (an "Authorized Leave of Absence"), you will continue to earn Vesting Service and Point Service while the authorized leave continues for a period of up to 12 months. Service crediting will cease as of the expiration of this 12 month period or, if earlier, the date the Authorized Leave of Absence ends (unless you return to work at that time).

Disability—Vesting Service and Point Service are also impacted if you become Disabled (as defined in the Plan). To learn how a Disability affects your benefit and the Service you earn under the Plan, see "If You Become Disabled" found later in this Summary.

HOW THE PLAN WORKS

As explained at the beginning of this Summary, the AB II Benefit of the Plan is a "cash balance" pension plan. A cash balance pension plan is just like other pension plans in that it can provide you with a guaranteed monthly pension benefit for life after you retire. A cash balance plan is different from other pension plans in how it defines what your benefit will be. "Traditional" pension plans use a formula, often based on your years of service and average pay leading up to retirement, to define how much your monthly pension will be. Under this kind of plan, it is hard to know the value of what you will ultimately receive when you retire until you near or reach retirement.

A cash balance plan is designed to help you better understand the value of your benefit. Instead of using a formula to define your monthly retirement pension, a cash balance plan provides an accounting of the value of your benefit (the value of your **AB II Benefit**, also known as your "**Account**"). Your benefit is based on the value of the Account kept for you. As you work, credits are made to your Account. When you retire, you will receive the value of your Account in one of the payment forms available under the Plan (these are explained in detail later in this Summary).

Also, while most traditional pension plans only let you receive your benefit as a monthly payment (*i.e.*, an annuity), the AB II Benefit gives you the option of receiving a single lump sum cash payment. In addition, while many traditional defined benefit plans provide your benefit as a monthly annuity that ends at your death or your surviving spouse's death, with the AB II Benefit you can name any beneficiary to receive your benefit in the event of your death, such as a child or unrelated beneficiary, provided the consent requirements explained later in this Summary are satisfied.

Your Account

The Company sets up an account in your name (your "Account") once you become a participant in the Plan. Your Account is a bookkeeping account maintained for plan administration to keep track of your pay credits and interest credits and any distributions made to you from the Plan. *The dollar amount in your Account tells you the current cash value of the benefits payable to you at your retirement.*

Opening Balance

Transition from the FAP Benefit to the AB II Benefit—If you participated in the Final Average Pay Benefit ("FAP Benefit") under the Plan before becoming an AB II Benefit participant, your accrued FAP Benefit was converted to a lump sum "Opening Balance" and credited to your Account as of the date you converted to the AB II Benefit (your "Conversion Date"). The Opening Balance is calculated by following these steps:

1 *The value of your accrued FAP Benefit is determined as of your Conversion Date;*
2 If you became an AB II Benefit participant *on or after* the first day of the month following (or coincident with) your "Calculation Date" (defined below), then your Opening Balance will reflect an unreduced benefit;
3 If you became an AB II Benefit participant *before* the first day of the month following (or coincident with) your Calculation Date, then an early retirement reduction factor (0.25% per month) is applied based on the number of months between your Calculation Date and the later of (a) the Conversion Date or (b) the first day of the month following the date you reach age 60; and
4 The present value of the lump sum benefit is calculated using standard mortality and interest rate assumptions as provided in the Plan.

For purposes of the above Opening Balance calculation, your "*Calculation Date*" is generally the date that is three years before your Normal Retirement Date. Your "Normal Retirement Date" is defined later in this Summary as the first day of the month following the later of (1) your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born), or (2) the fifth anniversary of your participation in the Plan. (Note that if you first became a participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Normal Retirement Date is the first day of the month following your 65th birthday.)

Transition from the AB I Benefit to the AB II Benefit—If you participated in the AB I Benefit under the Plan before becoming an AB II Benefit participant, your Opening Balance will simply equal the balance of your AB I Benefit account as of your Conversion Date, including any Pay Credits or Interest Credits (described below) earned up to that date.

January 1, 2011 Conversion of Frozen FAP Benefit for Active Exempt Employees—In connection with the January 1, 2011 conversion of benefits of exempt employees to the AB II Benefit, all previously accrued FAP Benefits will be converted to an AB II Opening Balance for all active exempt employees who are accruing a benefit under the Plan on or after January 1, 2011 (whether through continued employment, transfer, or rehire). If you fall within this class of employees, your new Opening Balance will be calculated under the provisions of the plan in which the frozen benefit was accrued. The conversion will be effective on January 1, 2011 if you were an active exempt employee on such date or, if later, as of the date you become an active exempt employee accruing a benefit under the Plan. The following conditions shall apply to this Opening Balance:

- Your Opening Balance shall earn Interest Credits in accordance with the AB II Benefit provisions of the plan in which the frozen benefit was accrued.
- If your converted frozen benefit was not earned under the Plan, the benefit will remain in the plan in which it was earned and will be tracked separately from any benefit earned under the Plan.
- If your converted frozen benefit was earned under the Plan, the Plan Administrator may elect to track your previously accrued frozen benefit separately from your ongoing AB II Benefit under the Plan.
- You will never receive less than the previously accrued FAP Benefit earned prior to the conversion.

Determining Your Eligible Pay

As described below, your Pay Credits are based upon your **Eligible Pay**, which is a technical term under the Plan referring to the compensation on which your Pay Credits are calculated. Your Eligible Pay generally equals:

- Your annual base pay received from the Company, including
- Salary reduction contributions made for you under a cafeteria plan or a 401(k) plan, plus
- Commissions, if you are compensated in whole or in part on a commission basis, plus
- Performance based pay such as bonuses or annual incentive payments (provided such amounts are paid in or prior to the month of your termination of service), plus
- Any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay) (included effective September 1, 2009), plus
- Any amounts attributable to "banked" vacation and paid to you under the NiSource Vacation Policy.

However, Eligible Pay does not include all types of compensation you might receive from the Company. Specifically, items excluded from Eligible Pay include, but are not limited to the following:

- Overtime pay,
- Shift differential pay,
- Amounts deferred to a nonqualified plan,
- Any unused and accrued vacation paid on or after termination of service,
- Any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance based pay) when paid in any month following your termination of service, and
- Other special forms of compensation, such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

In general, Eligible Pay shall be determined on a monthly basis. If you are a full-time employee paid on a monthly, semi-monthly, biweekly, or weekly basis, your monthly Eligible Pay equals one-twelfth of your annual base rate of pay last in effect for the month, plus pay inclusions described above such as actual commissions paid in the month. If you are a part-time employee, your monthly Eligible Pay equals the sum of your actual Eligible Pay, plus pay inclusions described above (such as commissions) paid to you for each pay period during the month. For purposes of determining your Pay-Based Credits (described below), Eligible Pay means the sum of the monthly Eligible Pay for each month during the Plan Year in which you are an AB II Participant, including actual bonuses received by the Employee while actively employed in the month.

The IRS imposes a limit on the amount of Eligible Pay that may be taken into account by the Plan. As a result, Eligible Pay above $245,000 for 2011 (as adjusted annually by the IRS for cost-of-living increases) does not count for purposes of determining Pay Credits under the Plan.

Impact of Disability Leave, an Authorized Leave of Absence, or Other Absence on Your Eligible Pay—If you are participating in the Plan, and you are on a leave due to Disability (as defined in the Plan and as further described later in this Summary) or on an Authorized Leave of Absence or other absence approved by the Company, you will be deemed to receive Eligible Pay for purposes of calculating your Plan benefit during your period of leave. However, similar to service crediting described earlier, if on an Authorized Leave of Absence or other approved (non-Disability) leave, you will only receive Eligible Pay crediting for up to 12 months. Your Eligible Pay for each month during this period generally shall equal one-twelfth of your annual base rate of pay last in effect for the month in which the employment absence occurred. For more specific information on how Eligible Pay is calculated during any of the above-described absences from employment, please contact the NiSource Human Resource Department.

Pay Credits

The Plan provides for two types of Pay Credits: Basic Pay Credits and Excess Pay Credits. You are eligible to receive Basic Pay Credits and, if applicable, Excess Pay Credits effective as of the date you become an AB II Participant and up until the time you terminate service or otherwise stop accruing a benefit under the AB II Benefit provisions of the Plan.

The Company allocates Basic Pay Credits to your Account as of December 31 of each year. These Basic Pay Credits are equal to a percentage of your annual Eligible Pay. The total age and years of Point Service you accumulate each year, as measured on December 31, determines the annual Basic Pay Credit percentage. If you leave the Company mid-year, you will receive prorated Basic Pay Credits through your termination date.

The Company also allocates Excess Pay Credits as of December 31 of each year to qualifying participants' Accounts. Excess Pay Credits are available if you earn more than one-half of the Social Security Wage Base for that year. If you qualify, the Excess Pay Credit is 1% of your Eligible Pay that exceeds one-half of the Social Security Wage Base.

The table below shows how Basic Pay Credits and Excess Pay Credits are calculated:

AB II PAY CREDITS			
If your age plus years of Point Service at the end of the year total...	Less than 50	50-69	70+
Your Basic Pay Credit for that year will be equal to this percentage of your Eligible Pay...	4 %	5 %	6 %
Your Excess Pay Credit will be equal to an additional percentage of your Eligible Pay over one-half of the Social Security Wage Base* in effect that year...	1 %		

**The Social Security Wage Base (SSWB) is the maximum amount of eligible pay on which you and the Company pay Social Security (or OASDI) taxes each year. For 2011, the SSWB is $106,800. Because you do not pay Social Security taxes on eligible pay in excess of the SSWB, you also do not earn Social Security benefits on eligible pay in excess of the SSWB. To help compensate affected employees, the AB II Benefit provides additional credit on pay over one-half the SSWB, which is $53,400 in 2011 ($106,800 divided by two).*

Example

Assume that on December 31, 2011, a participant has attained age 40 years and 6 months and has earned Point Service of 8 years and 10 months. Because the participant will have a total age plus Point Service of 49 years and 4 months, he/she will be eligible for a Basic Pay Credit of 4%. Let's assume the participant earns $40,000 for the year. The participant would receive a Basic Pay Credit to his Account of $1,600 for 2011 (4% of $40,000). The participant would not be eligible for the Excess Pay Credit because his Eligible Pay is not in excess of one-half of the SSWB for the year. However, if the same participant's Eligible Pay were $60,000 for 2011, he would receive a Basic Pay Credit of $2,400 (4% of $60,000), plus an Excess Pay Credit of $66 (1% of $6,600, which is the excess of Eligible Pay over one-half of the SSWB).

Interest Credits

Interest is credited to your Account each Plan Year effective as of December 31 up until the time you commence retirement benefits. Interest Credits are based on the 30-year Treasury Securities Rate for September of the preceding year (but not less than 4%) and are applied to your Account based on the value of your Account as of the last day of the prior Plan Year.

Your Account will continue to receive Interest Credits until you commence your retirement benefit payments under the Plan, regardless of whether you have stopped working for the Company as an Eligible Employee. However, if you terminate employment with the Company before you are vested in your benefit, you will not receive Interest Credits after your termination. If you are subsequently reemployed, you will receive Interest Credits effective as of the date of your reemployment. In the year you begin receiving benefits, you will receive prorated Interest Credits for the portion of the year before the benefit starts. If you become a participant in the Plan mid-year, you will receive prorated Interest Credits from the date your participation began.

Example

Assume that on January 1, 2011, your Account is $50,000, and that the Interest Credit rate for the Plan Year is 4% (*i.e.*, the greater of the 30-year Treasury Securities rate for September 2010 or 4%). On December 31, 2011, your Account would receive an Interest Credit of $2,000 (or $50,000 x 4%).

Summing it Up: How Your Account Grows

Altogether, taking into account the Pay Credit (both Basic and Excess) and Interest Credit components, your Account is thus the sum of:

- **Your Opening Balance**, if any, under the Plan as of the beginning of the year; plus
- **Pay Credits** allocated to your Account as an annual percentage of eligible pay based on age plus Point Service as outlined in the table above; plus
- **Interest Credits** allocated to your Account based on the annual interest rate on 30-year Treasury Securities for the September immediately preceding the first day of the Plan Year (but no less than 4%).

Example

With the addition of both Interest and Pay Credits each year, you can see your Account balance grow. Here is an example of how your Account can grow in one year, using the assumptions set forth below.

First, calculate the Basic and Excess Pay Credit:

If you are 49 years old, have eligible earnings of $60,000 and have completed 17 years of Point Service at the end of 2011, your 2011 Pay Credit would be calculated as follows:

Basic Pay Credit

Your 2011 Eligible Pay	$60,000
Your Basic Pay Credit % (49 + 17 = 66 points = 5%)	x 5%
Your Basic Pay Credit amount on December 31, 2011	**$3,000**

Excess Pay Credit

Your 2011 Eligible Pay over ½ SSWB ($60,000 – $53,400)	$6,600
Your Excess Pay Credit %	x 1%
Your Excess Pay Credit amount on December 31, 2011	**$66**

Your total Pay Credit on December 31, 2011 is the sum of $3,000 + $66 or a total of $3,066 for the year.

Second, add the Interest Credit:

If the interest rate is at 4% for the Plan Year, your Interest Credit would be 4% of your Account balance as of the beginning of the Plan Year. Assuming your Account balance as of January 1, 2011 was $50,000, then you received an Interest Credit effective as of December 31, 2011 equal to $2,000.

Finally, total the Pay Credits and Interest Credit, and add to the Account balance at the beginning of the year:

January 1 Account Balance (includes your "Opening Balance," if any)	$50,000
	+
December 31 Interest Credit (4%)	$ 2,000
	+
December 31 Basic Pay Credit (5%)	$ 3,000
	+
December 31 Excess Pay Credit (1%)	$ 66
December 31 Account Balance	**$55,066**

Remember, how your Account grows over time depends on the actual base pay increases and performance-based pay you receive and the Interest Credits allocated to your Account.

Monitoring the Growth of Your Account

To help you track the growth of your Account, you will receive personalized statements (generally on an annual basis) that will keep you up-to-date on your Account activity. These statements show your:

- Account;
- Pay Credits since the last statement;
- Any applicable Interest Credits since the last statement.

You can also obtain information on the value of your Account any time by contacting MySource for Human Resources at **1-888-640-3320** or by visiting the Web site **www.mysourceforhr.com**.

Benefits From Your Account

Although your Account is communicated to you as a lump-sum amount, when you leave the Company and commence benefits, as previously mentioned, your Account can provide a monthly annuity based on prevailing interest rates at the time you commence benefits. See the "Payment Options Under the Plan" section later in this Summary for details on how you may receive your benefit, and see the "Designation of Beneficiary" section for details on how you may designate your spouse or another individual to receive your benefit in the event of your death.

For example, if your Account balance on the date you commence benefits is $200,000 and the annuity factor (to convert your Account to an annual benefit) at that time is 11, you would receive either a lump sum of $200,000 (minus applicable withholding taxes) or a monthly benefit for life of approximately $1,515, as follows:

CALCULATING ANNUITY EXAMPLE	
Account Balance:	$200,000
Annuity Factor:	÷ 11
Annual Benefit:	$ 18,182
	÷ 12
Monthly Benefit:	$ 1,515

Protected Benefit

In addition to your Account, the Plan may also consider a "Protected Benefit" in calculating your retirement benefit. If you previously participated in the FAP Benefit of the Plan, your Plan benefit under the AB II Benefit is guaranteed to be no less than the sum of 1) the lump sum actuarial equivalent of your accrued benefit under the FAP Benefit using eligible pay and Service through your Conversion Date (your **"Protected Benefit"**), plus 2) your Pay Credits (and Interest Credits earned on those Pay Credits) under the AB II Benefit from your Conversion Date (*i.e.*, the date of conversion to your AB II Benefit) through your termination of employment.

If you are eligible for this Protected Benefit, your benefit could be reduced if you elect to receive it prior to your "Normal Retirement Date" to reflect early commencement of payment. Because your Protected Benefit is derived from a traditional pension plan formula, you would generally not be able to receive your benefit until you retired. As noted earlier though, one benefit of the Plan's cash balance status is that you may receive your benefits anytime after your termination of employment. However, for purposes of valuing *only* the Protected Benefit portion of your Plan benefit, the Plan will consider whether you begin to receive benefits before your "Normal Retirement Date." The following subsections describe how the calculation of your Protected Benefit may be affected by when you choose to receive your benefit.

As a reminder, your AB II Benefit is calculated as described in the preceding portions of the "How the Plan Works" section. The following subsections apply *only* for any Protected Benefit portion of your Plan benefit and *do not* apply to the calculation of your AB II Benefit.

Normal Retirement

If you retire on or after your "Normal Retirement Date," your Protected Benefit will be not be impacted. Your "**Normal Retirement Date**" is the first day of the month following the later of (1) your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born) (your "**Normal Retirement Age**"); or (2) the fifth anniversary of the date you began participation in the Plan. (Note that if you first became a participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Normal Retirement Date is the first day of the month following your 65th birthday.) If you retire on or after your Normal Retirement Date, the amount of your Protected Benefit will be based on the full amount of your Protected Benefit up to your Conversion Date (*i.e.*, your benefit will not be reduced for early commencement of payment.)

Early Retirement

If you retire on or after your "Early Retirement Date" but before your Normal Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. Your "**Early Retirement Date**" is the first day of the month on

or after the date that you have (1) both attained age 60 or older and completed at least five years of Service; or (2) both attained age 55 (or older) and completed 10 years of Service. If you reach your Early Retirement Date, you may elect to retire and receive your benefits immediately or defer the commencement of your benefits until you reach your Normal Retirement Age. If you retire and elect to receive benefits at or after your Early Retirement Date, the amount of your Protected Benefit would be reduced by ¼% for each month by which your Early Retirement Date precedes the date that is three years prior to your Social Security Retirement Age.

If you defer the receipt of your benefits until your Normal Retirement Date, the amount of your Protected Benefit will be unreduced.

Distribution Prior to Early Retirement

If you terminate prior to your Early Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. If you elect to receive your benefit prior to your Early Retirement Date, the amount of your Protected Benefit will be reduced actuarially using the interest rate and mortality factors specified in the Plan.

Calculating Your Benefit

The calculation of your benefit under the Plan depends on how and when you wish to receive your benefit. Of course, if you terminate employment and elect to begin receiving your Plan benefit right away, your Account will have a smaller balance than if you had worked longer or waited to receive your benefits until a later date. Remember, you stop accruing Pay Credits when you terminate employment, and you no longer earn Interest Credits once you begin receiving your benefit. In addition, if you begin payment of your benefits prior to your Normal Retirement Age, your Protected Benefit (if applicable) would be reduced as explained above.

Your total benefit under the Plan is your Accrued Benefit. Your "**Accrued Benefit**" is the value of your benefit under the Plan as of any date before you reach your Normal Retirement Date. Your Accrued Benefit is generally the current value of your entire Account. However, if you have a Protected Benefit as described above, your Accrued Benefit is generally equal to the greater of:

1 Your entire Account (reflecting all Pay Credits, Interest Credits and any Opening Balance); or

2 Your benefit you earned under the FAP Benefit as of your Conversion Date (i.e., your Protected Benefit, which does not include any supplemental benefit), PLUS the portion of your AB II Benefit Account reflecting Pay Credits and Interest Credits earned from conversion to the AB II Benefit until termination of service (with Interest Credits continuing until commencement of benefits).

If you are interested in finding out your benefit under the Plan, you may have your benefit calculated by visiting the Web site **www.mysourceforhr.com**.

Funding: Who Pays For Your Benefit

The Plan is funded with contributions made by the Company. On an annual basis, the Plan Administrator actuarially determines the amount that the Company must contribute in order to fund the pension benefits for you and your fellow co-workers that participate in the Plan.

Vesting: When Do You Own Your Benefit

As discussed earlier in this Summary, to be vested means you have a permanent right to your Plan benefit and are entitled to receive that benefit whenever you stop working for the Company. You become fully vested in your Plan benefit once you have completed 3 years of Vesting Service (5

years of Vesting Service for employees terminating prior to January 1, 2008) (see "Service" section described earlier in this Summary). There is no partial vesting in your Plan benefit. You are not vested until you reach 3 years of Vesting Service, and you become fully vested once you reach 3 years of Vesting Service (5 years for employees terminating prior to January 1, 2008).

Thus, for example, if you terminate employment with only 2 years of Vesting Service, then you will receive no benefit under the Plan. That is, you are not vested in your benefit because you have less than 3 years of Vesting Service. If you terminate employment with 3 or more years of Vesting Service, you are fully vested in your benefit.

RECEIVING YOUR BENEFIT

When Is Your Benefit Paid?

Provided you are vested in your benefit as described above, you (or your beneficiary) may receive or begin to receive your benefit under the Plan as soon as possible following: (1) your termination of Service with the Company or an affiliate; or (2) your death (see "Death Benefits" found later in this Summary).

If you are vested in your benefit and terminate employment with the Company, you may receive your benefit at any time after your termination. If your benefit is $5,000 or less, you will automatically be paid a single lump sum as soon as practicable after your termination. Alternatively, if your vested benefit amount is more than $5,000, you may defer receipt of your benefit until a later time, such as the date you would have reached Early Retirement or Normal Retirement. By law, you must begin to receive payment of your Plan benefit by April 1 of the calendar year following the later of either (1) the year you turn age 70½, or (2) the year in which you retire.

The amount you would be eligible to receive would be the amount of your Account (subject also to any Protected Benefit provisions). Remember, if you leave the Company before you are vested in your benefit, you are not entitled to a benefit under the Plan.

How Is Your Account Paid?

Regardless of *when* you receive your benefits, generally you will need to elect the *form* of your benefit. You can elect to receive your Plan benefit in an immediate single lump-sum payment or in an annuity form. Once you terminate employment, you can request a distribution of your benefit at any time in any of the forms available under the Plan (described below).

A Note on "Actuarially Equivalent" Benefits

The various benefit form options are considered to be *"actuarially equivalent"* meaning that, statistically, they should produce the same total benefit amount even though they provide very different monthly benefit payments or the benefit may be paid in a lump sum. To calculate actuarial equivalence, the Plan uses specified interest rate and mortality factors for various purposes. For instance, to calculate the lump sum present value for your Protected Benefit (if applicable), the Plan uses as its interest rate the rate for 30-year Treasury Securities for September of the prior year (or a minimum interest rate prescribed by the IRS if it produces a larger benefit).

Note that to receive the current year's interest rate for certain calculations, such as calculating the Protected Benefit, the last day worked must be November 30 (*i.e.*, a December 1 benefits commencement date). A December 1 benefits commencement date requires a retirement date of December 1 and filing proper paperwork (described below) with MySource for Human Resources on or before November 30 requesting commencement of pension distribution.

Applying for Benefits

If you are retiring, you must call MySource for Human Resources at **1-888-640-3320** or visit the Web site **www.mysourceforhr.com** to request a pension benefit commencement kit. If you contact by phone, please ask to speak with a Retirement Specialist.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before your first payment is processed. However, once your payments begin, you may not change the form of

payment you have elected. Generally, all forms must be returned by the 10th of the month preceding the date your benefits are calculated to commence (your "**Benefit Commencement Date**"). The actual payment(s) will be made as soon as practicable following your Benefit Commencement Date.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively practicable after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Payment Options Under the Plan

When you retire or leave the Company, you may elect to receive your vested benefit under the Plan in any of the payment forms outlined below. As previously stated, various benefit forms are "actuarially equivalent." If you do not make a payment election, your benefit will be paid in the form of a "Single Life Annuity" if you are not married, or as a "50% Pop-Up Annuity" if you are married. If you are married, you may elect a different form of payment only with your spouse's notarized consent.

Lump-Sum Payment

You may receive your Account balance in a single lump-sum payment. If you select this distribution option, no further benefits would be payable from the Plan. If you are married at the time you want your pension benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less. Again, if your vested Plan benefit is $5,000 or less, the Plan automatically pays this amount as a lump sum distribution (*i.e.*, annuity payments are not available).

Rollovers—If you receive your Account balance under the Plan in the form of a single lump sum, you may elect to roll over all or a portion of the distribution into an individual retirement account annuity ("IRA") or to another eligible retirement plan that accepts rollovers. Note that if you do not make a payment election (direct payment vs. rollover) and your benefit is greater than $1,000 but less than or equal to $5,000, then the Plan Administrator will roll over your benefit to an IRA designated by the Plan Administrator. If your benefit is $1,000 or less when you leave the Company, and you do not elect whether to receive this benefit directly or to roll it over, then the Plan automatically pays this single lump-sum amount directly to you.

Annuity Payment Forms

If the value of your Account is over $5,000, you may choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan. If you elect this option, the value of your Account is converted to an annuity. To determine your monthly benefit, your Account balance is divided by an actuarial factor based on your age when benefits start. In calculating your benefit amount, the Plan considers the type of annuity you elect and, if applicable, your beneficiary's age. The following annuity options are available to you:

- **Single Life Annuity**—As stated above, if you are single, the single life annuity option is the automatic form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it as a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may not elect this form of payment without your spouse's notarized consent.
- **50% Pop-Up Annuity**—As stated above, if you are married, the 50% Pop-Up Annuity (with no reduction for the value of the pop-up feature), with your spouse as the contingent annuitant, is the automatic form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form.

  If you are married, you may choose the 50% Pop-Up Annuity distribution option, naming a beneficiary other than your spouse (and with a reduction for the value of the pop-up feature), provided your spouse consents to the alternate beneficiary. Your spouse's consent must be notarized.

If you are single, you may choose the 50% Pop-Up Annuity distribution option (also reduced for the value of the pop-up feature).

Under the 50% Pop-Up Annuity distribution option, you receive reduced benefits monthly for your lifetime. If you die before your beneficiary, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime.

If your beneficiary dies within 60 months after your Benefit Commencement Date and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death.

If your beneficiary dies more than 60 months after your Benefit Commencement Date and before you die, your monthly payment will remain the same as when your beneficiary was living and all payments will stop at your death.

- **33-1/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 33-1/3% of your benefit for his or her lifetime. If you are married, you may not elect this form of payment without your spouse's notarized consent.
- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.
- **75% Annuity** — Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 75% of your benefits for his or her lifetime. This option is available effective January 1, 2008. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.
- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.

Payments under any of these options will be based on your Account (as well as any Protected Benefit, if applicable). Subject to the spousal consent requirements noted above, you may choose any form of distribution as well as choose any beneficiary as your joint annuitant. If you die before an elected form of distribution begins, your (or your beneficiary's) benefit will be determined as provided in the "Death Benefits" section of this Summary.

A Comparison of Payment Options

If you choose to receive your benefit as a lump sum, you will receive the total vested value of your Account (or if greater, the benefit calculated under the Protected Benefit provisions described previously). If you choose to receive your benefit as an annuity, the total vested value of your benefit will be converted into an annuity form of payment. To determine how much any annuity option would pay, your benefit is first defined as a single life annuity. If you choose a different annuity payment option providing benefits for a beneficiary after your death, your actual payment will be reduced to reflect the cost or value of guaranteeing payments over the lives of two people. For example, assume you are married and retiring when both you and your spouse are age 55. Assume also that your Account is valued at $200,000 and the applicable interest rate is 3.77% at the time you retire (note that the applicable interest rate fluctuates from year to year). See below for examples of estimated monthly amounts under some of the payment options that you could

choose, and the amounts your surviving spouse could receive if you die after payments begin. Note that these examples do not incorporate any Protected Benefit you may have.

PAYMENT OPTIONS	YOUR MONTHLY BENEFIT FOR LIFE	YOUR SPOUSE'S MONTHLY BENEFIT FOR LIFE AFTER YOUR DEATH
Lump Sum Payment ($200,000)	None	None
Single Life Annuity	$996.36	$0.00
50% Pop-Up Annuity (unreduced for pop-up feature with spouse as beneficiary)	$952.52	$476.26
33-1/3 % Annuity	$967.46	$322.16
66-2/3% Annuity	$939.56	$626.69
75% Annuity	$932.59	$699.44
100% Annuity	$912.66	$912.66

Situations Affecting Your Plan Benefit

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed three years of vesting service (five years of vesting service if you terminated prior to January 1, 2008) you will not be entitled to a pension benefit and your pension benefit is forfeited.
- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.
- If you die before your pension benefits begin and are unmarried, your pension benefit is payable to your beneficiary, estate or trust. See "Death Benefits" below.
- If required by a qualified domestic relations order, all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. See "In the Event of Divorce or Dissolution" below.
- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan Administrator has the authority to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made. In addition, in the event that an overpayment is made from the Plan and no additional payments are due to be paid, the Plan Administrator has the authority to seek reimbursement of such overpaid amounts from the Participant (plus interest calculated in accordance with IRS guidance).
- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual

compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

A Note on Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. The Social Security office can advise you on the documents you will need in order to apply for this benefit.

DEATH BENEFITS

Death After Pension Payments Begin

If you die after you have begun receiving your pension benefit, additional payments to a named beneficiary will depend on the form of benefit payment you selected (see "Payment Options Under the Plan" above).

Death Before Pension Payments Begin

If you die before you begin receiving your pension benefit and you were vested under the Plan at the time of your death (see "Vesting: When Do You Own Your Benefit" above), the Plan will provide pre-retirement death benefits to your spouse or other beneficiary.

The death benefit payable will equal the full value of your vested Account. If you were married on the date of your death, your surviving spouse will be entitled to a Pre-retirement Survivor Annuity equal to the value of your vested Account (or if greater, equal to the survivor annuity portion of a joint and 50% survivor annuity calculated as if you terminated employment on the date of your death and considering any Protected Benefit calculation). Generally, a "**Pre-retirement Survivor Annuity**" provides your surviving spouse with a single life annuity benefit for his or her remaining lifetime. If you do not wish for your surviving spouse to receive a Pre-retirement Survivor Annuity in the event of your death, or if you wish to name a beneficiary other than your surviving spouse to receive benefits at your death, you may, with your spouse's written consent, waive the Pre-retirement Survivor Annuity and/or elect another beneficiary.

Even if you do not elect a different form of payment, your surviving spouse may elect to receive the death benefit as follows:

- **Single Life Annuity**—A monthly benefit payable for the life of your spouse, commencing as of the first day of the month following your death. Alternatively, your spouse can elect to delay beginning payment of this annuity up to the date you would have attained age 65, but no later.
- **Single Lump Sum**—Payment in the form of a single lump sum payable as soon as practicable after your death.

If your beneficiary is someone other than your spouse, your Account will be paid out as a lump sum. Note that if the present value of the death benefit payable to your spouse or other beneficiary is $5,000 or less, the Trustee will automatically distribute your death benefit to your surviving spouse or other beneficiary in a single lump sum payment.

Death Benefit Rollovers

Your beneficiary (whether spouse or non-spouse) may elect to rollover a lump sum death benefit to an individual retirement account/annuity (IRA) or, for a spouse beneficiary, to some other qualifying retirement plan. Note that non-spouse beneficiaries must request that the Plan make a "direct rollover" to the applicable IRA (*i.e.*, the Plan pays the lump sum death benefit directly to the IRA). A non-spouse beneficiary may not receive a distribution and then try to deposit it into an IRA as a rollover. For further information, see "Rollovers" below.

Designation of Beneficiary

When you first join the Plan, you will need to name a beneficiary of your AB II Benefit. A beneficiary designation form will be sent to you when you become eligible to join the Plan. On your beneficiary designation form, you indicate the person(s) who will receive the remaining payments of your Plan benefit, if any, in the event of your death. You may change your beneficiary at any time prior to commencing benefit payment(s) by completing and returning a new form. Contact MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com** to change your beneficiary.

If you are married—By law, you must name your spouse as your beneficiary. If you wish to designate someone other than your spouse, your spouse must consent to your election in writing. The consent must be witnessed by a Notary Public and returned to MySource for Human Resources.

If you are single—You may name anyone as your beneficiary.

Some points on naming a beneficiary:

- If you marry, **your spouse automatically becomes your beneficiary** regardless of your previous designation, unless your new spouse consents in writing to another designation. You should notify MySource for Human Resources of any changes in your marital status. See "In the Event of Divorce or Dissolution" (the following section) for an explanation of how a divorce may affect your beneficiary designation under the Plan.
- If you designate more than one beneficiary, payment of your Plan benefit will be divided evenly among your beneficiaries unless you designate otherwise.

Failure of Beneficiary Designation

If you do not designate a beneficiary, or if your beneficiary designation is for any reason illegal or ineffective, or if none of the beneficiaries that you have designated survives you, your Plan benefit will be paid in the following order of priority:

- your surviving spouse;
- your descendants, per stirpes; or
- to the legal representative of your estate.

Duty to Report Participant's Death

If you die while receiving pension payments, the Plan Administrator must be notified of your death so that appropriate action may be taken concerning your benefits (*e.g.,* beginning payments to a designated beneficiary; stopping payments; etc.). It is illegal for any person or entity to continue to receive after your death benefit payments that are supposed to be made only for the duration of your life. Accordingly, please advise those persons who may ultimately represent your estate, or who may be in a position to receive your benefit payments, of this legal duty to contact the Plan Administrator upon your death.

IN THE EVENT OF DIVORCE OR DISSOLUTION

If you are married and you go through a divorce or dissolution, such proceedings may affect your Plan benefit or your beneficiary designation under the Plan, as explained below. You must inform the Plan Administrator if you are divorced by contacting MySource for Human Resource at **1-888-640-3320.**

Beneficiary Designations After Divorce/Dissolution

If you are married and your marriage terminates by reason of divorce, dissolution or other similar operation of domestic relations law, any beneficiary designation you have previously made will remain unchanged. Note that while some state laws may invalidate a spousal beneficiary designation upon divorce, that is not the case under the Plan. Upon divorce, if you had named your former spouse as your beneficiary under the Plan, your beneficiary designation will not change unless you make a new beneficiary designation that revokes your prior beneficiary designation, or you remarry.

If you subsequently re-marry a different spouse, your previous beneficiary designation is *automatically* revoked and your new spouse becomes your beneficiary, unless a valid "qualified domestic relations order" provides otherwise. As explained below, a qualified domestic relations order may limit your ability to name another beneficiary in the event of a divorce or dissolution.

Qualified Domestic Relations Order (QDRO)

If you become divorced or legally separated, a specific type of court order could require that part of your benefit be paid to someone else – your former spouse, for example. This is known as a "qualified domestic relations order" ("QDRO"). By federal law, the Plan must comply with a QDRO. A QDRO is a legal judgment or decree that recognizes the rights of or support obligation toward a spouse, former spouse, child or other dependent. A domestic relations order must satisfy specific requirements to be "qualified," and it must be recognized by the Plan Administrator.

If required by a QDRO, all or a portion of your benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. A QDRO may require that your former spouse be treated as your surviving spouse for all or any part of the survivor benefits payable after your death. This means that if you re-marry, your subsequent spouse may not be treated as your surviving spouse for the portion of your benefit assigned to your former spouse if a valid QDRO so provides.

You and your beneficiaries may obtain, free of charge, a copy of the procedures used to determine the "qualified" status of a domestic relations order from MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com**. You or your spouse should submit a draft version of a domestic relations order to the Plan Administrator for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any court proceedings that may affect your Account, contact MySource for Human Resources at **1-888-640-3320**. When the Plan Administrator receives notice of a pending QDRO, a hold will be placed on your Account that will prevent you from making any withdrawals until the QDRO is processed.

CHANGES IN EMPLOYMENT STATUS

Rehired Employees

If you terminate employment after becoming a Plan participant and later return to employment as an Eligible Employee (*i.e.*, you are NOT an "exempt employee" rehired after January 1, 2010 or an otherwise ineligible employee), you will generally participate again immediately once you are rehired, unless the Break in Service rule (described earlier in this Summary) applies. Regardless of how you were previously covered under the Plan (*i.e.*, under the FAP Benefit, the AB I Benefit, or the AB II Benefit), you will be covered under the AB II Benefit once you are reemployed by the Company (provided that you are an "Eligible Employee" as described earlier).

If you previously participated under the FAP Benefit and did not receive a distribution of your benefit, then the Plan will create an Opening Balance for you as described above. See "How the Plan Works" above. If you previously participated under the AB I Benefit and did not receive a distribution, the Plan will convert your AB I Benefit to an AB II Benefit.

If you had received a lump sum distribution of your prior benefit, then when you are reemployed, you will begin participating in the Plan as a new employee (*i.e.*, with a $0 Opening Balance and 0 years of Point Service, though your prior Service will count for vesting purposes).

If you were receiving your benefits in the form of an annuity at the time of your return to employment, your annuity payments will be suspended and the unpaid portion of your prior benefit will be converted to an AB II Benefit Opening Balance as of the date of your reemployment. On your subsequent Benefit Commencement Date, your Protected Benefit (if any) will be reduced by the amount of annuity benefits you received. For purposes of calculating your Pay Credits (described earlier), you will be credited with Point Service both before and after your absence from employment. Further, your prior Service (as well as your Service earned after your reemployment) will count for vesting purposes. Note that the suspension of benefits and conversion to an Opening Balance may be impacted if you return to work after your Normal Retirement Age and you return to employment working less than 40 hours per month. In such instances, contact the Plan Administrator for additional details regarding the effect of reemployment on your retirement benefit.

Transfers Within the Plan

Changes between Exempt and Non-Exempt Status

If you are participating in the AB II Benefit and you transfer *from* an *exempt* position with the Company *to* a *non-exempt* position with the Company, you will continue to participate in the AB II Benefit after your transfer.

Subject to the exception described in the next paragraph, if you transfer *from* a *non-exempt* position with the Company *to* an *exempt* position with the Company, your benefit will be determined under the AB II Benefit. If you did not previously participate in the AB II Benefit of the Plan, your Plan benefit will be converted to an AB II Benefit Opening Balance in the Plan. You will receive credit for Point Service for your Service both before and after the transfer.

Exempt Employee Transfers When Hired or Rehired On or After January 1, 2010—If you transfer to an *exempt* position and were hired or rehired on or after January 1, 2010 (regardless of whether first hired as an exempt or non-exempt employee), then once you transfer to an exempt position, you are no longer eligible to participate in the Plan and your benefit accruals will cease upon your transfer.

Changes between Union and Non-Union Status

If you transfer *from* a *union* position with the Company *to* a *non-union* position with the Company, or if you transfer *from* a *non-union* position with the Company *to* a *union* position with the Company, your benefit will be determined under the AB II Benefit. If you did not previously participate in the AB II Benefit of the Plan, your Plan benefit will be converted to an AB II Benefit Opening Balance in the Plan. You will receive credit for Point Service for your Service both before and after the transfer.

Transfers to/from Affiliates

From An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under an affiliate's pension plan *to* an employment position with the Company otherwise providing coverage under the Plan. Unless specific provisions in the Plan or an affiliate's plan provides otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources Department for further information.

IF YOU TRANSFER FROM AN AFFILIATE IN THE FOLLOWING POSITION:	TO THE COMPANY IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Non-union (exempt or non-exempt)	Non-union (exempt or non-exempt)	You will remain in the affiliate's plan and will accrue no benefit under the Plan. In accordance with the terms of the affiliate's plan, you will remain subject to your plan benefit terms in effect prior to your transfer, except that any non-union non-exempt employee that becomes an exempt Eligible Employee (hired or rehired prior to January 1, 2010) shall become an AB II participant under such plan and shall have his/her benefit converted to an AB II Benefit opening balance under such plan.
Union	Non-union (exempt or non-exempt)	Your benefit under the affiliate's plan will be frozen as of your transfer date and you will begin to participate in the AB II Benefit of the Plan. Your prior benefit will remain in the affiliate's plan and you will begin participation in this Plan with a $0 Opening Balance. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer. With respect to your benefit under the affiliate's plan, you will cease to earn service for benefit accrual as of the date of transfer, except that service following transfer shall be counted solely for purposes of determining eligibility for an early retirement benefit under such plan. Note, however that if you transfer to an exempt employee position, you must be an "Eligible Employee" (i.e., you were hired or rehired prior to January 1, 2010) in order to begin to accrue a benefit under the Plan.
Non-union (exempt or non-exempt)	Union	
Union	Union	

To An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under the Plan *to* an employment position with an affiliate that does not sponsor the Plan (because the affiliate offers a different plan or no plan). Unless specific provisions in the Plan or an affiliate's plan provides otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources Department for further information.

<table>
<tr><th>IF YOU TRANSFER FROM THE COMPANY IN THE FOLLOWING POSITION:</th><th>TO AN AFFILIATE IN THE FOLLOWING POSITION:</th><th>THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:</th></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Non-union
(exempt or non-exempt)</td><td>You will remain in the AB II Benefit of the Plan and will continue to earn Vesting Service and Point Service under the Plan after the transfer. Note that if you are transferring from a non-exempt position to an exempt position, and you did not previously participate in the AB II Benefit of the Plan, then provided you were hired or rehired prior to January 1, 2010, your benefit in the Plan will be converted to an AB II Benefit Opening Balance and you will continue to participate in the Plan under the AB II Benefit after your transfer.</td></tr>
<tr><td>Union</td><td>Non-union
(exempt or non-exempt)</td><td rowspan="3">Your AB II Benefit Account in the Plan will be frozen as of the date of your transfer, but will continue to earn Interest Credits until you commence distribution of your benefit. With respect to your benefit under the Plan, you will cease to earn service for benefit accrual as of the date of transfer, except that service following transfer shall be counted solely for purposes of determining eligibility for an early retirement benefit under the Plan (i.e., for your Protected Benefit, if applicable). You will begin participating in the affiliate's plan as a new participant. If the affiliate's plan provides for your participation in an AB I or AB II Benefit option, you shall begin participation in such option with a $0 opening balance, though you will receive credit for vesting service and point service both before and after the transfer. If the affiliate's plan provides for your participation in a FAP Benefit option, you shall begin participation in such option with zero credited service.</td></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Union</td></tr>
<tr><td>Union</td><td>Union</td></tr>
<tr><td>Union</td><td>NiSource Corporate Services</td><td rowspan="2">Your benefit will remain in the Plan and will be determined under the AB II Benefit. If you did not previously participate in the AB II Benefit of the Plan, your Plan benefit will be converted to an AB II Benefit Opening Balance in the Plan. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer.</td></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>NiSource Corporate Services</td></tr>
</table>

If you transfer from employment providing coverage under the Plan to a union or a non-union position with an affiliate that does sponsor the Plan, then you will remain in the AB II Benefit of the Plan.

If You Continue to Work After Normal Retirement Age

If you choose to work beyond your Normal Retirement Age, you will continue to earn Pay Credits and Interest Credits until you retire. If you work 40 or more hours per month on and after reaching Normal Retirement Age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching Normal Retirement Age, you may begin receiving your pension benefit from the Plan.

If You Become Disabled

If you become Disabled while working for the Company, the calculation of your Plan benefit will be impacted as described in this section. In general, "**Disability**" or "**Disabled**" under the Plan means any physical or mental condition that constitutes a disability under the long-term disability plan (the "LTD Plan") maintained by the Company. A Disability commences when you first qualify for benefits under the Company's LTD Plan and ceases when you no longer qualify for benefits under such LTD Plan.

If you are considered Disabled under the Plan and later return to active employment as an Eligible Employee (*i.e.*, you are NOT an "exempt employee" that was originally hired or rehired after January 1, 2010 or an otherwise ineligible employee), you will be covered under the AB II Benefit once you return to active work. You will earn an AB II Benefit regardless of how you were previously covered under the Plan (*i.e.*, under the FAP Benefit, the AB I Benefit, or the AB II Benefit). If you previously participated under the FAP Benefit, then the Plan will create an Opening Balance for you as described above. See "How the Plan Works" above. If you previously participated under the AB I Benefit, the Plan will convert your AB I Benefit to an AB II Benefit.

Service Crediting—If you are considered Disabled under the Plan, you will continue to earn Vesting Service and Point Service while the Disability continues without regard to whether the Disability lasts beyond one year and could thus constitute a "Severance from Service" (as defined in the Plan). Point Service under the Disability provision shall cease to be credited as of the earliest of (1) the date on which your Disability ends pursuant to the Company LTD Plan (which shall be deemed your "Termination of Service" (as defined in the Plan) unless you return to employment with the Company or unless the Company determines a different "Termination of Service" date), (2) the date on which you return to employment, or (3) the date your benefit under the Plan commences. Note that if your Disability under the Company LTD Plan commenced prior to January 1, 2000, you earned Point Service during the period of your Disability prior to January 1, 2000 only if you were both Disabled under the Plan and eligible for disability benefits under the Social Security Act.

Your Account—You will continue to receive Pay Credits and Interest Credits to your Account while you are Disabled. For these purposes, you will be deemed to receive Eligible Pay at the same level of Eligible Pay in effect for the month when you became Disabled (but excluding any performance-based components of Eligible Pay). See the "How the Plan Works" section earlier this summary for an explanation of what compensation counts as Eligible Pay.

You may elect to start your Plan benefit payments at any time once you are considered to have terminated employment by the Company. You may receive your benefit under any of the payment options described in "Payment Options Under the Plan" above. Note that if you elect to begin benefit payments, you will stop earning Pay Credits and Interest Credits. In addition, commencing your Plan benefit might mean that your LTD benefits would no longer be payable. For more information about electing payment of your Plan benefit and whether such an election would impact your LTD payments, contact MySource for Human Resources and consult your LTD Plan.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

As stated above, to request your Plan benefits you must obtain a pension benefit commencement kit from MySource for Human Resources (**1-888-640-3320; www.mysourceforhr.com**).

Claim Denial and Appeal Process

If you disagree with any decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the administrative review procedure you must follow. If you think benefits owed to you are not paid, or are too low, or are paid at a time other than when you think they should be, you can make a "claim" for benefits to the Plan Administrator.

If your claim for a pension benefit is denied in whole or in part, you have the right to request a review of the denial. You (or your beneficiary) will be notified of a denial of your claim in writing by the Plan Administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice of the denial will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan Administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the NiSource Benefits Committee at the following address:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. If your appeal is denied, you will be told why and which Plan provisions support that decision. If the final determination is made in your favor, the determination shall be binding and conclusive. If the final determination is not made in your favor, the determination shall be binding and conclusive unless you notify the NiSource Benefits Committee within 90 days after the mailing or delivery of the determination that you intend to institute legal proceedings under Section 502(a) of ERISA challenging the determination, and you actually institute such legal proceedings within 180 days after such mailing or delivery. All questions arising with respect to the Plan during any such legal proceedings shall be governed by Indiana law, except to the extent superseded by federal law.

TAX CONSEQUENCES

How and When Your Plan Benefits are Taxed

Generally, federal and state income tax laws do not require you to pay tax on your Plan benefits *until you actually receive distributions under the Plan. Once you begin to receive benefit payments,* you will have taxable income on these payments in the year that your receive them. In the year(s) of any distribution from the Plan, you will receive a tax form that will provide you with the information you need to file your taxes. You may be able to defer federal income taxes and avoid any penalty taxes if you transfer or "roll over" your distribution (see the Rollover section below). You should consult your tax advisor concerning any distribution you receive from the Plan.

Withholding Requirements

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA, including a Roth IRA (see the Rollover section below). You should consult with your personal tax adviser regarding this matter.

Rollovers

If you receive your benefit under the plan in the form of a single lump-sum, you may elect to roll over all or a portion of the distribution to an Individual Retirement Account/Annuity (an "IRA") or into another retirement plan that accepts rollovers from qualified plans. If you directly roll over your distribution from the Plan into a traditional IRA or another retirement plan, no income tax will be due on the amount rolled over and earnings thereon until you begin withdrawing the funds from the traditional IRA or retirement plan. If you roll over your distribution to a Roth IRA, the amount rolled over *is* subject to income tax in the year of the rollover. Under certain circumstances, all or a portion of a distribution may not qualify for rollover treatment.

As stated above, if you elect to have your benefit paid directly to you in a lump-sum payment, rather than rolled over, 20% of your distribution will be withheld and paid to the IRS. Even if you elect to have your benefit paid directly to you, you may still decide to roll over all or a portion of your distribution to an IRA or another retirement plan. If you decide to roll over your distribution, *you must make the rollover within 60 days after your receive the distribution. If you choose to roll* over 100% of your distribution, you must replace the 20% that has been withheld with other money available to you within the 60-day period. If you do not replace the 20% that has been withheld and you roll over only the 80% that you actually received, you will be taxed on the 20% that was withheld.

Note that in contrast to a single lump-sum payment, you cannot roll over monthly benefit payments into an IRA or another retirement plan.

Distributions Prior to Age 59 ½

In addition to being taxed as ordinary income, the taxable portion of a distribution taken prior to age 59 ½ (an early distribution) may be subject to a nondeductible federal penalty tax of 10%. Additional penalties may exist under state tax law. Early distributions are exempt from federal penalty taxes if the distribution was made for one of the following reasons:

- Distribution to your named beneficiary due to your death;
- Distribution that is made in the form of annuity payments over your life expectancy or over the life expectancy of you and your beneficiary;
- Distribution is made after termination of employment if you terminate after you reach age 55;
- Distribution that is made because you are totally and permanently disabled;
- For deductible medical expenses;
- Payment to an alternate payee under a qualified domestic relations order upon dissolution of a marriage; or
- To roll over to an IRA or other retirement plan within 60 days of receipt.

Please contact your Plan Administrator to receive a copy of the Special Tax Notice regarding payments from the Plan. This notice contains important information that you need to know before making a payment/withholding election.

AMENDMENT OR PLAN TERMINATION

The Committee expects to continue the Plan, but reserves the right to suspend, amend, modify or terminate the Plan in whole or in part at any time. If the Plan is amended, the amendments will not decrease your Accrued Benefit as of the time an amendment is adopted.

The Committee may only amend the Plan in writing. Any amendments shall be duly authorized if approved or ratified by the Committee. Thus, the Plan may not be modified or amended simply by representations, oral or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or human resources representative, for instance. If you believe you have received information that is contrary to the terms of the Plan or this Summary, please contact the Plan Administrator for clarification or confirmation.

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be fully vested as of the date of the termination. Benefits will be paid, according to law, as described in the following paragraph. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan assets would be used to pay benefits to retirees, beneficiaries and active participants, up to the total amount of assets in the Plan's trust. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made in the following order of priority: (1) benefits that are being paid or that will begin to be paid within three years; (2) benefits guaranteed by the Pension Benefit Guaranty Corporation; (3) benefits that were already vested before the Plan's termination; and (4) all other benefits.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Your Benefits are Insured

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;

- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact MySource for Human Resources at **1-888-640-3320** or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

ADMINISTRATIVE / LEGAL OVERVIEW

Administrative Information

Plan Sponsor

The Plan Sponsor is Columbia Energy Group.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee (the "Committee"). In its discretion, the Committee may designate members of the NiSource Human Resources Department or other individuals to act on its behalf with respect to the administration of the Plan. The Committee has the sole authority to interpret the terms of the Plan. You may contact the Committee/Plan Administrator at:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for Columbia Energy Group is 13-1594808.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 001. The AB II Benefit is a cash balance plan. The official Plan name is the Columbia Energy Group Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Committee's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Legal Information/Issues

Employment Rights

The Plan is neither a contract for employment nor consideration for employment. Participation in the Plan is not a guarantee of or contract for new or continued employment. All employees remain subject to termination, layoff or discipline as if the Plan had never been put into effect.

If the Plan Becomes "Top-Heavy"; A Legal Limitation

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $160,000 (indexed for 2011), and employees who are 1 percent owners of the Company with annual compensation of more than $150,000 (not indexed), 5 percent owners of the Company and beneficiaries of the above. You will be notified if this affects you.

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Senior Vice President of Human Resources
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan Administrator or the trustee.

State Law

Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

Collective Bargaining Agreements

As stated earlier in this SPD, employees who are covered by a collective bargaining agreement are not eligible for the Plan unless the applicable collective bargaining agreement provides for participation in the Plan. For those employees who are covered by a collective bargaining agreement providing for participation in the Plan, the Plan is maintained pursuant to a collective bargaining agreement.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnished, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, *and copies of the latest annual report (Form 5500 Series) and updated Summary Plan* Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (Social Security retirement age) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day *until you receive the materials—unless the materials were not sent because of reasons* beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.
- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the "Publications Hotline" of the EBSA.

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SUMMARY PLAN DESCRIPTION FOR THE

Columbia Energy Group Pension Plan

A DESCRIPTION OF YOUR RETIREMENT PENSION BENEFITS

For Employees in the FAP Benefit

June 2011

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INTRODUCTION

Retirement can be the most exciting time of your life. Of course, you must work hard and save during your career to achieve the kind of financial security needed to enjoy those years to the fullest. Early on, you will need to ask yourself: "What sources of income will I have for my retirement?" You will likely be relying on (1) your pension benefit from the **Columbia Energy Group Pension Plan** (previously known as the Retirement Plan of Columbia Energy Group Companies, hereinafter referred to as the "**Plan**"), (2) a retirement benefit from Social Security, (3) your own personal savings, and (4) if applicable, savings under the NiSource Inc. Retirement Savings Plan or any other employer-sponsored retirement plan. Your employer, Columbia Energy Group, offers the Plan for the benefit of its employees and their beneficiaries in order to help provide for retirement.

Overview of the Plan

The Plan is a defined benefit pension plan funded entirely by contributions from NiSource Inc. or its affiliates. Its purpose is to provide you with retirement income that is in addition to any other retirement income you have or may be eligible to receive.

As an employee of Columbia Energy Group or any affiliate that adopts the Plan for its employees (collectively, the "**Company**") satisfying the criteria described in the "Eligibility and Enrollment" section, you are eligible for the Final Average Pay or "**FAP" Benefit** of the Plan. Note that if you are a union employee of the Company, you will not participate in the FAP Benefit unless the collective bargaining agreement that covers you provides for your participation.

Introduction to the FAP Benefit

You are covered under the **FAP Benefit** of the Plan. The FAP Benefit (formerly the "Final Average Pay Option Benefit") is a defined benefit pension option.

As a participant in the FAP Benefit of the Plan, you do not make any contributions to the Plan. The FAP Benefit is designed to provide you with a monthly benefit at retirement based on your years of Credited Service and your "final average pay" while a participant in the plan.

Your years of Credited Service are based on the total period of your participation in the Plan. Your final average pay is the average of your Eligible Pay earned over the 36 months that is the highest among the last 60 months of your employment. These terms are defined in more detail later in this summary.

In addition, the FAP Benefit also provides a monthly benefit payable to your eligible spouse (or, if applicable, your children under the age of 21) in the event of your death.

Again, it costs you nothing to participate because the Company makes all contributions necessary to fund your FAP Benefit under the Plan on your behalf.

About this Plan Summary and Plan Administration

This handbook serves as a Summary Plan Description ("SPD" or "Summary") of the Plan, prepared in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD

and the official Plan document. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. This SPD does not extend or change the Plan in any way.

The NiSource Benefits Committee (the "Committee") serves as business manager and administrator for the Plan (the "Plan Administrator"). The Plan Administrator utilizes the NiSource Human Resources Department and other specified individuals to carry out a number of administrative tasks for the Plan. See "Administrative Information" found later in this Summary. A trust fund has been established for the purpose of holding funds contributed to the Plan. The trust fund is administered by a trustee (the "Trustee") appointed by the Committee.

While the Committee intends to continue the Plan described in this handbook, the Committee reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion, subject to any applicable collective bargaining agreement.

HIGHLIGHTS: FAP BENEFIT

ARE THERE EMPLOYEE CONTRIBUTIONS?	No, all contributions are made by the Company
ARE THERE COMPANY CONTRIBUTIONS?	Yes; the Company makes contributions to fund your FAP Benefit, which is based on: • Your years of Credited Service; and • Your Eligible Pay, taking into consideration the Social Security Taxable Wage Base.
WHEN AM I VESTED IN MY BENEFIT?	You are fully vested after 3 years of service (if you terminated prior to January 1, 2008, you generally were vested after 5 years of service).
WHAT IS ELIGIBLE PAY FOR PURPOSES OF DETERMINING MY BENEFIT?	Eligible Pay includes your base salary and commissions, any salary reduction contributions made for a Company cafeteria or 401(k) plan, any "banked" vacation paid under the NiSource Vacation Policy, and, effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay). However, the Plan does not consider certain items to be Eligible Pay. These excluded items include, but are not limited to, overtime, shift differential pay, amounts deferred to a nonqualified plan and other special forms of pay such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, any performance-based or incentive-based pay and imputed income.
WHEN IS MY BENEFIT PAID?	Provided you are vested, you can be paid: • When you retire; • When you reach Early or Normal Retirement Age (defined later), if you have terminated employment prior to that time; • When you reach age 70½ (provided you have already terminated employment or are considered a 5% owner of the Company); or • In the event of your death.
HOW CAN I RECEIVE MY BENEFIT?	You may elect to receive your benefit in the form of: • One of several Monthly Annuity Options • A Lump Sum • A Rollover

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be an "Eligible Employee" to actively participate in the Plan. Generally, you are eligible to participate in the FAP Benefit of the Plan (*i.e.*, you are a "FAP Participant") only if you are a regular full-time or part-time "non-exempt employee" (as classified by the Company) and fall within one of the categories described in the box below. You are not eligible to participate in the Plan at all if you are an intern, an independent contractor or a leased employee of the Company, or if you are a union employee whose collective bargaining agreement does not provide for Plan participation. In addition, "exempt employees" (as classified by the Company) are not eligible to participate in the Plan as a FAP Participant either because they transitioned to the account balance benefit (AB II Benefit) effective January 1, 2011 (see the Summary applicable to the AB II Benefit) or because they were hired or rehired on or after January 1, 2010 and are not eligible to participate in the Plan.

More specifically, a FAP Participant is:

- Any non-exempt employee hired before January 1, 2000 who has not made an election to have his or her benefit determined under a different benefit option under the Plan.*
- Any union non-exempt employee hired prior to January 1, 2008, if the applicable collective bargaining agreement provides for participation in the FAP Benefit.
- Any union non-exempt employee hired prior to January 1, 2008, if the applicable collective bargaining agreement allowed the employee to elect the FAP Benefit and the employee made such election.*

Note that effective January 1, 2013, all non-exempt employees will be governed by the AB II Benefit provisions of the Plan (i.e., the Summary applicable to the AB II Benefit will apply on or after that date).

***Note:** Each Eligible Employee who participated in the FAP Benefit of the Plan as of December 31, 1999 had the opportunity to make an irrevocable Plan choice by April 30, 2000 to stay in FAP Benefit or switch to the AB I Benefit effective January 1, 2000 ("2000 Choice"). Subsequently, each FAP Participant as of December 31, 2003 who was not eligible to make an election under the 2000 Choice period had the opportunity to make an irrevocable choice by May 31, 2004 to switch to the AB I Benefit effective January 1, 2004 ("2004 Choice"). Each Exempt Employee under the Plan as of October 1, 2005 had the opportunity to make an irrevocable Plan choice by December 14, 2005 to stay in the FAP Benefit or switch to the AB II Benefit effective January 1, 2006 ("2006 Choice"). Again, if no 2000 Choice, 2004 Choice or 2006 Choice was made, the employee remained in the FAP Benefit. These Choice elections were made and documented in a manner specified by the Plan Administrator.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts on your first day of work with the Company. Once you start to participate in the Plan, you will continue to participate as long as you are an Eligible Employee of the Company. If you terminate employment after becoming a Plan participant and later return to employment as an Eligible Employee, you will participate in the Plan under the AB II Benefit provisions of the Plan (a different Summary applies). Upon rehire as an

Eligible Employee, your participation as an AB II Benefit participant will begin immediately; however, the "Break in Service" rules may impact your service crediting under the Plan. See the "Break in Service" section later in this Summary for an explanation of this rule and how it might affect your participation if you terminate employment and later become reemployed by the Company. Note that if you terminate employment and later return as an "exempt employee", you are no longer eligible to participate in the Plan (*i.e.*, "exempt employees" hired or rehired on or after January 1, 2010 are not eligible to participate in the Plan).

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an Eligible Employee (*i.e.*, you terminate employment or your employment status changes to one that is not eligible to participate in the Plan);*
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

* Note that once you are no longer an Eligible Employee, you will remain an inactive Plan participant until you take a full distribution of your vested benefit from the Plan.

Service

Your Service with the Company, and also any breaks in your Service, have an effect on your participation in and benefits under the Plan. As explained in the following paragraphs, your Service with the Company is used as a component to calculate your benefit under the Plan. Also, the Plan uses Service to determine when you are entitled to (or "vested" in) your benefit under the Plan.

Credited Service

"Credited Service" is used in calculating the amount of your benefit. Credited Service is also used to determine whether you are eligible to receive your FAP Benefit prior to the time you reach your normal retirement age.

Credited Service is the number of your years and partial years (*i.e.*, months, with a month of Service credited for any month in which you work one hour) of Service as a FAP Participant and an employee of the Company (or any affiliate of the Company that participates in the Plan). Credited Service is measured from the first day of the month in which your employment began through your termination of employment, for any reason, or if earlier, until the date that you transition out of the Plan or out of the FAP Benefit structure. In other words, if your FAP Benefit is converted to another form of benefit under the Plan (i.e., the AB I Benefit or AB II Benefit) due to either your election, transfer within the Company or rehire by the Company, you will not earn Credited Service after such conversion unless you again become a participant in the FAP Benefit.

Please see the "How the Plan Works" section later in this Summary for a complete explanation of how your Credited Service factors into the calculation of your FAP Benefit.

Vesting Service

"Vesting Service" is the number of your years of Service as an employee of the Company (or any affiliate) from your date of employment through the date of your termination of employment for any reason. To be "vested" means you have a non-forfeitable right to your Plan benefit. You are fully vested in your pension benefit after completing three years of Vesting Service with the

Company and/or an affiliate. Note that if you terminated prior to January 1, 2008, you had to complete five years of Vesting Service before becoming fully vested in your benefit (unless you terminated at a time when an even higher vesting requirement applied, in which case the terms of the Plan in effect at your termination will control).

Special rules may apply if you experience a break in service, become disabled or if you were previously a leased employee of the Company or an affiliate.

Break in Service

A break in employment (called a "Break in Service") may affect how you are credited with Service under the Plan. A Break in Service occurs if you terminate employment with the Company and are not employed for a period of 12 consecutive months. If you incur a Break in Service, the effect on your Vesting Service and Credited Service will depend on the following: (1) the length of your Break in Service; (2) whether you were vested in your pension benefit prior to the Break in Service; and (3) whether you received a distribution of your benefit under the Plan. Note that regardless of whether or not you have a Break in Service (or regardless of its length), if you terminate employment and are rehired as an Eligible Employee, you begin participation in the Plan under the AB II Benefit provisions. If you experience a transfer of employment within the Company or from/to an affiliate of the Company, see the section entitled "Changes in Employment Status" later in this Summary for an explanation of the impact on your benefit and Service crediting under the Plan.

Break in Service Less Than 1 Year

If you terminate employment and are reemployed by the Company within 12 consecutive months, you are not considered to have a Break in Service. In this case, the Plan will consider your period of absence as part of your Vesting Service and Credited Service under the Plan. However, as noted below, if you received a distribution of your benefit, then your Credited Service will start at zero upon your return to employment.

Break in Service of 1 to 5 Years

If you terminate employment and your Break in Service lasts more than 1 year but less than 5 years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. If you are re-employed, the period of your absence will not count as part of your Service for any purpose.

Break in Service More Than 5 Years

If you are not vested in your pension benefit prior to your Break in Service, and your Break in Service lasts for 5 or more years, you will lose credit for all of your prior Service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you are vested when you terminate employment and you are later re-employed after a Break in Service of 5 or more years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. However, the Company does not count the period of your absence as part of your Service.

If You Received a Distribution

If you experience a Break in Service *and* receive or begin to receive a distribution of your vested benefit under the Plan before your return to work, you will receive credit for your Service prior to the break for purposes of counting Vesting Service only. For benefit accrual purposes, you will be treated as a new participant (*i.e.* Service will start at zero upon your return to employment).

Effect of Leaves on Break in Service

If you are on an "Authorized Leave of Absence" as discussed below, the Break in Service rules do not apply to the extent you continue to earn Service during the authorized leave. If the authorized leave provisions don't apply and you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement, then different rules apply when determining if a Break in Service has occurred. In general, if you are absent from work for one of the foregoing reasons beyond the first anniversary of the first date of

your absence, you will not be considered to have a severance from Service until the second anniversary of the first date of your absence. In addition, you will not have a Break in Service if you are on an Authorized Leave of Absence pursuant to the Family and Medical Leave Act, or if you are absent from employment due to service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")) and if you return to work at the end of your Authorized Leave of Absence.

Other Circumstances Impacting Service

Authorized Leaves of Absence—If you are on a leave of absence that is approved by the Company in accordance with its procedures and the Plan (an "Authorized Leave of Absence"), you will continue to earn Vesting Service and Credited Service while the authorized leave continues for a period of up to 12 months. Service crediting will cease as of the expiration of this 12 month period or, if earlier, the date the Authorized Leave of Absence ends (unless you return to work at that time).

Disability—Vesting Service and Credited Service are also impacted if you become Disabled (as defined in the Plan). To learn how a Disability affects your benefit and the Service you earn under the Plan, see "If You Become Disabled" found later in this Summary.

HOW THE PLAN WORKS

As explained at the beginning of this Summary, the FAP Benefit of the Plan is a defined benefit pension plan. The FAP Benefit is designed to provide you with a guaranteed monthly pension benefit for life after you retire. The FAP Benefit uses a formula, based on your years of Credited Service and average pay leading up to retirement, to define the amount of your monthly pension.

When you retire, you will receive the monthly benefit you have accrued under the FAP Benefit, unless you elect to receive your benefit in another form (these are explained in detail later in this Summary).

Elements of Your FAP Benefit

In order to calculate your FAP Benefit, the Plan must consider the following factors: (1) your years of **Credited Service** (see "Service" section above), (2) your "**Final Average Pay**", and (3) the "**Social Security Wage Base**." To help you better understand your benefit calculation, this Summary briefly describes the terms below (which are further described and determined in accordance with the Plan document).

Determining Your Final Average Pay

Your "**Final Average Pay**" is determined by calculating the annual average of your highest 36 months of "Eligible Pay" earned within the 60 months preceding the earlier of (a) your termination of employment or (b) the date you are converted to the Plan's account balance benefit structure. For purposes of determining the 36 months of largest total Eligible Pay, such months do not have to be consecutive within the 60-month period.

Your "**Eligible Pay**" generally equals:

- Your annual base pay received from the Company, including
- Salary reduction contributions made for you under a cafeteria plan or a 401(k) plan, plus
- Commissions, if you are compensated in whole or in part on a commission basis, plus
- Any one-time payments in lieu of salary increases for a given year (i.e., lump-sum merit pay) (included effective September 1, 2009), plus
- Any amounts attributable to "banked" vacation and paid to you under the NiSource Vacation Policy.

However, Eligible Pay does not include all types of compensation you might receive from the Company. Specifically, items excluded from Eligible Pay include, but are not limited to the following:

- Overtime pay,
- Shift differential pay,
- Amounts deferred to a nonqualified plan, and
- Other special forms of compensation, such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, other performance-based or incentive-based pay and imputed income.

In general, Eligible Pay shall be determined on a monthly basis. If you are a full-time employee paid on a monthly, semi-monthly, biweekly, or weekly basis, your monthly Eligible Pay equals one-twelfth of your annual base rate of pay last in effect for the month, plus pay inclusions described above such as actual commissions paid in the month. If you are a part-time employee, your monthly

Eligible Pay equals the sum of your actual Eligible Pay, plus pay inclusions described above (such as commissions) paid to you for each pay period during the month.

The IRS imposes a limit on the amount of Eligible Pay that may be taken into account by the Plan. As a result, Eligible Pay above $245,000 for 2011 (as adjusted annually by the IRS for cost-of-living increases) does not count for purposes of determining your Final Average Pay or FAP Benefit under the Plan.

Impact of Disability Leave, an Authorized Leave of Absence, or Other Absence on Your Eligible Pay— If you are participating in the Plan, and you are on a leave due to Disability (as defined in the Plan and as further described later in this Summary) or on an Authorized Leave of Absence or other absence approved by the Company, you will be deemed to receive Eligible Pay for purposes of calculating your FAP Benefit during your period of leave. However, similar to service crediting described earlier, if on an Authorized Leave of Absence or other approved (non-Disability) leave, you will only receive Eligible Pay crediting for up to 12 months. Your Eligible Pay for each month during this period generally shall equal one-twelfth of your annual base rate of pay last in effect for the month in which the employment absence occurred. For more specific information on how Eligible Pay is calculated during any of the above-described absences from employment, please contact the NiSource Human Resource Department.

Social Security Wage Base and Your FAP Benefit

The Plan considers the Social Security Wage Base when determining your FAP Benefit. The **Social Security Wage Base** (**"SSWB"**) is the maximum amount of eligible pay on which you and the Company pay Social Security taxes each year. Because you do not pay Social Security taxes on eligible pay above the SSWB, you do not earn Social Security benefits on eligible pay in excess of the SSWB. As a result, Social Security as a percentage of your retirement replacement income may be lower. To help compensate affected employees, as described further below, the FAP Benefit provides a slightly higher benefit based on your Final Average Pay over one-half the SSWB for the year in which you retire. For 2011, the SSWB is $106,800 and one-half of the SSWB is $53,400.

Your FAP Benefit Formula

Your FAP Benefit is a monthly benefit, calculated as a single life annuity commencing on your Normal Retirement Date (described below). Your FAP Benefit is determined using a formula and is equal to one-twelfth of the sum of:

1.15% of your Final Average Pay that does not exceed one-half of the Social Security Wage Base ***times*** years of Credited Service up to a maximum of 30 years.

Plus

1.50% of your Final Average Pay that exceeds one-half of the Social Security Wage Base ***times*** years of Credited Service up to a maximum of 30 years.

Plus

0.50% of Final Average Pay ***times*** years of Credited Service in excess of 30 years (up to a maximum of 10 years).

Note that in the case of a Participant who transitions to an account balance benefit structure (either automatically or by election), that Participant's FAP Benefit (for purposes of determining the "Protected Benefit" under the account balance benefit structure) only considers Eligible Pay and Credited Service earned prior to the date of conversion to the account balance benefit structure.

Your FAP Benefit: Timing and Amount

The result you compute under the FAP Benefit formula outlined above is the monthly pension benefit you will generally receive if you work for the Company up until your "Normal Retirement Age" (defined below). If you retire or stop working before Normal Retirement Age, you are only entitled to a portion of the benefit you would receive if you had kept working until Normal Retirement Age. This section explains how terminating employment at different times will impact the amount of your retirement benefit.

Normal Retirement

Your FAP Benefit is stated as a monthly annuity payable for your life at your Normal Retirement Date. *This is known as your Normal Retirement Benefit. Your* "**Normal Retirement Date**" *is the* first day of the month on or following the later of (1) your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born) (your "**Normal Retirement Age**"); or (2) the *fifth anniversary of the date you began participation in the Plan. (Note that if you first became a* Participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Normal Retirement Date is the first day of the month following your 65th birthday.) If you retire on or after your Normal Retirement Age, the amount of your FAP Benefit will not be reduced for early commencement of payment.

Example:

Assume you retire in 2011 upon reaching your Normal Retirement Date. Assume also that your Final Average Pay is $60,000 (or $5,000 per month) and you have 32 years of Credited Service. As stated above, for 2011 one-half of the SSWB is $53,400. Your FAP Benefit will be calculated as follows:

NORMAL RETIREMENT MONTHLY BENEFIT EXAMPLE			
1.15% of $53,400 (your Final Average Pay that does not exceed one-half of the SSWB)	$614.10 x 30 years	=	$18,423.00
1.50% of $6,600 (your Final Average Pay that exceeds one-half of the SSWB)	$99 x 30 years	=	$2,970.00
0.50% of $60,000	$300 x 2 years	=	$600.00
Basic Annual Benefit			$21,993.00
Total Single Life Monthly Annuity			**$1,832.75**

Early Retirement

If you retire on or after your "Early Retirement Date" but before your Normal Retirement Date, you may elect to receive your Early Retirement Benefit. Your "**Early Retirement Date**" is the first day of the month following your employment termination on or after reaching your "Early Retirement Age" (or any month thereafter before your Normal Retirement Age in which you elect to begin receiving your benefit). You reach your "**Early Retirement Age**" once you either (1) reach age 55 with at least 10 years of Credited Service, or (2) reach age 60 with at least five years of Credited Service. Your Early Retirement Benefit is your FAP Benefit with a reduction to reflect the fact that *you will receive your benefit over a longer period of time. Specifically, your benefit would be*

reduced by 0.25% for each month by which your Early Retirement Date precedes the date that is three years prior to your full Social Security Retirement Age.

Example:

Assume that your full Social Security Retirement Age is age 65, and you retire in 2011 at age 55 with 10 years of Credited Service and with a Final Average Pay of $60,000 ($5,000 per month). As stated above, for 2011 one-half of the SSWB is $53,400. Your FAP Benefit will be calculated to include an early retirement reduction as illustrated below:

APPLICABLE EARLY RETIREMENT REDUCTION FACTOR	
Normal Retirement Age	65
Actual Retirement Age	55
3-year period for unreduced benefits	65 – 3 = 62
Number of months before 3 year period benefits are being paid	62 – 55 = 84 months
Reduction for Early Retirement	84 months x 0.25% = 21%

After determining your early retirement reduction, your FAP Benefit will be calculated as follows:

EARLY RETIREMENT MONTHLY BENEFIT EXAMPLE			
1.15% of $53,400 (your Final Average Pay that does not exceed one-half of the SSWB)	$614.10 x 10 years	=	$6,141.00
1.50% of $6,600 (your Final Average Pay that exceeds one-half of the SSWB)	$99 x 10 years	=	$990.00
0.50% of $60,000 (multiplied by number of years over 30)	$300 x 0 year	=	$0.00
Basic Annual Benefit at Normal Retirement Age			$7,131.00
Single Life Monthly Annuity Benefit at Normal Retirement Age			$594.25
Reduction for Early Retirement	$594.25 x 21%		$124.79
Total Single Life Monthly Annuity beginning at age 55 *(with reduced benefit factor applied)*			**$469.46**

Supplemental Benefit

A **"Supplemental Benefit"** is payable if you (1) are a FAP Participant at the time of your employment termination, (2) have reached your Early Retirement Age while employed by the Company, and (3) retire from active service on or before age 62. This Supplemental Benefit serves to increase your retirement income until you reach the age to be eligible for Social Security benefits (age 62). For eligible retirements, the monthly supplement is $16.00 multiplied by your years of Credited Service (up to a maximum of 30 years) paid until the earlier of the date you are eligible for Social Security benefits or your date of death.

Example:

Assume you retire in 2011, four years before your Normal Retirement Age with 25 years of Credited Service and a Final Average Pay of $60,000 (or $5,000 per month). Your monthly Early Retirement Benefit, factoring in the Supplemental Benefit, is calculated as follows:

SUPPLEMENTAL BENEFIT EXAMPLE			
Retirement Benefit			
1.15% of $53,400 (your Final Average Pay that does not exceed one-half of the SSWB)	$614.10 x 25 years	=	$15,352.50
1.50% of $6,600 (your Final Average Pay that exceeds one-half of the SSWB)	$99 x 25 years	=	$2,475.00
0.50% of $60,000 (multiplied by number of years over 30)	$300 x 0 years	=	$0.00
Basic Annual Benefit at Normal Retirement Age			$17,827.50
Single Life Monthly Annuity Benefit at Normal Retirement Age			**$1,485.63**
Reduction for Early Retirement (12 months x .25%)	$1,485.63 x 3%	=	$44.57
Single Life Monthly Annuity Benefit Beginning At Early Retirement Age			**$1,441.06**
Supplemental Benefit			
Supplement of $16 for each year of Credited Service to 30 years	$16 x 25 years	=	$400.00
Basic Single Life Monthly Annuity Benefit until age 62 plus Supplement	$1,441.06 + $400.00	=	$1,841.06
Basic Single Life Monthly Annuity Benefit after age 62 (without Supplement)			$1,441.06

To see how your benefit adds up, you can call MySource for Human Resources at **1-888-640-3320** at any time or visit the Web site (**www.mysourceforhr.com**) to request a calculation of your earned benefit.

Termination Prior to Normal or Early Retirement

If you terminate employment with the Company before your Normal or Early Retirement Date, you will be eligible to receive your vested FAP Benefit beginning the month following your attaining Normal Retirement Age. Alternatively, you may elect to begin receiving your FAP Benefit on the first of any month following your attainment of your Early Retirement Age. Your FAP Benefit (also called your "Deferred Vested Benefit") is based on your Final Average Pay and Credited Service up to your termination date. If you begin receiving your FAP Benefit prior to Normal Retirement Age, like the Early Retirement Benefit described above, your benefit will be reduced by 0.25% for each month payments begin before the date that is three years prior to your full Social Security Retirement Age.

Monitoring Your FAP Benefit

To monitor your FAP Benefit you can call MySource for Human Resources at **1-888-640-3320** at any time or visit the Web site **www.mysourceforhr.com** for information on your FAP Benefit or to run retirement estimates. Note that any estimates provided by My Source for Human Resources are estimates only and your actual retirement benefit may change based on your years of Credited Service, Eligible Pay, SSWB or the interest rate in effect under the Plan at the time of your actual retirement.

Funding: Who Pays For Your Benefit

The Plan is funded with contributions made by the Company. On an annual basis, the Plan Administrator actuarially determines the amount that the Company must contribute in order to fund the pension benefits for you and your fellow co-workers that participate in the Plan.

Vesting: When Do You Own Your Benefit

As discussed earlier in this Summary, to be vested means you have a permanent right to your Plan benefit and are entitled to receive that benefit whenever you stop working for the Company. You become fully vested in your Plan benefit once you have completed 3 years of Vesting Service (5 years of Vesting Service for employees terminating prior to January 1, 2008) (see "Service" section described earlier in this Summary). There is no partial vesting in your Plan benefit. You are not vested until you reach 3 years of Vesting Service, and you become fully vested once you reach 3 years of Vesting Service (5 years for employees terminating prior to January 1, 2008).

Thus, for example, if you terminate employment with only 2 years of Vesting Service, then you will receive no benefit under the Plan. That is, you are not vested in your benefit because you have less than 3 years of Vesting Service. If you terminate employment with 3 or more years of Vesting Service, you are fully vested in your benefit.

RECEIVING YOUR BENEFIT

When Is Your Benefit Paid?

Provided you are vested in your benefit as described above, you (or in the event of your death, your surviving spouse or minor children) may receive or begin to receive your benefit under the Plan as soon as possible following: (1) attainment of your Early or Normal Retirement Date; or (2) your death (see "Death Benefits" found later in this Summary).

If you are vested in your benefit and terminate employment with the Company with an accrued FAP Benefit of $5,000 or less, you will automatically be paid a single lump sum as soon as practicable after your termination. Alternatively, if your vested benefit amount is more than $5,000, receipt of your benefit will be deferred until the date you would have reached Early Retirement or Normal Retirement. In other words, once you have terminated employment and have reached your Early or Normal Retirement Date, you may elect to begin receiving your Plan benefit. By law, you must begin to receive payment of your Plan benefit by April 1 of the calendar year following the later of either (1) the year you turn age 70½, or (2) the year in which you retire.

The amount you would be eligible to receive would be the amount of your accrued FAP Benefit. Remember, if you leave the Company before you are vested in your benefit, you are not entitled to a benefit under the Plan.

How Is Your FAP Benefit Paid?

Regardless of *when* you receive your benefits, generally you will need to elect the *form* of your benefit. As stated earlier in this summary, your FAP Benefit is stated as a monthly annuity payable for your lifetime beginning at your Normal Retirement Date. However, you can elect to receive your Plan benefit in a single lump-sum payment or in one of several available annuity forms. Once you terminate employment and reach your Early or Normal Retirement Age, you can request a distribution of your benefit at any time in any of the forms available under the Plan (described below). Note that if you are married, your benefit will be paid in the joint and survivor annuity form as described below, unless you elect a different form of benefit with your spouse's consent.

A Note on "Actuarially Equivalent" Benefits

The various benefit form options are considered to be *"actuarially equivalent"* meaning that, statistically, they should produce the same total benefit amount even though they provide very different monthly benefit payments or the benefit may be paid in a lump sum. To calculate actuarial equivalence, the Plan uses specified interest rate and mortality factors for various purposes, applying statutory minimum requirements. For instance, to calculate the lump sum present value for your FAP Benefit, the Plan uses as its interest rate the rate for 30-year Treasury Securities for September of the prior year (or a minimum interest rate prescribed by the IRS if it produces a larger benefit).

Note that to receive the current year's interest rate for certain calculations, such as calculating the lump sum present value of the FAP Benefit, the last day worked must be November 30 (*i.e.*, a December 1 benefits commencement date). A December 1 benefits commencement date requires a retirement date of December 1 and filing proper paperwork (described below) with MySource for Human Resources on or before November 30 requesting commencement of pension distribution.

Applying for Benefits

If you are retiring, you must call MySource for Human Resources at **1-888-640-3320** or visit the Web site **www.mysourceforhr.com** to request a pension benefit commencement kit. If you contact by phone, please ask to speak with a Retirement Specialist.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before your first payment is processed. However, once your payments begin, you may not change the form of payment you have elected. Generally, all forms must be returned by the 10th of the month preceding the date your benefits are calculated to commence (your "**Benefit Commencement Date**"). The actual payment(s) will be made as soon as practicable following your Benefit Commencement Date.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively practicable after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Payment Options Under the Plan

When you retire or leave the Company, you may elect to receive your vested benefit under the Plan in any of the payment forms outlined below. As previously stated, various benefit forms are "actuarially equivalent." If you do not make a payment election, your benefit will be paid in the form of a "Single Life Annuity" if you are not married, or as a "50% Pop-Up Annuity" if you are married. If you are married, you may elect a different form of payment only with your spouse's notarized consent.

Lump-Sum Payment

You may receive your FAP Benefit in a single lump-sum payment. If you select this distribution option, no further benefits would be payable from the Plan. If you are married at the time you want your pension benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less. Again, if the actuarial equivalent of your vested FAP Benefit is $5,000 or less, the Plan automatically pays this amount as a lump sum distribution (*i.e.*, annuity payments are not available).

Rollovers—If you receive your FAP Benefit under the Plan in the form of a single lump sum, you may elect to roll over all or a portion of the distribution into an individual retirement account annuity ("IRA") or to another eligible retirement plan that accepts rollovers. Note that if you do not make a payment election (direct payment vs. rollover) and your benefit is greater than $1,000 but less than or equal to $5,000, then the Plan Administrator will roll over your benefit to an IRA designated by the Plan administrator. If your benefit is $1,000 or less when you leave the Company, and you do not elect whether to receive this benefit directly or to roll it over, then the Plan automatically pays this single lump-sum amount directly to you.

Annuity Payment Forms

If the actuarial equivalent of your FAP Benefit is over $5,000, you may choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan. In calculating your benefit amount, the Plan considers the type of annuity you elect and, if applicable, your beneficiary's age. The following annuity options are available to you:

- **Single Life Annuity**—As stated above, if you are single, the single life annuity option is the automatic form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it as a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may not elect this form of payment without your spouse's notarized consent.

- **50% Pop-Up Annuity**—As stated above, if you are married, the 50% Pop-Up Annuity (with no reduction for the value of the pop-up feature), with your spouse as the contingent annuitant, is the automatic form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form.

  If you are married, you may choose the 50% Pop-Up Annuity distribution option, naming a beneficiary other than your spouse (and with a reduction for the value of the pop-up feature), provided your spouse consents to the alternate beneficiary. Your spouse's consent must be notarized.

  If you are single, you may choose the 50% Pop-Up Annuity distribution option (also reduced for the value of the pop-up feature).

  Under the 50% Pop-Up Annuity distribution option, you receive reduced benefits monthly for your lifetime. If you die before your beneficiary, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime.

  If your beneficiary dies within 60 months after your Benefit Commencement Date and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death.

  If your beneficiary dies more than 60 months after your Benefit Commencement Date and before you die, your monthly payment will remain the same as when your beneficiary was living and all payments will stop at your death.

- **33-1/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 33-1/3% of your benefit for his or her lifetime. If you are married, you may not elect this form of payment without your spouse's notarized consent.
- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.
- **75% Annuity** — Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 75% of your benefits for his or her lifetime. This option is available effective January 1, 2008. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.
- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized consent.

Payments under any of these options will be based on your accrued FAP Benefit. Subject to the spousal consent requirements noted above, you may choose any form of distribution as well as choose any beneficiary as your joint annuitant. If you die before an elected form of distribution begins, your benefit will be determined as provided in the "Death Benefits" section of this Summary.

A Comparison of Payment Options

As stated above, you may choose for your FAP Benefit to be paid in the form of one of several annuity options or as a lump sum, and these options are actuarially equivalent. If you choose to receive your benefit as a lump sum, the total vested value of your FAP Benefit will be converted

from an annuity into a lump sum form of payment. If you choose an annuity payment option that provides benefits for a beneficiary after your death, your actual payment will be reduced to reflect the cost or value of guaranteeing payments over the lives of two people. For example, assume you are married and retiring when both you and your spouse are age 55. Assume also that your FAP Benefit produces a monthly benefit of $1,200.00 and the applicable interest rate is 3.77% at the time you retire (note that the applicable interest rate fluctuates from year to year). See below for examples of estimated monthly amounts under some of the payment options that you could choose, and the amounts your surviving spouse could receive if you die after payments begin. Note that the examples do not reflect the payment of a Supplemental Benefit as discussed above. The examples below are simply intended to provide you with a general idea of the amount differences between the various payment forms.

PAYMENT OPTIONS	YOUR MONTHLY BENEFIT FOR LIFE	YOUR SPOUSE'S MONTHLY BENEFIT FOR LIFE AFTER YOUR DEATH
Single life annuity	$1,200.00	$0.00
50% Pop-Up Annuity (unreduced for pop-up feature with spouse as beneficiary)	$1,131.60	$565.80
33-1/3 % Annuity	$1,153.20	$384.02
66-2/3% Annuity	$1,110.00	$740.37
75% Annuity	$1,100.40	$825.30
100% Annuity	$1,070.40	$1,070.40
Lump Sum Payment *($240,877)*	None	None

Situations Affecting Your Plan Benefit

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed three years of vesting service (five years of vesting service if you terminated prior to January 1, 2008) you will not be entitled to a pension benefit and your pension benefit is forfeited.
- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.
- If you die before your pension benefits begin and you are unmarried, a death benefit will be paid only if you are survived by children under the age of 21. See "Death Benefits" below.
- If required by a qualified domestic relations order, all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. See "In the Event of Divorce or Dissolution" below.
- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan Administrator has

the authority to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made. In addition, in the event that an overpayment is made from the Plan and no additional payments are due to be paid, the Plan Administrator has the authority to seek reimbursement of such overpaid amounts from the Participant (plus interest calculated in accordance with IRS guidance).

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

A Note on Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. The Social Security office can advise you on the documents you will need in order to apply for this benefit.

DEATH BENEFITS

Death After Pension Payments Begin

If you die after you have begun receiving your pension benefit, additional payments to a named beneficiary will depend on the form of benefit payment you selected (see "Payment Options Under the Plan" above).

Death Before Pension Payments Begin

Married Participants

If you are married and you die before you begin receiving your FAP Benefit, the Plan will provide pre-retirement death benefits to your surviving spouse, provided you were vested under the Plan at the time of your death (see "Vesting: When Do You Own Your Benefit" above). Benefit payments to your surviving spouse, if applicable, shall be paid until your surviving spouse's death. However, if your surviving spouse dies before your youngest surviving child attains age 21, the monthly death benefit shall continue to be paid until the youngest surviving child attains age 21.

Single Participants

If you are single and you die before commencing your vested FAP benefit, there is a death benefit ***only*** if you have surviving children under the age of 21. Benefit payments to your surviving children who are under the age of 21 at the time of your death, if applicable, shall be paid until the youngest surviving child reaches age 21. Each payment made to a FAP Participant's surviving children shall be divided equally among the surviving children who are under age 21 at the time the payment is made. No death benefit will be paid to any other non-married FAP Participant.

Death Benefit Amount and Commencement

The amount and timing of payment of your death benefit payment is described below.

If you are actively employed, on an authorized leave of absence or receiving long term disability benefits from the employer at the time of your death, the death benefit payable to your surviving spouse or children under age 21 will be equal to 75% of your FAP Benefit reduced by 0.25% for each month in excess of 60 months by which your age exceeds your spouse's age (subject to a minimum benefit amount). This benefit will be paid as a monthly annuity and will commence as of the first day of the month following the date of your death.

If you die after you have terminated employment but before you begin receiving your vested pension benefit, the death benefit payable to your surviving spouse or children under age 21 will be an annuity equal to the survivor portion of your FAP Benefit under the 50% Pop-Up Annuity as if you had survived to your Early Retirement Age, retired, elected this form of payment and died immediately thereafter. Generally, this benefit will be paid as a monthly annuity and will commence as of the first day of the month following the date of your death, or if later, as of the first day of the month following the date on which you would have attained Earliest Retirement Age (as defined in the Plan and the Code). Note that with respect to this death benefit only, your surviving spouse or children under age 21 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 you would have attained Normal Retirement Age, but not later than that date. The monthly amount of any

death benefit that commences after your Earliest Retirement Age shall be increased (as if you had deferred commencement of the benefit) to reflect this deferral.

Note that if the present value of the death benefit payable to your spouse or other beneficiary is $5,000 or less, the Trustee will automatically distribute your death benefit to your surviving spouse or children in a single lump sum payment.

Designation of Beneficiary

When you first join the Plan, you will need to name a beneficiary of your FAP Benefit. A beneficiary designation form will be sent to you when you become eligible to join the Plan. On your beneficiary designation form, you indicate the person(s) who will receive the remaining payments of your Plan benefit, if any, in the event of your death. You may change your beneficiary at any time prior to commencing benefit payment(s) by completing and returning a new form. Contact MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com** to change your beneficiary. *NOTE: If you die before beginning receipt of your benefits, your FAP Benefit will only be paid as described in the "Death Benefits" section above.*

If you are married—If you are married, your spouse will automatically be named as your beneficiary. If you wish to designate someone other than your spouse to be the beneficiary under a joint and survivor annuity option, your spouse must consent to your election in writing. The consent must be witnessed by a Notary Public and returned to MySource for Human Resources.

If you are single—You may name anyone as your beneficiary under a joint and survivor annuity option offered under the Plan.

- Note that if you marry, **your spouse automatically becomes your beneficiary** regardless of your previous designation, unless your new spouse consents in writing to another designation. You should notify MySource for Human Resources of any changes in your marital status. See "In the Event of Divorce or Dissolution" (the following section) for an explanation of how a divorce may affect your beneficiary designation under the Plan.

Duty to Report Participant's Death

If you die while receiving pension payments, the Plan Administrator must be notified of your death so that appropriate action may be taken concerning your benefits (e.g., beginning payments to a designated beneficiary; stopping payments; etc.). It is illegal for any person or entity to continue to receive after your death benefit payments that are supposed to be made only for the duration of your life. Accordingly, please advise those persons who may ultimately represent your estate, or who may be in a position to receive your benefit payments, of this legal duty to contact the Plan Administrator upon your death.

IN THE EVENT OF DIVORCE OR DISSOLUTION

If you are married and you go through a divorce or dissolution, such proceedings may affect your Plan benefit or your beneficiary designation under the Plan, as explained below. You must inform the Plan Administrator if you are divorced by contacting MySource for Human Resource at **1-888-640-3320.**

Beneficiary Designations After Divorce/Dissolution

If you are married and your marriage terminates by reason of divorce, dissolution or other similar operation of domestic relations law, any beneficiary designation you have previously made will remain unchanged. Note that while some state laws may invalidate a spousal beneficiary designation upon divorce, that is not the case under the Plan. Upon divorce, if you had named your former spouse as your beneficiary under the Plan, your beneficiary designation will not change unless you make a new beneficiary designation that revokes your prior beneficiary designation, or you remarry.

If you subsequently re-marry a different spouse, your previous beneficiary designation is *automatically* revoked and your new spouse becomes your beneficiary, unless a valid "qualified domestic relations order" provides otherwise. As explained below, a qualified domestic relations order may limit your ability to name another beneficiary in the event of a divorce or dissolution.

Qualified Domestic Relations Order (QDRO)

If you become divorced or legally separated, a specific type of court order could require that part of your benefit be paid to someone else – your former spouse, for example. This is known as a "qualified domestic relations order" ("QDRO"). By federal law, the Plan must comply with a QDRO. A QDRO is a legal judgment or decree that recognizes the rights of or support obligation toward a spouse, former spouse, child or other dependent. A domestic relations order must satisfy specific requirements to be "qualified," and it must be recognized by the Plan Administrator.

If required by a QDRO, all or a portion of your benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. A QDRO may require that your former spouse be treated as your surviving spouse for all or any part of the survivor benefits payable after your death. This means that if you re-marry, your subsequent spouse may not be treated as your surviving spouse for the portion of your benefit assigned to your former spouse if a valid QDRO so provides.

You and your beneficiaries may obtain, free of charge, a copy of the procedures used to determine the "qualified" status of a domestic relations order from MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com**. You or your spouse should submit a draft version of a domestic relations order to the Plan Administrator for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any court proceedings that may affect your FAP Benefit, contact MySource for Human Resources at **1-888-640-3320**. When the Plan Administrator receives notice of a pending QDRO, a hold will be placed on your FAP Benefit that will prevent you from making any withdrawals until the QDRO is processed.

CHANGES IN EMPLOYMENT STATUS[1]

Rehired Employees

If you terminate employment after becoming a Plan participant and later return to employment as an Eligible Employee (*i.e.*, you are NOT an "exempt employee" rehired after January 1, 2010 or an otherwise ineligible employee), you will generally begin participation in the Plan under the AB II Benefit provisions rather than the FAP Benefit provisions. As an Eligible Employee, you will begin participation immediately once you are rehired; however, the Break in Service rules (described earlier in this Summary) may impact your Service crediting under the Plan.

If you are participating under the FAP Benefit and you terminate employment but do not receive a distribution, then when you are reemployed, the Plan will convert your FAP Benefit to an AB II Benefit. If you terminate employment and had received a lump sum distribution of your FAP Benefit, then when you are reemployed, you will begin participating in the Plan as a new AB II Benefit employee (*i.e.*, with a $0 "opening balance" and 0 years of "point service" under the AB II Benefit, though your prior Service will count for vesting purposes). See the AB II summary plan description for an explanation of your AB II Benefit if these provisions apply to you.

If you were receiving your benefits in the form of an annuity at the time you return to employment as an Eligible Employee, your annuity payments will be suspended and the unpaid portion of your prior benefit will be converted to an AB II Benefit opening balance as of the date of your reemployment. On your subsequent Benefit Commencement Date, your FAP Benefit (i.e., your "Protected Benefit under the AB II Benefit structure) will be reduced by the amount of annuity benefits you previously received. For purposes of calculating your AB II "pay credits" (described in the AB II Benefit Summary), you will be credited with "point service" both before and after your absence from employment. Further, your prior Service (as well as your Service earned after your reemployment) will count for vesting purposes. Note that the suspension of benefits and conversion to an AB II opening balance may be impacted if you return to work after your Normal Retirement Age. In such instances, contact the Plan Administrator for additional details regarding the effect of reemployment on your retirement benefit.

NOTE: If you are rehired by the Company on or after January 1, 2010 as an exempt employee, you will not participate in the Plan under any benefit option. Any prior FAP Benefit you had accrued during your previous employment with the Company that had not been paid out to you prior to your rehire date will remain in the Plan, and any service you accrue after rehire will count for purposes of vesting in your prior benefit. However, you will accrue no new benefit under the Plan under either the FAP Benefit provisions nor any other benefit option.

Transfers Within the Plan

Change from Non-Exempt to Exempt Status[2]

Subject to the exception described in the next paragraph, if you transfer from a non-exempt position with the Company to an exempt position with the Company, your benefit will be

[1] Note the rehire provisions of this section are applicable to any participant rehired on or after January 1, 2008. Note the transfer provisions of this section are applicable to transfers occurring on or after January 1, 2009.

[2] Note that this Summary does not provide a description applicable for a change from exempt to non-exempt status because any active participant accruing a FAP Benefit as an exempt employee in the Plan as of January 1, 2011 was automatically converted to an AB II Benefit as provided by the Plan's terms.

determined under the AB II Benefit provisions on and after the date of transfer. Your FAP Benefit accrued up to the date of transfer will be converted to an AB II Benefit opening balance in the Plan. After the transfer, you will receive credit for your Vesting Service both before and after the transfer. If this section applies to you, see the summary plan description for your AB II Benefit for additional detail on the conversion of your FAP Benefit under the Plan.

If You Were Hired or Rehired On or After January 1, 2010—If you were hired or rehired on or after January 1, 2010 as an Eligible Employee, participate in the FAP Benefit of the Plan, and you subsequently transfer to an *exempt* position, you will no longer be eligible to participate in the Plan upon your transfer and your benefit accruals will cease.

Changes between Union and Non-Union Status

If you transfer *from* a *union* position with the Company *to* a *non-union* position with the Company, or if you transfer *from* a *non-union* position with the Company *to* a *union* position with the Company, your benefit will be determined under the AB II Benefit. Your FAP benefit under the Plan will be converted to an AB II Benefit opening balance in the Plan. After the transfer, you will receive credit for your Service as "point service" both before and after the transfer. If this section applies to you, see the summary plan description for your AB II Benefit for additional detail on the conversion of your FAP Benefit under the Plan.

Transfers to/from Affiliates

From An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under an affiliate's pension plan *to* an employment position with the Company otherwise providing coverage under the Plan. Unless specific provisions in the Plan or an affiliate's plan provides otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources Department for further information.

Note that as described below, transferring from a Company affiliate means that you either stay in the affiliate's plan or you become an AB II Benefit participant in the Plan. Either way, this Summary applicable to the FAP Benefit of the Plan will not apply. The chart below is provided for informational purposes only. If you transfer from an affiliate, please see the Summary applicable to you.

IF YOU TRANSFER FROM AN AFFILIATE IN THE FOLLOWING POSITION:	TO THE COMPANY IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Non-union (exempt or non-exempt)	Non-union (exempt or non-exempt)	You will remain in the affiliate's plan and will accrue no benefit under the Plan. In accordance with the terms of the affiliate's plan, you will remain subject to your plan benefit terms in effect prior to your transfer, except that any non-union non-exempt employee that becomes an exempt Eligible Employee (hired or rehired prior to January 1, 2010) shall become an AB II participant under such plan and shall have his/her benefit converted to an AB II Benefit opening balance under such plan.

IF YOU TRANSFER FROM AN AFFILIATE IN THE FOLLOWING POSITION:	TO THE COMPANY IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Union	Non-union (exempt or non-exempt)	Your benefit under the affiliate's plan will be frozen as of your transfer date and you will begin to participate in the AB II Benefit of the Plan. Your prior benefit will remain in the affiliate's plan and you will begin participation in this Plan with a *$0 opening balance. You will receive credit for your Service* for purposes of vesting and determining "point service" both before and after the transfer. With respect to your benefit under the affiliate's plan, you will cease to earn service for benefit accrual as of the date of transfer, except that service following transfer shall be counted solely for purposes of determining eligibility for an early retirement benefit under such plan. Note, however that if you transfer to an exempt employee position, you must be an "Eligible Employee" (*i.e.*, you were hired or rehired prior to January 1, 2010) in order to begin to accrue a benefit under the Plan.
Non-union (exempt or non-exempt)	Union	
Union	Union	

To An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under the Plan *to* an employment position with an affiliate that does not sponsor the Plan (because the affiliate offers a different plan or no plan). Unless specific provisions in the Plan or an affiliate's plan provide otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources Department for further information.

IF YOU TRANSFER FROM THE COMPANY IN THE FOLLOWING POSITION:	TO AN AFFILIATE IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Non-union (non-exempt)	Non-union (non-exempt)	You will remain in the FAP Benefit of the Plan and will continue to earn Vesting Service and Credited Service under the Plan after the transfer.
Non-union (non-exempt)	Non-union (exempt)	*Hired or Rehired by the Company Prior to January 1, 2010.* If you were hired or rehired prior to January 1, 2010, your benefit in the Plan will be converted to an AB II Benefit opening balance and you will remain in the Plan but will participate in the AB II Benefit option after your transfer. You will continue to earn Service for vesting and "point service" after the transfer. *Hired or Rehired by the Company On or After January 1, 2010.* If you were hired or rehired on or after January 1, 2010, you will no longer earn a benefit either under the Plan or under an affiliate's plan. Your FAP Benefit will be frozen as of the date of your transfer, but you will continue to earn Vesting Service under the Plan after the transfer.

IF YOU TRANSFER FROM THE COMPANY IN THE FOLLOWING POSITION:	TO AN AFFILIATE IN THE FOLLOWING POSITION:	THE IMPACT ON PLAN BENEFITS WILL BE AS FOLLOWS:
Union	Non-union (exempt or non-exempt)	Your FAP Benefit in the Plan will be frozen as of the date of your transfer. With respect to your benefit under the Plan, you will cease to earn service for benefit accrual as of the date of transfer, except that Service following transfer shall be counted solely for purposes of determining eligibility for an early retirement benefit under the Plan. You will begin participating in the affiliate's plan as a new participant (assuming you are an "Eligible Employee" in the Plan). If the affiliate's plan provides for your participation in an AB I or AB II Benefit option, you shall begin participation in such option with a $0 opening balance, though you will receive credit for vesting service and point service both before and after the transfer. If the affiliate's plan provides for your participation in a FAP Benefit option, you shall begin participation in such option with zero credited service.
Non-union (non-exempt)	Union	
Union	Union	
Union	NiSource Corporate Services	Your benefit will remain in the Plan and will be determined under the AB II Benefit. Your FAP Benefit will be converted to an AB II Benefit opening balance in the Plan. You will receive Service credit both before and after the transfer for purposes of determining vesting and "point service" under the Plan *Exception.* If you were hired or rehired before January 1, 2010, and then transfer to an exempt position with NiSource Corporate Services, you will no longer earn a benefit under either the Plan or under any NiSource pension plan. Your FAP Benefit in the Plan will be frozen as of the date of your transfer. You will continue to earn Vesting Service under the plan after the transfer.
Non-union (exempt or non-exempt)	NiSource Corporate Services	

If You Continue to Work After Normal Retirement Age

If you choose to work beyond your Normal Retirement Age, you will continue to earn Credited Service under the FAP Benefit provisions of the Plan until you retire. If you work 40 or more hours per month on and after reaching Normal Retirement Age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching Normal Retirement Age, you may begin receiving your pension benefit from the Plan.

If You Become Disabled

If you become Disabled while working for the Company, the calculation of your Plan benefit will be impacted as described in this section. In general, **"Disability"** or **"Disabled"** under the Plan means any physical or mental condition that constitutes a disability under the long-term disability plan (the "LTD Plan") maintained by the Company. A Disability commences when you first qualify for benefits under the Company's LTD Plan and ceases when you no longer qualify for benefits under such LTD Plan.

If you are considered Disabled under the Plan and later return to active employment as an Eligible Employee (*i.e.*, you are NOT an "exempt employee" originally hired or rehired after January 1, 2010 or an otherwise ineligible employee), you will be covered under the AB II Benefit once you return to active work. The Plan will convert your FAP Benefit to an AB II Benefit.

Service Crediting—If you are considered Disabled under the Plan, you will continue to earn Vesting Service and Credited Service while the Disability continues without regard to whether the Disability lasts beyond one year and could thus constitute a "Severance from Service" (as defined in the Plan"). Credited Service under the Disability provision shall cease to be credited as of the earliest of (1) the date on which your Disability ends pursuant to the Company LTD Plan (which shall be deemed your "Termination of Service" as that term is defined by the Plan unless you return to employment with the Company or the Company determines a different "Termination of Service" date), (2) the date on which you return to employment, or (3) the date your benefit under the Plan commences. Note that if your Disability under the Company LTD Plan commenced prior to January 1, 2000, you earned Credited Service during the period of your Disability prior to January 1, 2000 only if you were both Disabled under the Plan and eligible for disability benefits under the Social Security Act.

Your FAP Benefit—You will continue to accrue a FAP Benefit while you are Disabled. For these purposes, you will be deemed to receive Eligible Pay at the same level of Eligible Pay in effect for the month when you became Disabled (but excluding any performance-based components of Eligible Pay). See the "How the Plan Works" section earlier this Summary for an explanation of what compensation counts as Eligible Pay for purposes of calculating Final Average Pay and your FAP Benefit.

You may elect to start your Plan benefit payments at any time once you are considered to have terminated employment by the Company on or after reaching your Early or Normal Retirement Age. You may receive your benefit under any of the payment options described in "Payment Options Under the Plan" above. Note that when you elect to begin benefit payments, you will stop accruing a FAP Benefit. In addition, commencing your Plan benefit might mean that your LTD benefits would no longer be payable. For more information about electing payment of your Plan benefit and whether such an election would impact your LTD payments, contact MySource for Human Resources and consult your LTD Plan.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

As stated above, to request your Plan benefits you must obtain the a pension benefit commencement kit from MySource for Human Resources (**1-888-640-3320; www.mysourceforhr.com**).

Claim Denial and Appeal Process

If you disagree with any decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the administrative review procedure you must follow. If you think benefits owed to you are not paid, or are too low, or are paid at a time other than when you think they should be, you can make a "claim" for benefits to the Plan Administrator.

If your claim for a pension benefit is denied in whole or in part, you have the right to request a review of the denial. You (or your beneficiary) will be notified of a denial of your claim in writing by the Plan Administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice of the denial will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan Administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the NiSource Benefits Committee at the following address:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. . If your appeal is denied, you will be told why and which Plan provisions support that decision. If the final determination is made in your favor, the determination shall be final and binding. If the final determination is not made in your favor, the determination shall be binding and conclusive unless you notify the NiSource Benefits Committee within 90 days after the mailing or delivery of the determination that you intend to institute legal proceedings under Section 502(a) of ERISA challenging the determination, and you actually institute such legal proceedings within 180 days after such mailing or delivery. All questions arising with respect to the Plan during any such legal proceedings shall be governed by Indiana law, except to the extent superseded by federal law.

TAX CONSEQUENCES

How and When Your Plan Benefits are Taxed

Generally, federal and state income tax laws do not require you to pay tax on your Plan benefits until you actually receive distributions under the Plan. Once you begin to receive benefit payments, you will have taxable income on these payments in the year that your receive them. In the year(s) of any distribution from the Plan, you will receive a tax form that will provide you with the information you need to file your taxes. You may be able to defer federal income taxes and avoid any penalty taxes if you transfer or "roll over" your distribution (see the Rollover section below). You should consult your tax advisor concerning any distribution you receive from the Plan.

Withholding Requirements

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA, including a Roth IRA (see the Rollover section below). You should consult with your personal tax adviser regarding this matter.

Rollovers

If you receive your benefit under the plan in the form of a single lump-sum, you may elect to roll over all or a portion of the distribution to an Individual Retirement Account/Annuity (an "IRA") or into another retirement plan that accepts rollovers from qualified plans. If you directly roll over your distribution from the Plan into a traditional IRA or another retirement plan, no income tax will be due on the amount rolled over and earnings thereon until you begin withdrawing the funds from the traditional IRA or retirement plan. If you roll over your distribution to a Roth IRA, the amount rolled over *is* subject to income tax in the year of the rollover. Under certain circumstances, all or a portion of a distribution may not qualify for rollover treatment.

As stated above, if you elect to have your benefit paid directly to you in a lump-sum payment, rather than rolled over, 20% of your distribution will be withheld and paid to the IRS. Even if you elect to have your benefit paid directly to you, you may still decide to roll over all or a portion of *your distribution to an IRA or another retirement plan. If you decide to roll over your distribution,* you must make the rollover within 60 days after your receive the distribution. If you choose to roll over 100% of your distribution, you must replace the 20% that has been withheld with other money available to you within the 60-day period. If you do not replace the 20% that has been withheld and you roll over only the 80% that you actually received, you will be taxed on the 20% that was withheld.

Note that in contrast to a single lump-sum payment, you cannot roll over monthly benefit payments *into an IRA or another retirement plan.*

Distributions Prior to Age 59 ½

In addition to being taxed as ordinary income, the taxable portion of a distribution taken prior to age 59 ½ (an early distribution) may be subject to a nondeductible federal penalty tax of 10%. Additional penalties may exist under state tax law. Early distributions are exempt from federal penalty taxes if the distribution was made for one of the following reasons:

- Distribution to your named beneficiary due to your death;
- Distribution that is made in the form of annuity payments over your life expectancy or over the life expectancy of you and your beneficiary;
- Distribution is made after termination of employment if you terminate after you reach age 55;
- For deductible medical expenses;
- Payment to an alternate payee under a qualified domestic relations order upon dissolution of a marriage; or
- To roll over to an IRA or other retirement plan within 60 days of receipt.

Please contact your Plan Administrator to receive a copy of the Special Tax Notice regarding payments from the Plan. This notice contains important information that you need to know before making a payment/withholding election.

AMENDMENT OR PLAN TERMINATION

The Committee expects to continue the Plan, but reserves the right to suspend, amend, modify or terminate the Plan in whole or in part at any time. If the Plan is amended, the amendments will not decrease your Accrued Benefit as of the time an amendment is adopted.

The Committee may only amend the Plan in writing. Any amendments shall be duly authorized if approved or ratified by the Committee. Thus, the Plan may not be modified or amended simply by representations, oral or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or human resources representative, for instance. If you believe you have received information that is contrary to the terms of the Plan or this Summary, please contact the Plan Administrator for clarification or confirmation.

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be fully vested as of the date of the termination. Benefits will be paid, according to law, as described in the following paragraph. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan assets would be used to pay benefits to retirees, beneficiaries, and active participants, up to the total amount of assets in the Plan's trust. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made in the following order of priority: (1) benefits that are being paid or that will begin to be paid within three years; (2) benefits guaranteed by the Pension Benefit Guaranty Corporation; (3) benefits that were already vested before the Plan's termination; and (4) all other benefits.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Your Benefits are Insured

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;

- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact MySource for Human Resources at **1-888-640-3320** or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

ADMINISTRATIVE / LEGAL OVERVIEW

Administrative Information

Plan Sponsor

The Plan Sponsor is Columbia Energy Group.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee (the "Committee"). In its discretion, the Committee may designate members of the NiSource Human Resources Department or other individuals to act on its behalf with respect to the administration of the Plan. The Committee has the sole authority to interpret the terms of the Plan. You may contact the Committee/Plan Administrator at:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for Columbia Energy Group is 13-1594808.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 001. The official Plan name is the Columbia Energy Group Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan Trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Committee's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the Plan Trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Legal Information/Issues

Employment Rights

The Plan is neither a contract for employment nor consideration for employment. Participation in the Plan is not a guarantee of or contract for new or continued employment. All employees remain subject to termination, layoff or discipline as if the Plan had never been put into effect.

If the Plan Becomes "Top-Heavy"; A Legal Limitation

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or accrued benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than

$160,000 (indexed for 2011), and employees who are 1 percent owners of the Company with annual compensation of more than $150,000 (not indexed), 5 percent owners of the Company and beneficiaries of the above. You will be notified if this affects you.

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Senior Vice President of Human Resources
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan Administrator or the Plan Trustee.

State Law

Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

Collective Bargaining Agreements

As stated earlier in this SPD, employees who are covered by a collective bargaining agreement are not eligible for the Plan unless the applicable collective bargaining agreement provides for participation in the Plan. For those employees who are covered by a collective bargaining agreement providing for participation in the Plan, the Plan is maintained pursuant to a collective bargaining agreement.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnished, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including

insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (Social Security retirement age) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.
- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the "Publications Hotline" of the EBSA.

Summary Plan Description and Prospectus

for the

NiSource Inc. Retirement Savings Plan

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933. It covers NiSource Inc. common stock offered through the NiSource Inc. Retirement Savings Plan. These securities have not been approved or disapproved by the Securities Exchange Commission, nor has the Commission passed upon the adequacy of this Summary Plan Description and Prospectus. Any contrary representation is a criminal offense.

July 2010

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INTRODUCTION

Retirement can be the most exciting time of your life. Of course, you must work hard and save during your career to achieve the kind of financial security needed to enjoy those years to the fullest. Early on, you will need to ask yourself: "What sources of income will I have for my retirement?" No doubt you will be relying on (1) your retirement benefit from the **NiSource Inc. Retirement Savings Plan** (the "**Plan**"),* (2) a retirement benefit from Social Security and (3) your personal savings. In addition, if you are (or were) eligible to participate in one of the pension plans sponsored by NiSource Inc. or an affiliate, you will also rely on any retirement benefit that you receive under your pension plan.

NiSource Inc., Columbia Energy Group, Northern Indiana Fuel & Light Company, Kokomo Gas & Fuel Company ("Kokomo"), Bay State Gas Company ("Bay State"), Northern Indiana Public Service Company ("NIPSCO") or any affiliated companies that have adopted the Plan (collectively or individually, as the context requires, referred to as the "**Company**"), offer the Plan in order to help its Eligible Employees to financially prepare for their retirement years. Accordingly, the Plan is designed to provide you with retirement benefits when you terminate employment with the Company.

* Prior to December 31, 2008, rather than the NiSource Inc. Retirement Savings Plan, certain Eligible Employees participated in the Northern Indiana Public Service Company Bargaining Unit Tax Deferred Savings Plan or the Bay State Gas Company Savings Plan for Operating Employees. On and after December 31, 2008, all Eligible Employees participate in the Plan, which includes these former plans (merged into the Plan on that date).

Why save through the Plan?

- *Automatic Payroll Deductions:* Often, the most difficult part about saving is doing it regularly and consistently. With the Plan, you decide how much to contribute. You can contribute from 1% to 50% of your eligible compensation on a pre-tax or Roth basis and up to 25% on an after-tax basis (subject to IRS limitation). That amount is *automatically* deducted from your paycheck. In addition, you can make "catch-up" contributions commencing in the year you turn age 50. You are always 100% vested in your own contributions to your account.

- *Company Matching Contributions:* The Company matches a portion of your contributions every payroll period (catch-up contributions are not matched). You are always 100% vested in your Company matching contributions.

- *Tax Advantages:* The Plan offers the option of saving on a before-tax basis -- meaning your contributions are deducted from your pay before most taxes have been withheld, effectively lowering your taxes today. In addition, the investment earnings of your Plan account are not taxed until you withdraw them from your account.

- *A Variety of Investments:* Regardless of your goals or investment preferences, the funds offered through the Plan fit a wide range of "comfort" levels (*i.e.,* different investment risk levels). You decide how your contributions are invested among a variety of investment options.

- *Flexibility:* With the Plan, you are never locked into just one way of saving or investing. Recognizing that your needs change over time, the Plan allows you to frequently change your investment elections and contribution amounts.

- *Access Before Retirement:* Although the goal of the Plan is to help you save for retirement through long-term investment, there may be times before retirement when you need your money. Depending on your circumstances, you may be able to borrow from part of your account for those needs. You may request a withdrawal from your rollover or after-tax contributions at any time, which may be subject to tax consequences.

- *Benefit Payment Options*: If you leave the Company, you generally can elect the following benefit payment options: defer payment (until no later than age 70½), take a lump sum distribution, receive installment payments, or roll over your account. If you die, your designated beneficiary or beneficiaries will be eligible to receive your Plan account.

- *Benefit Information Access*: You can call Fidelity Benefits Service Center at **1-800-305-401k** (4015) for your Account information, 24 hours a day, seven days a week. You can also visit NetBenefits at **www.401k.com** to view your account online.

Plan Overview

The Plan is a "**401(k)**" plan. The term "401(k)" refers to a specific section of the Internal Revenue Code that authorizes this type of plan. This term describes the feature of the Plan that permits you to elect to have the Company contribute a portion of your pay from the Company to the Plan. These payments to your Account are called "**Elective Deferral Contributions**" or "**Catch-Up Contributions**." The Plan also allows you to make "**After-Tax Contributions**" to your Account. The Company makes "**Matching Contributions**" to encourage employees to participate in the 401(k) savings program and may make certain other contributions as described on the attached applicable Schedule (collectively, "**Company Contributions**"). The Plan also permits you to make "**Rollover Contributions**" to the Plan from another qualified retirement plan. (See "Rollover Contributions," below).

As a participant in the Plan, you will have a separate account (an "**Account**") established which will hold your share of contributions to the Plan. Under the Plan, you will not receive a fixed dollar amount of retirement benefits. Instead, your actual distribution of funds will depend on the amount of your Account at the time you receive your benefit. At your retirement or termination of your employment, you are entitled to receive a distribution equal to the value of your Account. The balance of your Account will reflect the amount of the contributions that you made to your Account and contributions made by the Company, plus the return on your investments for the period of time you participated in the Plan.

The NiSource Benefits Committee (the "**Committee**") serves as business manager and administrator for the Plan (the **"Plan Administrator"**). The Plan Administrator utilizes Fidelity Investments ("**Fidelity**") to carry out a number of administrative tasks for the Plan. In addition, the Plan Administrator in its discretion may also delegate other administrative tasks to the Company's Human Resource Department or other designated individuals. See "Administrative Information" found later in this Summary. A trust fund ("**Trust Fund**") has been established for the purpose of holding funds contributed to the Plan. The Trust Fund is administered by a trustee (the "**Trustee**") appointed by the Committee. The Trustee oversees all investments and will invest the Trust Fund assets in a variety of securities and investments considered sound investments for retirement plans. The Committee may permit you to direct the investment of some or all of the money in your Account. If so, you and other Participants will be provided with rules governing such investments.

About This Plan Summary

This handbook (including the attached applicable Schedule of Benefit Information, the "**Schedule**") serves as a Summary Plan Description ("**SPD**" or "**Summary**") of the Plan, prepared in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). It is not intended to be a complete description of the Plan, but merely a brief summary of Plan highlights. This Summary is based on official documents that may include policies, contracts, plans and trust agreements. Note that this Summary is not an invitation to participate in the Plan nor is it an offer to buy or sell securities. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. Although every effort has been made to ensure that this explanation of the Plan is accurate, the official Plan document will always govern if there is any conflict between that document and this Summary. Likewise, any confusion about the Plan that arises from reading this Summary should be resolved by referring to the Plan document (and separate trust agreement, if applicable). This Summary does not interpret, extend or change the Plan in any way.

➔ Note that when you see this arrow symbol, you should be aware that an applicable Schedule at the end of this Summary more fully describes specific provisions of the Plan as it applies to you. Please refer to your specific Schedule as you review this Summary.

This Summary describes the Plan as it operates effective as of May 2010. **We strongly urge you to read this Summary (including the attached applicable Schedule) in its entirety.** If you have further questions, or if you would like to read the Plan document (and/or trust agreement, if applicable), copies of the documents are available from the Company for a nominal charge.

While the Committee intends to continue the Plan described in this Summary, the Committee reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion.

Highlights of the Plan

	ELECTIVE DEFERRAL CONTRIBUTIONS	AFTER-TAX CONTRIBUTIONS
VESTING	100% vested in your Elective Deferral Contributions, Catch-Up Contributions & the Company Contributions made to your Account and earnings	100% vested in your After-Tax Contributions and earnings
EMPLOYEE CONTRIBUTION **(See "Employee Contribution" Section)**	Can choose to contribute from 1% to 50% of your compensation. The maximum Elective Deferral Contribution under IRS limits for 2010 is $16,500	Can choose to contribute up to 25% of your compensation, subject to annual IRS limits (your combined Elective Deferral (including Catch-Ups) & After-Tax Contributions cannot exceed 75%)
"CATCH-UP" CONTRIBUTIONS AT AND AFTER AGE 50 **(See "Catch-Up Contributions" Section)**	$5,500 in 2010 *Catch-Up contributions are not eligible for match*	N/A
COMPANY CONTRIBUTIONS	See "Company Contributions" and attached applicable Schedule	See "Company Contributions" and attached applicable Schedule
ELIGIBLE COMPENSATION	See "Compensation" as referenced under the "Contributions" section below and described in the attached applicable Schedule	See "Compensation" referenced under the "Contributions" section below and described in the attached applicable Schedule
TAX ADVANTAGES	For pre-tax contributions -- Current tax savings on contributions and earnings For Roth contributions -- Current tax savings on earnings	Current tax savings on earnings only
LOANS	Loans are available, subject to IRS rules and Plan restrictions	Loans are available, subject to IRS rules and Plan restrictions
IN-SERVICE WITHDRAWALS	• After age 59-1/2 • Company Contributions, under certain circumstances • Hardships	• Withdrawals of After-Tax Contributions can be made for any reason
DISTRIBUTION OPTIONS	• Lump Sum • Installments	• Lump Sum • Installments
SURVIVOR BENEFIT	Yes	Yes

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be an "**Eligible Employee**" to actively participate in the Plan (*i.e.*, to become a "**Participant**" in the Plan). Generally, if you are a regular full-time or part-time employee of the Company, you are eligible to participate in the Plan as described in the attached applicable Schedule. Leased employees, interns, independent contractors and union employees who are not covered by a collective bargaining agreement providing for participation in the Plan are not Eligible Employees.

➔ See the attached applicable Schedule for a description of when you become eligible to participate in the Plan.

How to Enroll

If you would like enroll in the Plan, or adjust the automatic Pre-Tax Contribution amount (see below), you may do so through the Fidelity Benefits Service Center. As a newly eligible Participant, you will receive an enrollment packet with the enrollment, beneficiary designation and investment option forms. You may enroll in the Plan online at NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015). To enroll, you will need to:

- Set up a Personal Identification Number (PIN);
- Elect what percentage of your Compensation you want to contribute to the Plan;
- Elect if your contributions should be deducted from your pay on a pre-tax, Roth (see "Contributions" section) or after-tax basis; and
- Elect the funds in which you want your contributions to be invested.

You will receive a written confirmation of the elections you make when you enroll in the Plan within 7 to 10 business days after enrolling.

Your actual payroll deductions will begin as soon as administratively possible.

Automatic Enrollment and Opting Out

Although participation in the Plan is voluntary, if the Plan's automatic enrollments provisions apply to you as described in the attached applicable Schedule, you will be deemed to defer three percent (3%) of your Compensation (an "automatic Pre-Tax Contribution") unless you direct otherwise. You may elect not to participate in the Plan (and avoid automatic enrollment) by contacting Fidelity Benefits Service Center at **1-800-305-401k** (4015) or online at **www.401k.com** and completing the necessary forms to "opt out" of automatic enrollment in the Plan. Provided you have returned any required forms or completed the online process, your opt out election will be effective as soon as administratively practicable following your Plan eligibility date or any following monthly date.

➔ See the attached applicable Schedule to confirm whether the Plan's automatic enrollment provisions apply to you.

When Participation Begins

As an Eligible Employee, you can elect to be automatically enrolled in the Plan as described above (if the automatic enrollment provisions apply to you as described in the attached applicable Schedule). Alternatively, you can enroll in the Plan and become a Participant on the first pay period after you meet any participation requirements as described in the applicable Schedule (or as soon as administratively feasible thereafter). To enroll in the Plan (or change deferral elections if you were automatically enrolled in the Plan), you can log on to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015). Typically, you can

expect your deductions to begin one or two pay periods after enrollment. **Please note:** there are no retroactive deductions for pay periods that occurred prior to your enrollment being processed.

When Participation Ends

Your participation in the Plan ends when:

- You are no longer an Eligible Employee;
- The Company terminates its participation in the Plan;
- The Plan ends; or
- You die.

Participation Upon Re-employment

Once you become a Participant in the Plan, you will continue to participate in the Plan as long as you are an Eligible Employee of the Company. If you terminate employment with the Company, your participation in the Plan (*i.e.*, additional contributions going into your Account) stops automatically on your date of termination. If you terminate employment after becoming a Participant and later return to employment, you are eligible to participate in the Plan as soon as administratively practicable following the date on which you are re-employed. You must re-enroll in the Plan to begin participating after your re-employment. Alternatively, if applicable and if you do not re-enroll in the Plan after your re-employment, you may participate in the Plan again pursuant to the automatic enrollment and opt out provisions described above.

CONTRIBUTIONS

Your retirement benefits from the Plan will be funded from contributions you and the Company make to your Account and from your Account's earnings on these contributions. A number of different types of contributions may be made, and different rules and conditions apply to each type of contribution. Some of the different types of contributions are based on or affected by your "Compensation" from the Company (as defined in the attached applicable Schedule). For all employees, Compensation shall include any differential wage payments made by the Company while an employee is on active duty in the uniformed services for a period of more than 30 days, and any one-time payments in lieu of salary increases. The Internal Revenue Service ("IRS") limits the amount of your Compensation that can be considered under the Plan. The limit is $245,000 for 2010.

➔ See the attached applicable Schedule for a description of how the Plan calculates your Compensation.

Employee Contributions

Elective Deferral Contributions and After-Tax Contributions

You may elect to have the Company make Elective Deferral Contributions (explained below) and After-Tax Contributions to your Account by electing to reduce the Compensation otherwise payable to you. As a Participant, you can elect to contribute by payroll deductions from 1 percent to 50 percent of your eligible Compensation on a combined pre-tax or Roth basis ("**Elective Deferral Contributions**") and up to 25 percent on an after-tax basis ("**After-Tax Contributions**"). Your combined Elective Deferral (including Catch-Up Contributions explained further below) and After-Tax Contributions cannot exceed 75 percent of your Compensation (subject to annual IRS limits).

The maximum amount you may contribute annually to the Plan as an Elective Deferral Contribution for 2010 is $16,500 (unless you are eligible to make additional Elective Deferral Contributions known as "**Catch-Up Contributions**," explained below). Periodically, this limit will be further adjusted by the IRS to reflect changes in the cost of living.

Under the Plan, there are **two types of Elective Deferral Contributions**:

- **Pre-Tax Contributions**. Currently, you may make Elective Deferral Contributions to the Plan by reducing your Compensation on a pre-tax basis in a specified percentage ("**Pre-Tax Contributions**"). All of your Pre-Tax Contributions are generally made before taxes are withheld. This means that you generally pay no federal or state income tax on the amount you defer until it is later withdrawn or paid to you as a retirement benefit.

- **Roth Contributions:** Starting in 2010, you may also elect to have all or a portion of your Elective Deferral Contributions under the Plan treated as designated Roth contributions ("**Roth Contributions**"). Roth Contributions are still considered Elective Deferral Contributions, but unlike Pre-Tax Contributions, Roth Contributions are included in your gross income and are taxed at the time they are contributed to the Plan. Qualified distributions of Roth Contributions and earnings will be tax free.

Accordingly, you can elect to make Pre-Tax Contributions, Roth Contributions, or both, subject to the limitations stated above ($16,500 for 2010 or, if less, 50% of your Compensation). As noted above, in addition to these Elective Deferral Contributions, you may also elect to make After-Tax Contributions to your Account. While After-Tax Contributions and Roth Contributions are both contributed on an after-tax basis, these two kinds of contributions are different under the Plan and subject to different rules and restrictions. Please consider them separately when making your Plan contribution decisions.

Automatic Contributions

If the Plan's automatic enrollment provisions apply to you (as described in the applicable Schedule and discussed above), unless you elect otherwise, you will be automatically enrolled in the Plan as of the first pay period that is 30 days from the date you are notified of the automatic enrollment. This means that amounts will be taken from your Compensation and contributed to the Plan by the Company on your behalf. These automatic contributions (also

considered "Elective Deferral Contributions") will be made on a pre-tax basis and will be in the amount of 3% of your Compensation each pay period. You can elect to make more or less than this percentage amount as described below (see "Changing Your Contributions").

➔ See the attached applicable Schedule to confirm whether the Plan's automatic enrollment provisions apply to you.

Catch-Up Contributions

If you reach age 50 during the calendar year and you are making the maximum Elective Deferral Contribution allowed by the Plan or the Internal Revenue Code, you may make an additional Elective Deferral Contribution (either as a Pre-Tax or Roth Contribution or a combination of both) in the form of a Catch-Up Contribution each pay period. The maximum annual Catch-Up Contribution for 2010 is $5,500.

Catch-Up Contributions are a part of your Elective Deferral Contributions in your Account and they are fully vested and nonforfeitable at all times. Please note that these Catch-Up Contributions are not matched by the Company.

Changing Your Contributions

You may change the amount you are contributing at any time during the year, subject to any IRS limits that may apply. To increase or decrease the amount you are contributing or to suspend your contributions, go online to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Transactions are processed the same business day for transactions made by the time the market closes and the end of the next business day if you make a transaction after such time, or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days. It can take up to two payroll checks for your contribution change to be processed.

Automatic Increase Program

If you would like to contribute a smaller percentage of your Compensation and automatically increase that amount over time, the Plan offers an "Automatic Increase Program" in which you can elect to participate. Under this program, you can elect to contribute 1% of your Compensation which will automatically increase in 1% increments up to the limits imposed by the Plan. In other words, unless you change your election to participate in the program, the automatic increases stop once you reach a deferral of 50% of Compensation or reach the deferral dollar limit imposed by the IRS. Under the program, you choose the date and frequency that the increases go into effect. Note that the Automatic Increase Program applies only to Pre-Tax Contributions you elect to make, and does not apply to Roth Contributions. For more information or to enroll, go online to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Rollover Contributions

You are permitted to roll over into the Plan pre-tax contributions from other qualified plans such as:

- Qualified retirement plans;
- Individual Retirement Account (IRAs);
- 403(b) plans; or
- Governmental 457(b) retirement plans.

By rolling over money into the Plan, you can continue to defer federal and state income tax on the money until you ultimately receive it. Rollovers are deposited into a Rollover Contribution Account within your Plan Account. You will not receive a matching contribution on any rollover you make to the Plan.

You may also be able to roll over Roth contributions from another qualified retirement plan. Note that with respect to Roth Contributions, you must satisfy a 5-year-taxable period before a distribution of Roth Contributions will be afforded the full taxation benefits available. This 5-year-taxable period will be treated as beginning with the earlier of (1) the first taxable year for which you made a Roth Contribution to the Plan, or (2) in the case of a rollover of Roth contributions from another plan, the first taxable year for which you made a Roth contribution to such plan.

For more information on the rollover or distribution of Roth Contributions, see the "Contributions" and "Rollovers" portions of the "Tax Consequences" section later in this Summary.

If you want to arrange a rollover, call Fidelity Benefits Service Center at **1-800-305-401k** (4015) for more information.

Company Contributions

In addition to the contributions noted above that you can make to the Plan, you will also receive certain contributions made by the Company as described in the attached applicable Schedule. Company "**Matching Contributions**" are additional contributions made by the Company to your Account based on the amount of Elective Deferral Contributions (but excluding Catch-Up Contributions) that you elect to contribute to your Account. In addition, as described in the attached applicable Schedule, the Company may also make Matching Contributions based on your After-Tax Contributions, if any.

All Company Matching Contributions will be made to the Company Stock Fund (unless provided otherwise in the attached applicable Schedule). Once the Matching Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

Maximizing Your Company Matching Contribution

The Company Matching Contribution is made each pay period. Once you reach the IRS limit on Elective Deferral Contributions and the combined Plan limit of Elective Deferral and After-Tax Contributions, you will no longer receive a Company Matching Contribution for the remainder of that calendar year. Therefore, if you want to maximize your Company Matching Contributions, you need to spread your Elective Deferral and/or After-Tax Contributions evenly throughout the year.

➔ See the attached applicable Schedule for details on the Matching Contributions (and any other Company Contributions) that you may receive.

INVESTMENT OF ACCOUNT BALANCES

All contributions are deposited in the Plan's Trust Fund. The Plan generally permits you to direct the investment of your Account balance as described below. Your investment elections and the various investment options under the Plan are managed by the Plan's Trustee who is appointed by the Committee. The Committee may also employ professional investment advisors to assist in carrying out investment responsibilities. The Committee reserves the right to change investment procedures. In addition, the Committee may change the type and number of investment options which are available to you from time to time.

Note that the Trustee may invest Plan assets in short-term, interest-bearing investments or maintain in cash certain portions of the available funds during periods prior to distribution or investment, or when money is being transferred from one investment option to another. The Trustee selects the short-term investment vehicles to be used for this purpose.

Your Investment Options

The Plan offers a variety of investment options, each with a different objective. At the time of your enrollment, you must make your investment choices in whole 1% increments. For more complete information on the Plan's investment options, including historical fund performance, fees and expenses visit Fidelity NetBenefits at **www.401k.com** and click on the Asset Allocation Worksheet in the "Tools" section, or visit the interactive tools on NetBenefits at **www.401k.com**. Additional help is available by calling the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

For a brief description of the investment options available under the Plan, please refer to the Appendix at the end of this document.

Investment Options for Automatic Pre-Tax Contributions

If you are automatically enrolled in the Plan (under the automatic enrollment process explained above), your automatic Pre-Tax Contributions will initially be invested in a default investment fund or funds established by the Committee in compliance with applicable rules and regulations established by the Department of Labor. Currently, the Committee has designated the Fidelity Freedom K Funds as the default investment option for automatic contributions (see attached Appendix for further information). Unless you elect otherwise, your automatic contributions will be invested in the appropriate Fidelity Freedom K Fund based on your age and anticipated date of retirement. You may subsequently change this default investment by following the procedures explained in the "*Changing Your Investment Election*" section.

Investment Options for Company Contributions

The Company Contributions you receive are automatically invested in the NiSource Stock Fund (unless provided otherwise in the attached applicable Schedule). You can redirect that money into any of the other investment options available under the Plan.

You can elect whether to reinvest your dividend from the NiSource Stock Fund or receive it in cash. However, if the dividend is less than $10, it will automatically be reinvested. If you do not make an election, your dividend will automatically be reinvested.

If you elect to receive your dividend in cash, it will be subject to income taxes in the year you receive it. However, it is not subject to the 10% penalty tax that applies to premature distributions from your Plan. No taxes will be withheld from your dividend check. You will be responsible for making all tax payments when you file your income tax return. Applicable tax forms will be provided to you by Fidelity.

To make an election, contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Changing Your Investment Election

You may make investment transfers (reallocations) at any time. You can move in percentages, dollar amounts, or number of shares among investment options. To make transfers in your Account, log on to NetBenefits at **www.401k.com**, or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

There is generally no limit to the number of times you may change your investment elections per year, but you can make only one change per day. There may, however, be short-term trading and excessive trading restrictions as outlined in the prospectus for each investment option. Transactions are processed the same business day for transactions made by the time the market closes and the end of the next business day if you make a transaction after such time, or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days.

Additional Information Relating to the Investment Options

Investment Funds

The value of Plan accounts invested in a fund other than the NiSource Stock Fund will be net of any investment manager fees that may be charged with respect to that particular fund. The prospectus for each fund describes the fees and expenses associated with investing in that fund. You will not be charged any fees or expenses with respect to investments in the NiSource Stock Fund.

Equity securities in the funds, except for the NiSource Stock Fund, will be voted by the Trustee. If you have invested in the NiSource Stock Fund, you are entitled to exercise any voting, tender or similar rights attributable to the shares of Company stock that are allocated to your Account. The Company will furnish the Trustee with notices and information statements when voting, tender and similar rights are to be exercised. The Trustee will notify you of each occasion for the exercise of voting, tender and similar rights and will forward copies of any proxy material within a reasonable time after it is secured from the Company. You may elect to exercise your right by filing written voting or tender instructions with the Trustee at the time and in the form specified by the Trustee. Any instructions that you submit to the Trustee will be held in the strictest confidence and will not be divulged or released to any person including officers, directors or employees of the Company. The Plan Administrator will establish procedures designed to safeguard the confidentiality of information as to your purchase, holding and sale of interests in the NiSource Stock Fund, and your exercise of voting, tender and similar rights with respect to common stock held therein (except to the extent necessary to comply with federal laws or with state laws that are not preempted by ERISA). The Trustee will not vote or tender shares of Company stock allocated to your Account if it does not receive your instructions by the specified deadline.

If you exercise your tender rights, the proceeds obtained when your shares of Company stock are sold will be invested in the investment funds, other than the NiSource Stock Fund, in the same proportions as are included in your investment election on file with the Plan.

Accounting Methods Used for Record Keeping

The Plan uses units rather than shares to account for contributions to the NiSource Stock Fund. This means that your investment in these funds is maintained in units, not actual shares. Each unit has a value that is calculated by dividing the total market value of the fund by the total number of units held in the fund. The number of units you hold in the fund increases or decreases as you make contributions, withdrawals, or transfers into or out of the fund. The value of your Account in the fund at any time is equal to the unit value multiplied by the number of units you hold. To find out the approximate number of actual shares of stock represented in the NiSource Stock Fund, divide the fund value by the current share price of Company stock.

The other investment funds are subject to share accounting, which means that your investment in these funds is maintained in actual shares of the fund. Thus, shares are bought and sold to cover your contributions, withdrawals or transfers into or out of the fund.

Purchase and Sale of NiSource Stock

NiSource stock is listed on the New York Stock Exchange. The Plan generally purchases or sells NiSource stock as soon as administratively possible after it receives any election by a participant to transfer amounts into or out of this

investment option. Each such purchase or sale will be made at the market price for the stock on the New York Stock Exchange at the time of the purchase or sale.

Section 16 of the Securities Exchange Act of 1934

If you are subject to the short-swing profit provisions of Section 16 of the Securities Exchange Act of 1934 (an "insider"), you may be limited in your ability to purchase and sell NiSource stock under the Plan. Further information covering the operation of Section 16 to insiders will be provided by the Company.

Resale Restrictions

Although the Company has registered the sale of NiSource stock pursuant to the Plan, special restrictions may apply to the resale of the shares distributed to you from the Plan if you are an "affiliate" of the Company at the time of the resale, as such term is used in Rules 144 and 405 of the Securities Act of 1933. An affiliate may not reoffer or resell such shares without further registration under the Securities Act of 1933 unless the reoffer or resale is pursuant to an applicable exemption, such as Rule 144. Generally, only the Company's executive officers would be considered affiliates of the Company. Any person who may be an affiliate may wish to consult with legal counsel before transferring any NiSource stock.

For More Information About Plan Investments

Additional information about the investment options offered by the Plan is available upon request. You may request information regarding each investment option (*e.g.*, annual operating expenses, prospectus documents, financial statements, reports and other materials) by contacting the Fidelity Benefits Service Center at **1-800-305-401k** (4015) or visit the interactive tools on NetBenefits at **www.401k.com**.

Results of Recent Performance of the Investment Options

The Appendix found at the end of this document includes certain information about the relative historical performance of each of the currently available investment funds. Participants are advised that past performance is not necessarily indicative of the future performance of these funds.

Limiting Investment Liability

The Plan is intended to meet the provisions of Section 404(c) under ERISA. This means that Plan fiduciaries (those responsible for administering the Plan) may be relieved of liability for losses resulting from your investment instructions.

As a Plan participant, you may request (and the Plan fiduciary must provide):

- A description of the annual operating expenses of each investment option (*e.g.*, investment management fees, administrative fees and transaction costs) which reduce the rate of return to participants, and the total amount of such expenses expressed as a percentage of the investment option's average net assets.
- Copies of any annual reports, financial statements and reports, and any other materials relating to the investment options available under the Plan, to the extent such information is provided to the Plan.
- A list of the assets in the portfolio of each investment option; the value of each asset (or the proportion of the investment option which it comprises); and the fixed-rate investment contracts, the name of the bank, savings and loan association, or insurance company issuing the contract, the term of the contract and the rate of return of the contract.
- Information concerning the value of shares or units in the available investment options, as well as the past and current investment performance determined, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment options held in your Account.

Available Stock Information

The Company is offering a maximum of 13,492,416 shares and an indeterminate number of participation interests in connection with the NiSource Stock Fund of the Plan. These shares were registered as follows: 12,000,000 shares were registered on the Company's Post-Effective Amendment No. 11 on Form S-8 to Form S-4, filed on November 2, 2000 (Commission File Nos. 333-33896-01 and 333-33896) and 1,492,416 shares were registered on the Company's Form S-8 filed on August 7, 2003 (File No. 333-107748) (individually or collectively, the "Registration Statement").

The Company and the Plan are required to file documents with the SEC pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities and Exchange Act of 1934. All such documents filed by NiSource or the Plan after the effective date of this SPD will be considered incorporated by reference in the Registration Statement and this SPD and Prospectus until the Company or the Plan files a post-effective amendment that states that all NiSource stock offered by the Registration Statement has been sold, or deregisters all NiSource stock that remains unsold. Incorporated by reference into this Prospectus are the following documents and information filed with the SEC:

- NiSource Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2009 (filed February 26, 2010) (File No. 001-161891);
- The Plan's Annual Report on Form 11-K for the year ended December 31, 2008 (filed June 29, 2009) (File No. 001-161891);
- All other reports NiSource Inc. has filed pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 since December 31, 2008 (File No. 001-161891); and
- The description of NiSource Inc. Common Stock set forth under the caption "Description of Capital Stock" contained in NiSource's Amendment No. 1 to Registration Statement on Form S-4, filed on April 24, 2000 (File No. 333-33896-01), together with any amendment or report filed with the Commission for purposes of updating such description.

The Company will provide, without charge to each Plan participant, upon his or her written or oral request: (i) a copy of any of the documents incorporated by reference in the Registration Statement other than exhibits to such documents which are not specifically incorporated by reference into the information that this document incorporates, and (ii) a copy of its Annual Report to Shareholders for its most recent fiscal year. Requests for copies of these documents should be directed to the Plan Administrator as follows:

NiSource Inc.
Attention: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

IN-SERVICE WITHDRAWALS

Access to Your Account While Employed

In general, the Internal Revenue Code contains restrictions on when you can get access to money that has been set aside in your Account in the Plan. These restrictions are imposed because of the tax benefits you receive in conjunction with making contributions to the Plan. The Plan generally does not allow you to withdraw any portion of your Account prior to the time that you terminate employment, retire, become disabled, die, or reach age 59½.

You are, however, permitted to obtain access to your Account or portions of your Account under certain circumstances. If you meet certain requirements, you may make a loan withdrawal from the Plan. In addition, you may be permitted to access your Account in the event of financial hardship. Finally, as explained below you may withdraw any After-Tax Contributions or Rollover Contributions that you have made to the Plan at any time while you are an active employee, and certain Company Contributions.

Any amounts withdrawn will be taken pro-rata from the various investments in which your Account is invested. Note that, like distributions upon termination, in-service withdrawals from your Account can have tax implications. You should consult your own tax advisor concerning any distribution that you receive from the Plan.

Loans

You may apply for a loan from the Plan while you are still an active employee by logging on to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

- When you take a loan from the Plan, you are borrowing from yourself and paying your Account back with interest. If you pay your loan back as agreed, your loan is not subject to income or penalty taxes.
- You may borrow from your Account for any reason.
- You may have up to two loans outstanding at any time from all Company-related retirement savings plans. Note if you pay off one of two outstanding loans, there is a 14-day waiting period before you can apply for a new loan.
- The minimum loan amount is $1,000.
- The maximum loan amount is the lesser of: (1) $50,000 reduced by any outstanding loan balances over the previous 12 months; and (2) 50 percent of your total vested account balance. Loan repayments, plus interest, are automatically deducted from your paycheck through after-tax payroll deductions.
- Loans are taken from your investment options on a pro rata basis.
- The loan term can be from one to five years (15 years if the loan is to purchase your primary residence), as long as you will receive a paycheck in an amount at least as much as the loan repayment each pay period. You may also make a lump-sum repayment of the full amount remaining on your loan balance at any time. However, lump-sum payments of only a partial amount of your outstanding loan will not be accepted.
- The interest rate applied on these loans is the prime rate published in *The Wall Street Journal* on the last day of the previous month.
- You can prepay your loan(s) in full and without penalty at any time.
- If you fail to make any required loan payments, the balance of your loan (and any other charges or expenses incurred because of your default) will be treated as a taxable distribution to you on your default date and will be deducted from your Plan Account. Note that defaulted loans can prevent you from taking additional loans from your Plan Account in the future.

- If your employment with the Company terminates or if you no longer receive compensation from the Company (e.g., you are receiving long-term disability benefits), payments of principal and interest on any outstanding loan may be made through direct debit from your bank account, in accordance with the electronic loan payment procedures established by the Plan Committee. If you do not authorize payments through direct debit from your bank account, your outstanding loan will be considered in default.
- Loans are processed and serviced by Fidelity. A $35 loan origination fee and a $3.75 quarterly fee will be deducted from your 401(k) Account for each loan.
- Typically, you can expect to receive a check within five to eight business days after your loan is approved. Your signature on the back of the check will indicate your approval of the loan terms contained in the accompanying paperwork.

Hardship Withdrawals

You can withdraw up to your entire Account balance (except for earnings on your Elective Deferral Contributions from and after January 1, 1989) for financial hardships as defined by the IRS. *Investment earnings cannot be withdrawn until you reach age 59-1/2 or leave the Company.*

IRS regulations currently define hardship withdrawals as:

- Purchase of your primary residence (but not mortgage payments);
- Tax deductible medical expenses for yourself, your spouse, your dependents or your beneficiary;
- Tuition and related educational fees (including room and board) for up to the next 12 months of post-secondary education for yourself, your spouse, your dependents or your beneficiary;
- Prevention of eviction from, or foreclosure on, your primary residence;
- Funeral expenses for your spouse, your dependents or your beneficiary;
- Expenses for the repair of damage to the Participant's principal residence that would qualify for the casualty deduction under Code Section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income); or
- Any other need as the Committee, or it's delegate, determines to be a hardship expressly specified in Treasury Regulations announced by the Commissioner of the Internal Revenue Services issued under Code Section 401(k).

You will have to provide documentation of the hardship showing an immediate and serious financial need and the amount required to meet the hardship. Your withdrawal cannot be more than the amount required to meet the financial hardship, plus a reasonable estimate of amounts needed to pay federal, state or local income taxes or penalties, up to certain limits. A hardship withdrawal is considered taxable income to you, and if you are not yet age 59½, may also be subject to a 10% penalty tax.

When you take a hardship withdrawal, the IRS and the Plan also impose certain other rules that will affect your Plan participation:

- If you can take a loan from the Plan, you must take a loan up to the maximum amount available prior to applying for a hardship withdrawal—unless repaying the loan in itself would be a hardship.
- If you maintain any investments in the Company Stock Fund, you must elect to receive any dividends attributable to your Account invested in the Company Stock Fund.
- You will need to withdraw any available After-Tax Contributions, Rollover Contributions and Company Matching Contributions, to the extent available, plus the earnings on those contributions first.
- If you take a hardship withdrawal, you will not be allowed to contribute to the Plan for six months. Following the six-month suspension period, you may re-enter the Plan at any time and must call the Fidelity Benefits Service Center at **1-800-305-401k** (4015) to do so.

- You will also need to sign a statement indicating that other financial resources have been exhausted.

Other In-Service Withdrawals

In addition to loans and hardship withdrawals, you may be able to make the following withdrawals from your Account while you are an active employee:

- Withdrawals after age 59½;
- Voluntary withdrawals from the After-Tax Contributions, Rollover Contributions, Company Contributions in your Account; or
- Withdrawals during military service.

You can request a minimum withdrawal of $250 (or your entire balance, if lower). Distributions will be taxed as ordinary income in the year withdrawn and may also be subject to an early withdrawal penalty if taken before age 59½, unless eligible rollover distributions are rolled over to another qualified plan or an IRA. (This excludes any withdrawals of After-Tax Contributions.) A 20% mandatory federal income tax withholding applies to withdrawals that are eligible for rollover that are not directly rolled over to another qualified plan or an IRA.

For more information or to request a withdrawal, log on to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Withdrawals After Age 59½

Once you reach age 59½, you are eligible to make withdrawals from all or a portion of your vested Account balance in the Plan. Your distribution will be processed as soon as administratively practicable following your request for withdrawal.

Voluntary Withdrawals (After-Tax, Rollover, Company Contributions)

If you have made After-Tax and/or Rollover Contributions to the Plan, you may make a full or partial withdrawal of those funds while you are an active employee. Although you are not taxed on the withdrawal of your After-Tax Contributions, you will be taxed on your Rollover Contributions and earnings on both your After-Tax and Rollover Contributions.

Unless the attached applicable Schedule provides otherwise, you may withdraw any portion or all of your Company Contributions from your Account, provided that you have been a Participant in the Plan for at least 60 months. If you have been a Participant in the Plan for less than 60 months, you generally may not withdraw your Company Contributions. (However, if you had Company Contributions made on your behalf prior to July 1, 2009 and on that date you had been a Participant in the Plan between 24 and 60 months, then you may have the ability to withdraw part of your Company Contributions regardless of whether you have completed 60 month of participation. See the Plan Administrator for additional details.) If you are withdrawing Company Contributions, you will be taxed on your withdrawal.

Withdrawals are funded by a pro rata withdrawal from your investment options. Withdrawals from the Company Stock Fund may be made in cash and/or stock at your request. Withdrawals from any other investment option are made in cash.

Withdrawals During Military Service

Effective as of January 1, 2009, you may be eligible to make a withdrawal from your vested Account balance in the Plan if you are performing active service in the uniformed services for a period of more than 30 days. If you qualify for this withdrawal right, you may request withdrawal of all or a portion of your vested Account balance. However, if you elect to receive such a withdrawal, you will not be allowed to contribute to the Plan for six months from the date of withdrawal. To restart your contributions following the six-month suspension period, you must call the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

RECEIVING YOUR PLAN BENEFIT

When Your Benefit is Paid

You or your beneficiaries are entitled to receive the full value of your Account as soon as possible after:

- You terminate employment with the Company;
- You qualify for disability under the Plan; or
- You die.

If your Account balance is $5,000 or less when you terminate employment, the Plan Administrator automatically pays you your Account balance as soon as administratively practicable following your termination. See the following "Forms of Benefit Payment" section for an explanation of how this automatic distribution may be made. Otherwise, if the value of your Account is over $5,000, you can elect to receive the value of your Account, or you may defer payment to a later date. *If you defer payment to a later date, your Account will remain invested in the Plan's investment options. You can change your investment option election at any time under the regular rules of the Plan.*

By law, you must begin to receive payment of your Account balance by the April 1 of the calendar year following the later of either (1) the year you turn age 70½, or (2) the year in which you retire.

Forms of Benefit Payment

Regardless of when you elect to receive your benefit, your Account balance will be distributed to you (or your beneficiary) in one of the following forms:

- *Lump Sum* (Your entire benefit paid directly to you or rolled over to an Individual Retirement Account/Annuity ("IRA") or another employer's retirement plan);
- *Partial Lump Sum* (A portion of your benefit paid directly to you or rolled over, as described above, and the remaining portion of your benefit paid at a later date); or
- *Installments (annual, semi-annual, quarterly or monthly)* (Your benefit paid in regular installments directly to you or in certain instances, as a rollover).

Note that if your Account balance is less than or equal to $5,000 at your termination, you are not eligible to elect installment payments. Instead, the Plan automatically pays your benefit as a lump sum, which you can elect to receive directly or roll over to an IRA or another employer's retirement plan. If you (or your surviving spouse in the event of your death) do not make an election (direct payment vs. rollover), then the Plan will pay your benefit as follows: (1) if your Account balance is $1,000 or less, the Plan Administrator will pay your benefit directly to you as a lump sum payment; (2) if your Account balance is more than $1,000 but less than or equal to $5,000, the Plan Administrator will roll your balance to a designated IRA. See "Rollovers" found later in this Summary for further information on rollovers generally.

Unless you elect otherwise, the balance of your Account invested in the Company Stock Fund will be distributed in installments of not more than five years (unless such balance exceeds a certain limit). You may request that your Account in the Company Stock Fund be paid to you in shares of Company common stock, in cash or in a combination of the two.

DEATH BENEFITS

If you die before your Account balance has been paid to you, the Plan will distribute your Account balance as a death benefit to your surviving spouse or other beneficiary you have named under the rules of the Plan (provided the proper forms have been filed) as described below. No separate death benefit is payable after your Account balance has been distributed from the Plan.

Form and Timing of Death Benefit

Your Account balance will be paid to your surviving spouse or other named beneficiary in one of the following forms:

- Lump Sum (full or partial, but subject to any death benefit timing requirements)
- Installments (annual, semi-annual, quarterly or monthly)

In general, any death benefit payment(s) of your Account can be made as soon as administratively practicable following your death and after filing any required paperwork. If your beneficiary is your surviving spouse, payments must begin by December 31st of the calendar year in which you would have reached age 70½, or, if later, by December 31 of the calendar year immediately following the calendar year of your death. In general, payments to a non-spouse beneficiary must begin by December 31st of the calendar year following the calendar year of your death. If there is no designated beneficiary, the Plan will distribute your Account in accordance with the terms of the Plan to the parties listed in the portion of the "Designation of Beneficiary" section below that applies if you fail to designate a beneficiary.

In addition, your beneficiary may be able to roll over your Account balance to an IRA or another retirement plan. See the "Rollovers" portion of the "Tax Consequences" section later in this Summary for more information.

Designation of Beneficiary

When you enroll in the Plan or make a Rollover Contribution, you should name a beneficiary (someone to receive your benefits from the Plan in the event of your death) by completing a beneficiary designation online through NetBenefits at **www.401k.com**. You may also request a paper beneficiary designation form online or by calling the Fidelity Benefits Service Center at **1-800-305-401k** (4015)

You may designate any person or persons, or a trust fund, as your primary beneficiary to receive death benefits that are payable from the Plan. You may also designate a contingent beneficiary who will receive your benefits in the event your primary beneficiary does not survive you.

If you are married: By law, if you are married, your spouse is automatically your beneficiary unless you designate someone else. If you wish to designate someone else, your spouse must give his or her consent in writing by signing the beneficiary designation form in the presence of a notary public or a Plan representative. The beneficiary designation form provided to you will contain a place for your spouse to sign to consent to your designation of someone else as your primary beneficiary. If you are married and your spouse will not consent to your designation of someone else, then this designation will not be valid and your spouse will be treated as your primary beneficiary. If your marital status changes, it is important that you complete a new beneficiary designation form. See "In the Event of Divorce or Dissolution" (the following section) for an explanation of how a divorce may affect your beneficiary designation under the Plan.

If you are single: If you are single, you may name anyone as your beneficiary.

If you fail to designate a beneficiary, your benefits will be payable as follows:

- To your surviving spouse, or if none;
- To your descendants, per stirpes, or if none;

- To your father and mother, in equal parts, or if none;
- To your brothers and sisters, in equal parts, or if none;
- To your estate.

You may change your beneficiary at any time by making a new beneficiary designation through NetBenefits at **www.401k.com**, or by requesting and submitting a new form. However, if you name someone other than your spouse, your spouse must give his or her consent by signing the beneficiary designation form in the presence of a notary public or a Plan representative.

IN THE EVENT OF DIVORCE OR DISSOLUTION

If you are married and you go through a divorce or dissolution, such proceedings may affect your Plan benefit or your beneficiary designation under the Plan, as explained below. *If your marital status changes, you must inform the Plan Administrator if by contacting the Fidelity Benefits Service Center at* **1-800-305-401k (4015)**.

Beneficiary Designations After Divorce/Dissolution

If you are married and your marriage terminates by reason of divorce, dissolution or other similar operation of domestic relations law, any beneficiary designation you have previously made will remain unchanged. Note that while some state laws may invalidate a spousal beneficiary designation upon divorce, that is not the case under the Plan. Upon divorce, if you had named your former spouse as your beneficiary under the Plan, your beneficiary designation will not change unless you make a new beneficiary designation that revokes your prior beneficiary designation, or you remarry.

If you subsequently re-marry a different spouse, your previous beneficiary designation is *automatically* revoked and your new spouse becomes your beneficiary, unless a valid "qualified domestic relations order" provides otherwise. As explained below, a qualified domestic relations order may limit your ability to name another beneficiary in the event of a divorce or dissolution.

Qualified Domestic Relations Order (QDRO)

By federal law, the Plan must comply with a qualified domestic relations order ("QDRO"). A QDRO is a legal judgment or decree that recognizes the rights of or support obligation toward a spouse, former spouse, child or other dependent. A domestic relations order must satisfy specific requirements to be "qualified," and it must be recognized by the Plan Administrator.

If required by a QDRO, all or a portion of your benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet obligations for the division of marital property rights, for child support or alimony. A QDRO may require that your former spouse be treated as the your surviving spouse for all or any part of the survivor benefits payable after your death. This means that if you re-marry, your subsequent spouse may not be treated as your surviving spouse for the portion of your benefit assigned to your former spouse if a valid QDRO so provides.

You and your beneficiaries may obtain, free of charge, a copy of the procedures used to determine the "qualified" status of a domestic relations order from the Plan Administrator. You or your spouse should submit a draft version of a domestic relations order to the Plan Administrator for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any domestic relations proceedings that may affect your Account, contact the Plan's QDRO administrator as follows: (a) call 1-888-858-5500; (b) send an e-mail to QOCenter@hewitt.com; or(c) visit the website at www.QOCenter.com. When the Plan Administrator receives notice of a pending QDRO, a hold will be placed on your Account that will prevent you from making any withdrawals, including any distributions, loans or hardship withdrawals, until the QDRO is processed.

TAX CONSEQUENCES

How and When Your Plan Benefits Are Taxed

Generally, federal and state income tax laws do not require you to pay tax on your Plan benefits until you actually receive a distribution under the Plan. Once you receive a benefit payment, however, you will have taxable income on this payment in the year your receive it. In the year of any distribution from the Plan, you will receive a tax form that will provide you with the information you need to file your taxes.

The discussion of Federal income tax consequences that follows is included for general information only. It does not describe all relevant tax matters (such as state and local income and inheritance taxes and federal estate and gift taxes) that should be considered in connection with participation in the Plan and does not completely describe all provisions associated with the tax matters discussed. Accordingly, you should not rely exclusively on this discussion and are advised to consult a personal tax adviser for tax planning relevant to the Plan.

Withholding Requirements

Your benefit payments are subject to withholding for deferral taxes. (Note that your benefit payments may be subject to state and local taxes, including tax withholding, as well.) "Withholding" is an advance payment on federal income taxes that you may owe as a result of any Plan distributions that you receive. When making a distribution, the Plan is required by law to withhold 20% of your payment unless you make a direct rollover to an IRA (including to a Roth IRA) or to another retirement plan (see the Rollovers section below).

Contributions

The Plan is a qualified plan under Sections 401(a), 401(k) and 401(m) of the Internal Revenue Code. As a result, the amount of your Compensation that you elect to defer under the Plan through Pre-Tax Contributions, Company Contributions and Rollover Contributions, and any earnings thereon, are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts.

The amount of your Compensation that you elect to defer through Roth Contributions, in contrast, will not be subject to federal income taxes at distribution because these amounts were already taxed at the time they were contributed to the Plan. Earnings on Roth contributions will also not be subject to federal income taxes at distribution provided the distribution is a "qualified distribution." A distribution of Roth Contributions is generally a qualified distribution if it has been in the Plan for five taxable years and is made after the earliest of your attainment of age 59-½, death or disability. If the distribution is not a qualified distribution, then the portion of the distribution representing your Roth Contributions will not be taxable to you, but the portion of the distribution representing earnings on the Roth Contributions will be taxable to you in the year you receive the distribution, unless you comply with the rollover rules as described below.

The amount of your Elective Deferral Contributions (Pre-Tax Contributions and Roth Contributions) will be included in your income in the year in which these amounts are considered earned for purposes of Social Security (FICA) taxes. In addition, some states, cities or counties may impose taxes on your Elective Deferral Contributions.

Although After-Tax Contributions are deducted from your Compensation after all applicable taxes have been withheld, the earnings on such contributions are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts.

Distributions

In addition to being taxed as ordinary income, the taxable portion of a distribution you receive from the Plan before you reach age 59-1/2 may be subject to a nondeductible federal penalty tax of 10%, unless the distribution or withdrawal is (1) rolled over to another eligible retirement plan or to an IRA, (2) made to a beneficiary after your

death, (3) made on account of your termination due to disability, (4) made after separation from service after you attain age 55, (5) made to you for payment of medical expenses that could be deducted on your tax return, (6) paid in equal installments over your life or life expectancy or the lives or life expectancy of you and your beneficiary, or (7) made to an alternate payee pursuant to a qualified domestic relations order.

Note that these rules apply to in-service withdrawals as well as distributions upon termination of employment.

To the extent that you receive shares of Company stock, your tax liability is based on the value of the stock that is contributed to the Plan for the Company Matching Contributions to your Account. This value is taxed at ordinary income tax rates. Tax on any gain is deferred until you actually sell the stock. At that time, any gain is taxed at the capital gains tax rate.

Lump Sum Distributions

If you receive a lump sum distribution and you were born before January 1, 1936, (1) you can make a one-time election to figure the tax on the distribution by using "10-year averaging" at 1986 rates; and (2) you may elect to have the part of your distribution that is attributable to your pre-1974 participation in the Plan (if any) taxed as long-term capital gain at a rate of 20%. You generally can elect this special tax treatment only once in your lifetime and if you have previously rolled over a payment from the Plan, you cannot use this special tax treatment for later payments from the Plan. You should consult your tax advisers as to your eligibility for and the manner of electing this special treatment.

Rollovers

You generally can roll over a distribution or withdrawal of your Account to an eligible retirement plan that accepts rollovers or to an IRA, if the distribution is an "eligible rollover distribution" as defined in the Code. If you roll over a distribution of your Account to an eligible retirement plan or a traditional IRA, the amount rolled over and earnings thereon are not subject to income tax until subsequently distributed to you or your beneficiary. If you roll over your distribution to a Roth IRA, the amount rolled over *is* subject to income tax in the year of the rollover. As stated above, any taxable amount of an eligible rollover distribution that is not rolled over will be subject to a mandatory 20% withholding requirement.

You may roll over an eligible rollover distribution that consists of Roth Contributions and earnings (whether or not it is a qualified Roth distribution) either (1) by direct rollover to another 401(k) Plan or 403(b) Plan that accepts Roth Contributions, or (2) by direct rollover (or indirect rollover within 60 days of distribution) to a Roth IRA. Alternatively, you can roll over the taxable portion of a non-qualified Roth distribution by an indirect rollover within 60 days of distribution to a 401(k) or 403(b) plan that accepts Roth Contributions.

In addition, in the event of your death, your designated beneficiary may roll over a distribution of your Account. If your designated beneficiary is your spouse, he or she may elect to roll your Account over to another eligible retirement plan or an IRA. If you have designated a non-spouse beneficiary, the beneficiary may elect to roll your Account over from the Plan directly to an IRA established for the purpose of receiving the distribution.

A distribution or withdrawal is not an "eligible rollover distribution" and may not be rolled over, if it is (1) a series of substantially equal period installments over ten years or more, or over your life expectancy or the joint life expectancies of you and your beneficiary, (2) a required distribution due to your attainment of age 70-1/2 (or retirement if later), (3) a hardship distribution or (4) a distribution made to a non-spouse beneficiary before May 1, 2007.

A taxable distribution or withdrawal that is not an "eligible rollover distribution" is subject to voluntary Federal income tax withholding. Prior to receiving a distribution of any amounts from the Plan, you will receive a Notice of Tax Treatment to assist you in determining your tax liability. The rules governing the Federal income taxation of a distribution are complex and are subject to change, and you should seek the advice of your tax advisers in connection with a distribution from the Plan.

To make a direct rollover, you must contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015). A Fidelity representative will ask you for specific information on the IRA or the other employer's plan to which you are requesting the rollover and let you know if a rollover is available to you.

SITUATIONS AFFECTING YOUR PLAN BENEFITS

This section describes how the Plan provides you or your beneficiary with benefits. It is important that you understand the conditions under which benefits could be less than expected, not paid at all or otherwise limited, including:

- ***Investment Losses.*** If the investment funds you choose experience losses, the value of your contributions can decrease.
- ***Code Limitations.*** If you are affected by total annual contribution or compensation limits under the Internal Revenue Code, the amounts you and the Company contribute on your behalf may be limited. If you are affected by these limits, you will be notified.
- ***Nondiscrimination Testing.*** If the Plan does not pass required nondiscrimination testing, all or a portion of the contributions made on behalf of highly compensated employees may be reduced. Nondiscrimination testing is required by law to ensure a fair mix of contributions from and for employees at all income levels. If you are affected by these limits, you will be notified.
- ***Application Failures.*** If you fail to make proper application for benefits or fail to provide necessary information, your benefits could be delayed.
- ***Address Changes.*** If you do not keep your most recent address on file and the Plan Administrator cannot locate you, your benefit payment may be delayed. Once you (or your beneficiary, if you die) provide a current address, benefit payments can be made. Accordingly, if you are a current employee and experience a change of address, please give your new contact information to the Company's Human Resource Department. If you have terminated employment with the Company and experience a change of address, please provide your new contact information to the Company's Human Resource Department and provide this same information to the Fidelity Benefits Service Center at **1-800-305-401k** (4015).
- ***"Top Heavy" Limitations.*** As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60 percent of accumulated Account balances are payable to certain "key employees." Key employees are employees who are officers of the Company with annual compensation greater than $160,000, 1 percent owners of the Company with annual compensation greater than $150,000, 5 percent owners of the Company and beneficiaries of the above. You will be notified if this affects you.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

You must file an application with the Plan Administrator in order to receive your benefits under the Plan. When an event occurs that entitles you to a distribution of your benefits under the Plan, the Plan Administrator will generally notify you that an application should be filed. In order to receive your benefit, you must complete and submit a benefit election form no more than 180 days before you are scheduled to receive your benefit.

Claim Denial and Appeal Process

If you disagree with any decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the administrative review procedure you should follow. If benefits you think are owed to you are not paid, or are too low, or are paid at a time other than when you think they should be, you can make a "claim" for benefits to the Plan Administrator.

If the Plan Administrator determines it should deny benefits to you or to your beneficiary, the Plan Administrator will give you or your beneficiary adequate notice in writing setting forth specific reasons for the denial, referring you or your beneficiary to the pertinent provisions of the Plan that support the Plan Administrator's decision and indicating any additional material needed for you to pursue your claim further. Generally, the Plan Administrator renders its decision on your claim within 90 days (180 days if special circumstances apply). If you receive no response within this time limit, you should consider the claim denied.

You or your authorized representative may review all documents related to any denial of a benefit. If you disagree with the Plan Administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Plan Administrator.

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan Administrator are final and binding.

Benefits Paid to Other Parties

The Plan is intended to pay benefits only to you or to your beneficiary. Your Plan benefit cannot be used as collateral for a loan, sold, transferred, garnished, or assigned in any other way. Your Account may generally not be sold, assigned, transferred, pledged or garnished under most circumstances. However, benefits may be divided in a court ordered property settlement in case of divorce or other situations that divide property (see the Qualified Domestic Relations Order" section earlier in this Summary).

If you become incapacitated and unable to manage your own affairs, the Plan may make any unpaid benefit payments to such person or entity that the Plan Administrator deems appropriate to receive distributions in order to provide for your comfort, maintenance and support. For instance, such person (or entity) may be a relative, guardian, person possessing a valid Power of Attorney, or an institution charged with your care or custody.

ADDITIONAL INFORMATION

Amendment or Termination of the Plan

The Committee reserves the right to suspend, amend or terminate the Plan at any time, in whole or in part. Generally, Account balances cannot be reduced except for investment losses, even by a Plan amendment. Termination of the Plan is unlikely, but if the Plan is terminated, your Account automatically will remain 100 percent vested. If any material changes are made to the Plan in the future, you will be notified.

The Committee may only amend the Plan in writing. Any amendments shall be duly authorized if approved or ratified by the Committee. Thus, the Plan may not be modified or amended simply by representations, oral or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or a human resources representative, for instance. If you believe that you have received information that is contrary to the terms of the Plan or this Summary, please contact the Company for clarification or confirmation.

Benefits Are Not Insured

The Plan is a defined contribution plan providing specifically defined levels of contributions. This type of plan is not eligible for benefit insurance through the Pension Benefit Guaranty Corporation ("PBGC"), and no particular dollar level of benefits is guaranteed. All of the contributions are deposited with the Trustee. All payments of Plan benefits are made from the Plan's Trust Fund.

Collective Bargaining Agreements

As stated earlier in this SPD, employees who are covered by a collective bargaining agreement are not eligible for the Plan unless the applicable collective bargaining agreement provides for participation in the Plan. For those employees who are covered by a collective bargaining agreement providing for participation in the Plan, the Plan is maintained pursuant to a collective bargaining agreement.

No Guarantee

The information in this SPD does not state or imply that participation in the Plan is a guarantee of continued employment with the Company, nor is it a guarantee that contribution levels will remain unchanged in future years.

Plan Expenses

Administrative expenses of the Plan, including fees of the Trustee, counsel, accountants or other experts appointed under the Plan, will be paid out of the Trust Fund to the extent not paid by the Company.

Plan Statements

As a Plan Participant, you will receive a statement of your Plan Account quarterly from Fidelity that shows your Account balance as of the end of the most recent quarter. You can elect to receive your statement online. You can view your statement online beginning the day after the end of the quarter and going back for 24 months. Check your statement to be aware of your Account activity. Please contact Fidelity within 60 days of receiving your statement if you think there is an error.

Your Account is valued by Fidelity at the close of every business day. You can call Fidelity Benefits Service Center at **1-800-305-401k** (4015) or log on to your Account at **www.401k.com** seven days a week to review your current Account balance.

ADMINISTRATIVE INFORMATION

Plan Sponsor

The Plan Sponsor is NiSource Inc.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee. The Plan Administrator has the sole authority to interpret the terms of the Plan. For more information about the Plan and its administration, you may contact the Plan Administrator at:

NiSource Inc.
Attention: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

Pursuant to authority granted in the Plan document, the Plan Administrator delegates various administrative functions to other entities or individuals, including Fidelity and the NiSource Human Resources Department. To the extent the context requires, reference to Plan Administrator in this Summary may include or mean one or more of these delegates.

Employer I.D. Number

The Employer Identification Number ("EIN") assigned by the IRS and associated with the Plan is 35-2108964.

Plan Type, Name and Number

The Plan is classified as a defined contribution plan and has been assigned Plan number 005. It also is a Code section 401(k) plan and an ERISA section 404(c) plan. The official Plan name is the NiSource Inc. Retirement Savings Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan Trustee is responsible for holding the assets of the Trust Fund according to the Participants' and the Company's directions, and for distributing Plan payments. The money in the Trust Fund is set aside for the exclusive benefit of Plan Participants and their beneficiaries.

The trustee for the Plan is: Fidelity Management Trust Company
82 Devonshire Street
Boston, MA 02109

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Senior Vice President of Human Resources
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

Legal process may also be served on the Plan Administrator or the Trustee.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain from the Plan Administrator, once a year, a statement of your total benefits accrued and your nonforfeitable (vested) retirement benefits (if any), or the earliest date on which benefits will become nonforfeitable (vested). The Plan may require a written request for this statement, but it must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Domestic Relations Order ("QDRO"), you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

- You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A copy of the Plan document is on file at NiSource's corporate offices, 801 E. 86th Avenue, Merrillville, IN 46410. These documents may be read by you, your beneficiaries or your legal representatives at any reasonable time. Additionally, if you make a written request, you may receive a copy of the Plan document. You may be charged for the copies.

If you have any questions regarding either the Plan or this SPD, you should contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

NISOURCE INC. RSP

Appendix 1

Understanding investment performance: As you review this update, please remember that the performance data stated represents past performance, which does not guarantee future results. Investment return and principal value of an investment will fluctuate; therefore, you may have a gain or loss when you sell your shares. Current performance may be higher or lower than the performance stated. To learn more or to obtain the most recent month-end performance, call Fidelity or visit www.401k.com (log in, choose plan, select Investment Choices & Research, and then pick investment option.).

			Cumulative Total Returns % Period Ending June 30, 2010		Average Annual Total Returns % Quarter Ending June 30, 2010				Calendar Year Returns						
Product Name:	**VRS Code**	**Ticker**	**3 Month**	**YTD**	**1 Year**	**3 Year**	**5 Year**	**10 Year**	**LOF**	**2009**	**2008**	**2007**	**Date of Inception**	**Short-term Trading Fee (% / days)**	**Expense Ratio**	**Exp. Ratio Date**
Fidelity Freedom K® 2010 Fund	02174	FFKCX	-5.03	-2.08	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	07/02/2009	N/A	*0.53*	05/29/2010
Fidelity Freedom K® 2020 Fund	02176	FFKDX	-6.80	-3.52	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	07/02/2009	N/A	*0.57*	05/29/2010
Fidelity Freedom K® 2030 Fund	02178	FFKEX	-8.61	-5.09	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	07/02/2009	N/A	*0.61*	05/29/2010
Fidelity Freedom K® 2040 Fund	02180	FFKFX	-9.82	-6.16	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	07/02/2009	N/A	*0.62*	05/29/2010
Fidelity Freedom K® 2050 Fund	02182	FFKHX	-10.73	-7.07	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	07/02/2009	N/A	*0.63*	05/29/2010
Fidelity Freedom K® Income Fund	02171	FFKAX	-1.22	1.06	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	07/02/2009	N/A	*0.42*	05/29/2010
Fidelity Institutional Money Market Portfolio - I 7-Day Yield* % as of 6/30/2010: 0.25 7-Day Yield* WOR% as of 6/30/2010: 0.24	00059	FMPXX	0.06	0.11	0.32	2.17	3.20	2.89	4.83	0.73	3.05	5.32	07/05/1985	N/A	*0.22*	05/29/2010
Managed Income Portfolio 7-Day Yield* % as of 6/30/2010: 1.28	00632	N/A	0.31	0.60	1.16	2.73	3.26	4.06	5.26	1.65	3.75	4.37	09/07/1989	N/A	*N/A*	N/A
PIMCO Long-Term U.S. Government Fund - Institutional Class	93598	PGOVX	12.12	14.57	17.07	12.34	6.62	8.63	9.62	-2.08	13.60	9.20	07/01/1991	N/A	*0.48*	04/30/2010
PIMCO Low Duration Fund - Institutional Class	93687	PTLDX	0.81	2.74	8.99	6.99	5.32	5.29	6.67	13.36	-1.28	7.92	05/11/1987	N/A	*0.49*	03/31/2010
PIMCO Total Return Fund - Institutional Class	99622	PTTRX	2.75	5.80	13.31	11.12	7.44	7.83	8.51	13.83	4.82	9.07	05/11/1987	N/A	*0.64*	03/31/2010
Vanguard Total Bond Market Index Fund - Institutional Shares	44511	VBTIX	3.62	5.41	9.45	7.69	5.62	6.33	6.29	6.09	5.19	7.05	09/18/1995	N/A	*0.07*	04/27/2010
Vanguard Inflation Protected Securities Fund - Admiral Shares	49268	VAIPX	3.92	4.36	9.64	7.32	4.82	N/A	4.93	10.96	-2.78	11.69	06/10/2005	N/A	*0.12*	04/27/2010
Fidelity Balanced Fund - Class K	02077	FBAKX	-5.63	-1.65	16.11	-4.46	2.71	4.93	8.79	28.29	-31.22	8.99	11/06/1986	N/A	*0.50*	10/30/2009
Fidelity Equity-Income Fund - Class K	02085	FEIKX	-12.25	-6.82	15.64	-12.90	-1.65	1.40	11.21	29.80	-41.57	1.40	05/16/1966	N/A	*0.54*	04/01/2010
MFS® Massachusetts Investors Trust - Class R3 Shares	85064	MITHX	-12.20	-8.15	11.93	-6.69	1.28	N/A	1.56	27.86	-32.70	10.51	04/01/2005	N/A	*0.83*	05/01/2010
Spartan® 500 Index Fund - Investor Class	00650	FUSEX	-11.44	-6.68	14.37	-9.83	-0.84	-1.67	8.58	26.51	-37.03	5.43	02/17/1988	N/A	*0.10*	04/29/2010
Fidelity *Contrafund*® - Class K	02080	FCNKX	-8.08	-4.74	16.56	-5.20	3.12	2.84	11.98	29.43	-37.10	19.78	05/17/1967	N/A	*0.86*	03/01/2010

Fidelity Growth Company Fund - Class K	02090 FGCKX	-11.45	-6.08	17.50	-4.74	3.31	-2.29	12.07	41.45	-40.82	19.89	01/17/1983	N/A	*0.72*	01/29/2010
Fidelity *Magellan*® Fund - Class K	02096 FMGKX	-12.77	-8.34	11.72	-11.03	-2.06	-3.16	16.32	41.39	-49.34	18.83	05/02/1963	N/A	*0.59*	05/29/2010
Spartan® Extended Market Index Fund - Investor Class	00398 FSEMX	-9.84	-1.06	24.19	-7.16	1.79	1.72	4.43	36.65	-38.45	5.38	11/05/1997	*0.75/90*	*0.10*	04/29/2010
Invesco U.S. Small Cap Value Fund - Class Y Shares	93588 MPSCX	-9.31	1.45	24.20	-4.48	5.06	5.78	10.42	30.60	-26.99	0.13	07/01/1986	*2.00/30*	*0.82*	06/01/2010
Northern Small Cap Value Fund	40796 NOSGX	-9.90	-2.28	22.79	-7.75	0.56	6.33	8.49	17.77	-23.43	-8.71	03/31/1994	N/A	*1.38*	09/30/2009
Perkins Small Cap Value Fund - Institutional Class	91771 JSIVX	-6.32	0.05	24.84	1.07	5.75	10.24	12.43	36.91	-21.63	3.21	02/14/1985	N/A	*1.06*	02/16/2010
Columbia Acorn USA Fund - Class Z	93540 AUSAX	-12.13	-6.25	22.76	-8.68	-0.66	6.68	8.81	41.49	-39.22	3.46	09/04/1996	N/A	*1.03*	05/01/2010
American Funds® EuroPacific Growth Fund® - Class R5	46088 RERFX	-11.97	-11.26	9.81	-7.64	5.29	N/A	7.22	39.55	-40.38	19.22	05/15/2002	N/A	*0.56*	06/01/2010
Fidelity Overseas Fund - Class K	02099 FOSKX	-15.14	-15.85	-0.27	-15.69	-0.16	-1.27	9.82	25.52	-47.26	21.82	12/04/1984	*1.00/30*	*0.78*	12/30/2009
Spartan® International Index Fund - Investor Class	00399 FSIIX	-14.75	-14.07	4.73	-13.53	0.81	-0.01	3.17	28.48	-41.43	10.72	11/05/1997	*1.00/90*	*0.20*	04/29/2010
NiSource Stock Fund	20831 N/A	-6.93	-2.96	31.86	-5.37	-5.00	N/A	-0.12	50.68	-38.01	-17.71	11/08/2000	N/A	*0.00*	03/31/2010

Primary Index

Index Name	Cumulative Total Returns % Period Ending June 30, 2010		Average Annual Total Returns % Quarter Ending June 30, 2010				Calendar Year Returns		
	3 Month	YTD	1 Year	3 Year	5 Year	10 Year	2009	2008	2007
BC US Aggregate Bond	3.49	5.33	9.50	7.55	5.54	6.47	5.93	5.24	6.97
S&P 500	-11.43	-6.65	14.43	-9.81	-0.79	-1.59	26.46	-37.00	5.49
CG 3-Month Treasury Bill	0.04	0.05	0.12	1.40	2.63	2.56	0.16	1.80	4.74
IM First Tier Money Mkt	0.02	0.03	0.09	1.82	2.89	2.65	0.34	2.61	5.06
BC US Long Treasury	12.17	13.20	12.02	10.65	6.11	7.99	-12.92	24.03	9.81
BofA ML 1-3 Yr US Treas	1.16	1.87	2.69	4.78	4.24	4.37	0.78	6.61	7.32
BC US TIPS (Ser L)	3.82	4.41	9.52	7.62	4.98	7.46	11.41	-2.35	11.63
Russell 3000 Value	-11.09	-4.83	17.57	-12.13	-1.56	2.74	19.76	-36.25	-1.01
Russell 3000 Growth	-11.55	-7.25	13.95	-6.97	0.44	-4.89	37.01	-38.44	11.40
DJ US Completion TSM	-9.82	-0.97	24.27	-7.26	1.73	1.66	37.43	-39.03	5.39
Russell 2000 Value	-10.60	-1.64	25.07	-9.85	-0.51	7.48	20.58	-28.92	-9.78
Russell 2000	-9.92	-1.95	21.48	-8.60	0.37	3.00	27.17	-33.79	-1.57
MSCI AC Wld ex US (G)	-12.26	-10.80	10.87	-10.28	3.84	2.29	42.14	-45.24	17.12
MSCI EAFE (Net MA)	-13.88	-13.14	6.02	-13.26	1.02	0.42	31.93	-43.28	11.33

FOOTNOTES

Total returns are historical and include change in share value and reinvestment of dividends and capital gains, if any. Cumulative total returns are reported as of the period indicated. Life of Fund figures are reported as of the inception date to the period indicated. These figures do not include the effect of sales charges, if any, as these charges are waived for contributions made through your company's employee benefit plans. If sales charges were included, returns would have been lower.

Spartan® 500 Index Fund: As of January 22, 2010, this fund changed its name from Spartan® U.S. Equity Index Fund - Investor Class.

Invesco U.S. Small Cap Value Fund: As of June 1, 2010, this fund changed its name from Morgan Stanley Institutional Fund Trust: U.S. Small Cap Value Portfolio - Class I Shares.

Fidelity *Contrafund*®, Fidelity *Magellan*® Fund, Fidelity Balanced Fund, Fidelity Equity-Income Fund, Fidelity Growth Company Fund: On May 9, 2008, an initial offering of the retirement (K) class took place. Returns and expenses prior to that date are those of the non-K, non-advisor class. Had K class expenses been reflected in the returns shown, total returns would have been higher.

Spartan® International Index Fund, Fidelity Institutional Money Market Portfolio: Fidelity is temporarily reimbursing a portion of the fund's expenses. Absent such reimbursement, returns would have been lower.

Indices are unmanaged and you cannot invest directly in an index.

Morningstar, Inc., provided data on the non-Fidelity mutual funds. Although the data is gathered from reliable sources, accuracy and completeness cannot be guaranteed by Morningstar.

*The current yield of the money market mutual fund listed above reflects the current earnings of the fund, while the total return refers to a specific past holding period.

With the exception of domestic equity mutual funds, investment options have been assigned to investment categories based on Fidelity's analysis. Fidelity has verified the accuracy of the placement of certain third party non-mutual funds with either the plan sponsor or the plan sponsor's consultant. Within Domestic Equities, mutual funds are listed according to their actual Morningstar categories as of the date indicated. Morningstar categories are based on a fund's style as measured by its underlying portfolio holdings over the past 3 years and may change at any time. These style calculations do not

represent the funds' objectives and do not predict the funds' future styles.

Managed Income Portfolio: This investment option is not a mutual fund.

Company stock investment options are neither mutual funds nor diversified or managed investment options.

Expense Ratio Footnotes

For a mutual fund, the expense ratio is the total annual fund or class operating expenses (before waivers or reimbursements) paid by the fund and stated as a percent of the fund's total net assets. Where the investment option is not a mutual fund, the figure displayed in the expense ratio field is intended to reflect similar information. However, it may have been calculated using methodologies that differ from those used for mutual funds. Mutual fund data has been drawn from the most recent prospectus. For non-mutual fund investment options, the information has been provided by the trustee or plan sponsor. When no ratio is shown for these options it is due to the fact that none was available. Nevertheless, there may be fees and expenses associated with the investment option.

Investment Risk

Foreign investments, especially those in emerging markets, involve greater risk and may offer greater potential returns than U.S. investments. This risk includes political and economic uncertainties of foreign countries, as well as the risk of currency fluctuation.

Investments in mid-sized companies may involve greater risk than those of larger, more well known companies, but may be less volatile than investments in smaller companies.

In general the bond market is volatile and bonds entail interest rate risk (as interest rates rise bond prices usually fall and vice versa). This effect is usually pronounced for longer-term securities. Bonds also entail the risk of issuer default, issuer credit risk and inflation risk.

Target date investments are generally designed for investors expecting to retire around the year indicated in each investment's name. The investments are managed to gradually become more conservative over time. The investment risks of each target date investment change over time as its asset allocation changes. They are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad and may be subject to risks associated with investing in high yield, small cap and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates.

Investments in smaller companies may involve greater risk than those in larger, more well known companies.

An investment in a money market fund is not insured or guaranteed by the FDIC or any other government agency. Although money market funds seek to preserve the value of your investment at $1 per share, it is possible to lose money by investing in these funds.

Index Definitions

BC US Aggregate Bond: The Barclays Capital U.S. Aggregate Bond Index is an unmanaged market value-weighted index for U.S. dollar denominated investment-grade fixed-rate debt issues, including government, corporate, asset-backed, and mortgage-backed securities with maturities of at least one year.

BC US Long Treasury: The Barclays Capital Long-Term Treasury Index is an unmanaged index comprised of fixed-income securities with various maturities greater than 10 years. Unless otherwise noted, index returns reflect the reinvestment of dividends and capital gains, if any, but do not reflect fees, brokerage commissions or other expenses of investing. It is not possible to invest directly in an index.

BC US TIPS (Ser L): The Barclays Capital U.S. TIPS Index is an unmanaged index designed to represent securities that protect against adverse inflation and provide a minimum level of real return. To be included in this index, bonds must have cash flows linked to an inflation index, be sovereign issues denominated in U.S. currency, and have more than one year to maturity, and, as a portion of the index, total a minimum amount outstanding of 100 million U.S. dollars.

BofA ML 1-3 Yr US Treas: The Merrill Lynch 1-3 Year U.S. Treasury Index is an unmanaged market index made up of U.S. Treasury issues with maturities from one to three years

CG 3-Month Treasury Bill: The Citigroup 3-Month Treasury Bill Index is an unmanaged index designed to represent the average of T-bill rates for each of the prior three months, adjusted to a bond-equivalent basis.

DJ US Completion TSM: The Dow Jones U.S. Completion Total Stock Market Index is an unmanaged index that represents all U.S. equity issues with readily available prices, excluding components of the S&P 500.

IM First Tier Money Mkt: The iMoneyNet First Tier Institutional Money Market Funds Average is the average return of money market funds in the iMoneyNet's First Tier Institutional Category. This includes only non-government institutional money market funds that also are not holding any second tier securities. Portfolio holdings of First Tier funds include U.S. Treasury, U.S. Government agency securities, repos, time deposits, domestic bank obligations, foreign bank obligations, first tier commercial paper, floating rate notes, and asset-backed commercial paper. The iMoneyNet First Tier Institutional Money Market Funds Average is not the stated benchmark for the Portfolio and is provided for comparison purposes only. The asset composition of the iMoneyNet First Tier Institutional Money Market Funds Average may differ from that of the Portfolio.

MSCI AC Wld ex US (G): The MSCI All Country World Index ex-U.S. Index is an unmanaged market capitalization-weighted index representing both the developed and the emerging markets excluding the U.S. Excludes securities in which trading is restricted or difficult for foreigners.

MSCI EAFE (Net MA): The Morgan Stanley Capital International Europe, Australasia and Far East (MSCI EAFE) Index (net MA tax) is an unmanaged market capitalization-weighted index of equity securities of companies domiciled in various countries. The index is designed to represent performance of developed stock markets outside the United States and Canada and excludes certain market segments unavailable to U.S. based investors. The index returns for periods after 1/1/1997 are adjusted for tax withholding rates applicable to U.S.-based mutual funds organized as Massachusetts business trusts.

Russell 2000: The Russell 2000® Index is an unmanaged market capitalization-weighted index of 2,000 small company stocks of U.S. domiciled companies.

Russell 2000 Value: The Russell 2000® Value Index is an unmanaged market capitalization-weighted index of value-oriented stocks of U.S. domiciled companies that are included in the Russell 2000 Index. Value-oriented stocks tend to have lower price-to-book ratios and lower forecasted growth values.

Russell 3000 Growth: The Russell 3000 Growth Index is an unmanaged market capitalization-weighted index of growth-oriented stocks of U.S. domiciled companies that are included in the Russell 3000 Index. Growth-oriented stocks tend to have higher price-to-book ratios and higher forecasted growth values.

Russell 3000 Value: The Russell 3000® Value Index is an unmanaged market capitalization-weighted index of value-oriented stocks of U.S. domiciled companies that are included in the Russell 3000 Index. Value-oriented stocks tend to have lower price-to-book ratios and lower forecasted growth values.

S&P 500: The S&P 500® Index is a registered service mark of The McGraw-Hill Companies, Inc., and has been licensed for use by Fidelity Distributors Corporation and its affiliates. It is an unmanaged index of the common stock prices of 500 widely held U.S. stocks that includes the reinvestment of dividends.

Before investing in any mutual fund, please carefully consider the investment objectives, risks, charges and expenses. For this and other information, call or write Fidelity for a free prospectus. Read it carefully before you invest.

Fidelity Brokerage Services LLC, Member NYSE, SIPC, 900 Salem Street, Smithfield, RI 02917
556182.2.0

STOP!

MAKE SURE THAT YOU REFER TO THE CORRECT SCHEDULE!

The following Schedule of Benefits attachments reflect different benefit provisions for different employee groups that participate in the Plan.

ONLY ONE SCHEDULE WILL APPLY TO YOU!

PLEASE REVIEW THE FOLLOWING TABLE OF CONTENTS FOR THE ATTACHED SCHEDULES TO FIND THE SCHEDULE THAT FURTHER DESCRIBES YOUR PLAN BENEFIT PROVISIONS.

IF YOU HAVE QUESTIONS ABOUT WHICH SCHEDULE APPLIES TO YOU, PLEASE CONTACT THE NISOURCE INC. HUMAN RESOURCES DEPARTMENT FOR FURTHER CLARIFICATION.

SPD Schedules for
NiSource Inc. Retirement Savings Plan

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SCHEDULE OF BENEFIT INFORMATION

For Exempt Employees Hired on or after January 1, 2010*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. The Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

You will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer three percent (3%) of your Compensation. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Exempt Employee Employer Contributions

As an Eligible Employee who was hired or rehired on or after January 1, 2010 and classified by the Company as an "exempt employee," you are eligible for the Exempt Employee Employer Contribution. Each pay period, the Company will make an Exempt Employee Employer Contribution in the amount of 3% of Compensation to the account of each exempt employee eligible for this contribution. You will receive this contribution each pay period whether or not you make contributions to the Plan. All Exempt Employee Employer Contributions will be made to the Company Stock Fund. Once the Employer Contributions are in your Account, you may diversify them among any of the investment options available under the Plan. Your eligibility for and receipt of Exempt Employee Employer Contributions shall not affect your eligibility for, and shall be in addition to, the Profit Sharing Contributions described below.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $5,400, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contribution:	**1,800 ($60,000 x 3%)**
Matching Contribution:	**+ 1,800 ($3,600 x 50%)**
Total Annual Contribution:	**$7,200**

*P! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Exempt Employees hired on or after January 1, 2010 who participate in the plan. Other Eligible Employees who participate in the plan should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. Unless your collective bargaining agreement (if applicable) provides otherwise, you will receive this contribution *each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of* the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

SCHEDULE OF BENEFIT INFORMATION

For Participants Under the AB II Benefit

(formerly referred to as the Account Balance 2011 Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. If you were hired or re-hired on or after January 1, 2008, the Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

If you are hired or re-hired on or after January 1, 2008, you will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer three percent (3%) of your Compensation. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **$1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 6% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,200, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 3,600 ($3,600 x 100%)**
Total Annual Contribution:	**$7,200**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. Unless your collective bargaining agreement (if applicable) provides otherwise, you will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

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*STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees (other than Bay State union employees) that participate in the AB II Benefit under the applicable pension plan sponsored by NiSource Inc. or an affiliate. Bay State union employees that participate in the AB II Benefit should refer to the Schedule applicable to their specific division or union group. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants Under the AB II Benefit

(formerly referred to as the Account Balance 2011 Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. If you were hired or re-hired on or after January 1, 2008, the Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

If you were hired or re-hired on or after January 1, 2008, you will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer three percent (3%) of your Compensation. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program).

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **$1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 6% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,200, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 3,600 ($3,600 x 100%)**
Total Annual Contribution:	**$7,200**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the withdrawal right of Company Contributions depending whether or not participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees of Brockton Clerical/Technical, Brockton Operating or Lawrence that participate in the AB II Benefit under the applicable Bay State pension plan. Other Eligible Employees that participate in the AB II Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Participants Under the AB I Benefit
(formerly referred to as the Account Balance Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan generally.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the AB I Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **75¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 4.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,300, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 2,700 ($3,600 x 75%)**
Total Annual Contribution:	**$6,300**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

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*STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees (other than NIFL union or NIPSCO union employees) who participate in the AB I Benefit under the applicable pension plan sponsored by NiSource Inc. or an affiliate. NIFL union and NIPSCO union employees that participate in the AB I Benefit should refer to the Schedule applicable to their specific union group. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For NIFL Union Participants Under the AB I Benefit
(formerly referred to as the Account Balance Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the AB I Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, if applicable, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **75¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 4.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,300, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 2,700 ($3,600 x 75%)**
Total Annual Contribution:	**$6,300**

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to NIFL Union Eligible Employees who participate in the AB I Benefit under the applicable pension plan sponsored by NiSource Inc. Other Eligible Employees that participate in the AB I Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For NIPSCO Union Participants Under the AB I Benefit

(formerly referred to as the Account Balance Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. If you were hired or re-hired on or after June 1, 2009, the Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

If you were hired or re-hired on or after June 1, 2009, you will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer three percent (3%) of your Compensation. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). Compensation also includes any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **75¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 4.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,300, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 2,700 ($3,600 x 75%)**
Total Annual Contribution:	**$6,300**

*P! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to NIPSCO Union Eligible Employees who participate in the AB I Benefit under applicable pension plan sponsored by NiSource Inc. Other Eligible Employees that participate in the AB I Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For NIPSCO Union Participants Under the FAP Benefit
(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

With respect to NIPSCO Union employees, the Plan's automatic enrollment provisions only apply to those employees hired or re-hired on or after June 1, 2009. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions. As stated above, see "How to Enroll" for additional details on participating in the Plan.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage, bonus, commissions, overtime, sick pay and shift differential paid to you by the Company. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). Compensation also includes any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **10¢** for each **90¢** that you contribute as an Elective Deferral Contribution (Pre-Tax or Roth). In other words, the Company makes a Matching Contribution equal to 11.1% of your Elective Deferral Contributions each pay period. Note that the Company does not match any Catch-up Contributions or After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 year and contribute 10% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,666, as follows:

Example of Matching Contributions	
Your Contributions:	**$6,000 ($60,000 x 10%)**
Employer Contributions:	**+ 666 ($6,000 x 11.1%)**
Total Annual Contribution:	**$6,666**

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to NIPSCO Union Eligible Employees who participate in the FAP Benefit un the applicable pension plan sponsored by NiSource Inc. Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you hav questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For NiSource Salaried Participants Under the FAP Benefit

(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage, bonus, commissions, overtime, sick pay and shift differential paid to you by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **10¢** for each **90¢** that you contribute as an Elective Deferral Contribution (Pre-Tax or Roth). In other words, the Company makes a Matching Contribution equal to 11.1% of your Elective Deferral Contributions each pay period. Note that the Company does not match any Catch-up Contributions or After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 10% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,666, as follows:

Example of Matching Contributions	
Your Contributions:	**$6,000 ($60,000 x 10%)**
Employer Contributions:	**+ 666 ($6,000 x 11.1%)**
Total Annual Contribution:	**$6,666**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

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*STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to non-union Eligible Employees of NiSource Inc. or an affiliate (commonly referred to as "NiSource Salaried Employees") who participate in the FAP Benefit under the applicable NiSource pension plan. Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Columbia Energy Group Participants Under the FAP Benefit
(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage and commissions, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, if any applicable collective bargaining agreement provides, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account based on how long you have participated in the Plan as described below.

Participation in the Plan 10 Years or Less
During the first 120 months of your participation in the Plan, the Company makes a Matching Contribution equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account.

Participation in the Plan 10 to 20 Years
From the 121st month through the 240th month of your participation in the Plan, the Company makes a Matching Contribution equal to **75¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 4.5% of Compensation to your Account.

Participation in the Plan 20 or More Years
From the 241st month of your participation in the Plan onward, the Company makes a Matching Contribution equal to **$1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 6% of Compensation to your Account.

Example
Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you have participated in the plan 12 years. (Thus, the Company matches 75% of your contributions up to 6% of Compensation deferred.) Further, assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,300, as follows:

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees of Columbia Energy Group or an affiliate who participate in the FAP Benefit under the applicable NiSource pension plan (i.e., the Retirement Plan of Columbia Energy Group Companies). Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 2,700 ($3,600 x 75%)**
Total Annual Contribution:	**$6,300**

Note that the Company does not match any Catch-up Contributions you may make to the Plan.

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

SCHEDULE OF BENEFIT INFORMATION

For Non-Union NIFL Participants Under the FAP Benefit

(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage, bonus, commissions, overtime, sick pay and shift differential paid to you by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy (if this applies to you).

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 6% of Compensation.** So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $5,400, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 1,800 ($3,600 x 50%)**
Total Annual Contribution:	**$5,400**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to *Non-Union* Eligible Employees of Northern Indiana Fuel and Light Company Inc. ("NIFL") or an affiliate who participate in the FAP Benefit under the applicable NiSource pension plan (*i.e.*, the NiSource Subsidiary Pension Plan). Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Union NIFL Participants Under the FAP Benefit

(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage, bonus, commissions, overtime, sick pay and shift differential paid to you by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy (if this applies to you).

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $5,400, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 1,800 ($3,600 x 50%)**
Total Annual Contribution:	**$5,400**

*TOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to *Union* Eligible Employees of Northern Indiana Fuel and Light Company, Inc. ("NIFL") or an affiliate who participate in the FAP Benefit under the applicable NiSource pension plan (*i.e.*, the NiSource Subsidiary Pension Plan). Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Kokomo Salaried Participants Under the FAP Benefit

(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage, bonus, commissions, overtime, sick pay and shift differential paid to you by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **10¢** for each **90¢** that you contribute as an Elective Deferral Contribution (Pre-Tax or Roth). In other words, the Company makes a Matching Contribution equal to 11.1% of your Elective Deferral Contributions each pay period. Note that the Company does not match any Catch-up Contributions or After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 10% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,666, as follows:

Example of Matching Contributions	
Your Contributions:	**$6,000 ($60,000 x 10%)**
Employer Contributions:	**+ 666 ($6,000 x 11.1%)**
Total Annual Contribution:	**$6,666**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to non-union Eligible Employees of Kokomo Gas and Fuel Company or an affiliate who participate in the FAP Benefit under the applicable NiSource pension plan. Other Eligible Employees that participate in the FAP Benefit should refer to different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Kokomo Union Participants Under the FAP Benefit
(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

With respect to Kokomo Union employees, the Plan's automatic enrollment provisions only apply to those employees hired or re-hired on or after March 1, 2009. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions. As stated above, see "How to Enroll" for additional details on participating in the Plan.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wage, bonus, overtime, sick pay and shift differential paid to you by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy (if this policy applies to you).

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **10¢** for each **90¢** that you contribute as an Elective Deferral Contribution (Pre-Tax or Roth). In other words, the Company makes a Matching Contribution equal to 11.1% of your Elective Deferral Contributions each pay period. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 10% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,666, as follows:

Example of Matching Contributions	
Your Contributions:	**$6,000 ($60,000 x 10%)**
Employer Contributions:	**+ 666 ($6,000 x 11.1%)**
Total Annual Contribution:	**$6,666**

*STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible *Union* Employee of Kokomo Gas and Fuel Company ("Kokomo") or an affiliate who participates in the FAP Benefit under the applicable NiSource pension plan and whose collective bargaining agreement provides for participation in the Plan. Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Salaried Participants Under the FAP Benefit

(formerly referred to as the Final Average Pay Benefit)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid to you by the Company, including any one-time payments in lieu of salary increases for any Plan Year. Your "Compensation" includes your Pre-Tax Contributions to the Plan, your pre-tax contributions toward medical coverage or to a health care or dependent care reimbursement account, and your pre-tax contributions to a qualified transportation fringe benefit program (*e.g.* a pre-tax parking program). In addition, your Compensation for the year in which you terminate employment with the Company will include amounts attributable to "banked" vacation under the NiSource Vacation Policy.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account. Beginning January 1, 2010, the amount of the Company Matching contribution is equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 5% of Compensation.** So, if you contribute 5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 2.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Example: Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $4,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,000 ($60,000 x 5%)**
Employer Contributions:	**+ 1,500 ($3,000 x 50%)**
Total Annual Contribution:	**$4,500**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to non-union Eligible Employees of Bay State Gas Company ("Bay State") or an affiliate who participate in the FAP Benefit under the applicable NiSource pension plan (*i.e.*, the Bay State Gas Company Pension Plan). Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. *Human Resources Department for further clarification.*

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 326 – Lawrence Employees Hired Prior to January 1, 2008*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. Because the Plan's automatic enrollment provisions only apply to certain employees that are hired or re-hired on or after January 1, 2008, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 5% of Compensation**. So, if you contribute 5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 2.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $4,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,000 ($60,000 x 5%)**
Employer Contributions:	**+ 1,500 ($3,000 x 50%)**
Total Annual Contribution:	**$4,500**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

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*STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible Employee who is (a) employed by the **Lawrence Division** of Bay State Gas Company ("Bay State"); (b) a member of the International Brotherhood of Electrical Workers, **Local Union #326**; and (c) **hired prior to January 1, 2008**. Any other Eligible Employee not described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 273-Brockton Operating Employees Hired Prior to January 1, 2008*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. Because the Plan's automatic enrollment provisions only apply to certain employees that are hired or re-hired on or after January 1, 2008, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 5% of Compensation**. So, if you contribute 5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 2.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $4,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,000 ($60,000 x 5%)**
Employer Contributions:	**+ 1,500 ($3,000 x 50%)**
Total Annual Contribution:	**$4,500**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible Employee who is (a) employed as an Operating Employee of the **Brockton Division** of Bay State Gas Company ("Bay State"); (b) a member of the Utility Workers' Union of America, AFL-CIO, **Local Union #273**; and (c) **hired prior to January 1, 2008**. Any other Eligible Employee not described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 273-Brockton Clerical/Technical Hired Prior to January 1, 2008 and Previously Ineligible or Previously Waiving Post-Retiree Medical Benefits*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. Because the Plan's automatic enrollment provisions only apply to certain employees that are hired or re-hired on or after January 1, 2008, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution equal to (a) **$1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 1% of Compensation, plus (b) 50¢ for each $1 you contribute on the next 5% of Compensation.** So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $5,700, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**600 (1% x $60,000 x 100%)**
	+ 1,500 (5% x $60,000 x 50%)
Total Annual Contribution:	**$5,700**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

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* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible Employee who is (a) employed as a Clerical/Technical Employee of the **Brockton Division** of Bay State Gas Company ("Bay State"); (b) a member of the Utility Workers' Union of America, AFL-CIO, **Local Union #273**; (c) **hired prior to January 1, 2008**; and (d) previously ineligible for post-retiree medical coverage (or waived such coverage under procedures established by the Committee) pursuant to the collective bargaining agreement in effect on October 1, 1995 for Brockton Clerical/Technical Employees, and regardless of later eligibility for such coverage. Any other Eligible Employee not described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 273-Brockton Clerical/Technical Hired Prior to January 1, 2008 and Eligible for Post-Retiree Medical Benefits*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. Because the Plan's automatic enrollment provisions only apply to certain employees that are hired or re-hired on or after January 1, 2008, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 5% of Compensation**. So, if you contribute 5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 2.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $4,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,000 ($60,000 x 5%)**
Employer Contributions:	**+ 1,500 ($3,000 x 50%)**
Total Annual Contribution:	**$4,500**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g., plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals*). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible Employee who is (a) employed as a Clerical/Technical Employee of the **Brockton Division** of Bay State Gas Company ("Bay State"); (b) a member of the Utility Workers' Union of America, AFL-CIO, **Local Union #273**; (c) **hired prior to January 1, 2008**; and (d) previously eligible for post-retiree medical coverage (or did not waive such coverage under procedures established by the Committee) pursuant to the collective bargaining agreement in effect on October 1, 1995 for Brockton Clerical/Technical Employees. Any other Eligible Employee described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 12026-- Springfield Employees*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. The Plan's automatic enrollment provisions only apply to certain employees who are hired or re-hired on or after January 1, 2008 and do not apply to any employees of your division. Accordingly, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 5% of Compensation**. So, if you contribute 5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 2.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year, have met the eligibility requirements for a Matching Contribution and contribute 5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $4,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,000 ($60,000 x 5%)**
Employer Contributions:	**+ 1,500 ($3,000 x 50%)**
Total Annual Contribution:	**$4,500**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

*STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible Employee who is employed by the Springfield Division of Bay State (other than Northampton employees and those in the Clerical Technical Unit) and subject to the United Steelworkers of America, AFL-CIO, Local #12026. Any other Eligible Employee not described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 486—Springfield - Northampton*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. The Plan's automatic enrollment provisions only apply to certain employees who are hired or re-hired on or after January 1, 2008 and do not apply to any employees of your division. Accordingly, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 5% of Compensation**. So, if you contribute 5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 2.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $4,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,000 ($60,000 x 5%)**
Employer Contributions:	**+ 1,500 ($3,000 x 50%)**
Total Annual Contribution:	**$4,500**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! *This Schedule applies to any Eligible Employee who is employed by the Springfield Division* (Northampton) of Bay State and subject to the International Brotherhood of Electrical Workers, Local #486. Any other Eligible Employee not described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants: Local 12026—Springfield – Clerical/Technical Unit*

Eligibility, Participation and Automatic Enrollment

You are eligible to participate in the Plan (i.e., make Pre-Tax and After-Tax Contributions) as of the first day of the month after you complete a 60-day period of employment with the Company. See "How to Enroll" for additional details on participating in the Plan. The Plan's automatic enrollment provisions only apply to certain employees who are hired or re-hired on or after January 1, 2008 and do not apply to any employees of your division. Accordingly, you are not subject to the automatic enrollment provisions described earlier in this Summary.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means the straight time wages, exclusive of all daily or weekly overtime, bonuses, supplementary compensation payments, retirement benefits and other forms of non-recurring compensation, but inclusive of shift differentials, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson) and 75% of sales commissions paid (if applicable) while you are a Participant in the Plan during the current period. Compensation shall also include any one-time payments in lieu of salary increases for any Plan Year, if applicable.

Company Matching Contributions

The Company makes a Matching Contribution equal to **(a) $1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 2.5% of Compensation, plus (b) 50¢ for each $1 you contribute on the next 5% of Compensation**. So, if you contribute 7.5% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Example

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume that you make $60,000 a year and contribute 7.5% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,500, as follows:

Example of Matching Contributions	
Your Contributions:	**$4,500 ($60,000 x 7.5%)**
Employer Contributions:	**1,500 (2.5% x $60,000 x 100%)**
	+ 1,500 (5% x $60,000 x 50%)
Total Annual Contribution:	**$7,500**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

In-Service Withdrawals

In general, you have the ability to make in-service withdrawals from your Account as described earlier in the Summary (*e.g.*, plan loans, hardship withdrawals, age 59½ withdrawals, after-tax or rollover contribution withdrawals). However, with respect to the additional withdrawal right of Company Contributions upon participating in the Plan for 60 months, this particular in-service withdrawal right does not apply to your Plan benefit.

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*TOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to any Eligible Employee who is employed by the Springfield Division (Clerical/Technical Unit) of Bay State and subject to the United Steelworkers of America, AFL-CIO, Local #12026. Any other Eligible Employee not described in the foregoing sentence should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

NISOURCE
SHORT-TERM DISABILITY PLAN

As Amended and Restated
Effective as of March 14, 2008

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ARTICLE I

INTRODUCTION

Columbia Energy Group established and maintained the Columbia Energy Group Sick Leave Plan to provide short-term disability benefits for the participants and beneficiaries thereunder. This is an amendment and restatement of that Plan. The Columbia Energy Group Sick Leave Plan has been 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, has been renamed the NiSource Short-Term Disability Plan, effective as of the Plan Effective Date, and as of such date, will be sponsored and maintained by the Company.

ARTICLE II

DEFINITIONS

2.1 **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.

2.2 **Claims Administrator**. "Claims Administrator" means the person, persons or entity appointed by the Plan Administrator pursuant to Section 8.5.

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

2.4 **Committee**. "Committee" means the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

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

2.6 **Disability**. "Disability" means Total Disability or Partial Disability.

2.7 **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.

2.8 **Employer**. "Employer" means the Company and any Related Employer which adopts the Plan with the consent of the Plan Administrator, as set forth on Exhibit A.

2.9 **ERISA**. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.10 **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 Unites 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.

2.11 **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.

2.12 **Partial Disability**. "Partial Disability" means a Participant's mental or physical inability to perform the essential functions of his or her own occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience, on a full-time basis.

2.13 **Participant**. "Participant" means each Employee who is covered under the Plan.

2.14 **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.

2.15 **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.

2.16 **Plan**. "Plan" means the NiSource Short-Term Disability Plan set forth herein, together with any and all amendments and supplements thereto.

2.17 **Plan Administrator**. "Plan Administrator" means the Company. The Company has delegated its Plan administrative responsibilities to the Committee.

2.18 **Plan Effective Date**. "Plan Effective Date" means January 1, 2004.

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 **Total Disability**. "Total Disability" means a Participant's mental or physical inability to perform the essential functions of his or her own occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience.

2.22 **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, Years of Service are calculated on a calendar year basis. For Participants who are rehired, Years of Service will be calculated based on the most recent hire date. A Participant must be Actively at Work at least one day in a calendar year to be credited with an additional Year of Service for that year under the Plan.

2.23 **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

Each regular, Full-time Employee of an Employer will be covered under the Plan on the first day of the month coincident with or next following his or her completion of 6 continuous months of active, Full-time employment with an Employer. A "Full-time Employee" is an Employee characterized by an Employer as a full-time employee who regularly works 40 hours per week. For new hires, such Employee must be Actively at Work on the date coverage is scheduled to begin.

ARTICLE IV

CONTRIBUTIONS TO THE PLAN

4.1 **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.

4.2 **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

5.1 **Amount of Total Disability Benefits**. A Participant shall be entitled to a weekly benefit for the first 26 weeks of Total Disability based on his or her Pay and Years of Service as of the January 1st immediately prior to the date of Total Disability, in accordance with the following schedule:

Years of Service	Weeks of Total Disability benefit paid at 100 percent Pay	Weeks of Total Disability benefit paid at 60 percent Pay
More than 6 months (0.5 years) but less than 1 year from date of hire	1 week	0 weeks
1 year to 9 years	8 weeks	18 weeks
10 years to 19 years	16 weeks	10 weeks
20 years or more	26 weeks	0 weeks

The amount of benefit determined on a weekly basis shall be paid on a basis consistent with the Employer's payroll periods. In no instance will the benefit under the Plan extend beyond the Participant's normal retirement date as defined in any qualified retirement plan sponsored by the Company or an affiliate, or any successor plan, or the date benefits commence under the NiSource Long-Term Disability Plan.

5.2 **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 5.1). 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.

5.3 **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.

(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.

5.4 **Multiple Periods of Disability in Same Plan Year**. If a Participant suffers multiple periods of Disability, for related or unrelated reasons, during the same calendar year, his or her Disability benefits will resume each period based on the total benefits for which he or she is eligible in that calendar year minus the amount he or she received during his or her prior period(s) of Disability paid as part of that year's weeks of Disability benefits shown in the schedule in Section 5.1. If a Participant suffers multiple periods of Disability, for related or unrelated reasons, during two or more calendar years, his or her Disability benefits will be fully renewed, beginning on the date after he or she again becomes Disabled, provided that he or she returned to active, regular, Full-time employment with the Employer for at least one day prior to the subsequent period of Disability during that calendar year.

5.5 **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.

5.6 **Payment of Benefits**. All benefits shall be paid directly to the Participant, or if the Participant is deceased, in accordance with Section 5.8. 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.

5.7 **Duration of Benefit Payments**. This Plan provides benefits for a maximum of 26 weeks during a period of Disability. Subject to Section 5.3, 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) 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.

(f) Fraud. The Participant commits or partakes in any actions of fraud against the Plan, an Employer, or the Committee.

(g) Termination of Employment. The Participant has been terminated or voluntarily terminates employment with the Employer (other than transfer to a Related Employer), or dies.

(h) Termination of Participant. The Participant's participation in the Plan terminates pursuant to Section 10.1.

5.8 **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.

5.9 **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

7.1 **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.

7.2 **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.

7.3 **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.

7.4 **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.

7.5 **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

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

8.2 **The Committee**. The Company has appointed the Committee to administer the Plan in accordance with its provisions. The powers of the Committee are set forth below and in

the Board Resolution that created the Committee, as such Resolution may be modified from time to time.

8.3 **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.

8.4 **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.

8.5 **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

9.1 **Filing Initial Claim**. The entity designated by the Company (the "Claims Administrator") shall process benefit claims pursuant to the procedures set forth below.

9.2 **Consideration of Initial Claim**. The Claims Administrator shall provide notice to a claimant of its decision regarding his or her claim within a reasonable period of time, but generally not later than 45 days after receipt of the claim by the Plan. This 45-day period may be extended for up to 30 days if the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a Disability benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information, if any.

9.3 **If the Claims Administrator Denies the Initial Claim**. If the Claims Administrator denies a claim for a Disability benefit in whole or in part, it shall provide the claimant with a written notice of the denial stating (i) the specific reason or reasons for the denial; (ii) reference to the specific Plan provisions on which the denial is based; (iii) a

description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

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

9.4 **Appeal to the Claims Administrator**. If the Claims Administrator denies a claimant's Disability claim in whole or in part, the claimant has the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of his or her receipt of the claim denial notification.

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

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

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

The Claims Administrator will notify a claimant of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of a claimant's request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination on review.

9.5 **If the Claims Administrator Denies the Claim on Appeal**. If the Claims Administrator denies all or any portion of a claim on appeal, it will notify the claimant in a manner calculated to be understood by the claimant of (i) the specific reason or reasons for the

adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (iv) a statement indicating the claimant's right to file a lawsuit upon completion of the claims procedure process. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

9.6 **Appeal to the Plan Administrator**. If the Claim Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Plan Administrator, by sending a written request for review to the Plan Administrator within 45 days of the claimant's receipt of the Claim Administrator's claim denial notification.

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

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

Upon receipt of a claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the appeal to the Claim Administrator. The review will not afford deference to the Claim Administrator's decision.

The Plan Administrator will notify a claimant of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of a claimant's request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

9.7 **If the Plan Administrator Denies the Claim on Appeal**. If the Plan Administrator denies a claim on appeal, it will notify the claimant in a manner calculated to be understood by the claimant of (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable

access to, and copies of, all documents, records, and other information relevant to the claim; and (iv) a statement indicating the claimant's right to file a lawsuit upon completion of the claims procedure process. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

9.8 **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.

9.9 **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

10.1 **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;

(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.

10.2 **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

11.1 **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.

11.2 **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.

11.3 **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.

11.4 **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.

11.5 **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.

11.6 **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.

11.7 **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.

11.8 **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.

11.9 **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**. 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.

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 Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking proper corporate action to adopt the Plan and making such contributions to the cost of coverage as the Company may require.

(b) The Plan will terminate with respect to any Related Employer that has adopted the Plan pursuant to this Section if the Related Employer ceases to be an 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 Company 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

12.1 **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.

12.2 **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.

12.3 **Amendment**. The Company, through resolution of 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 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.

12.4 **Termination**. Although the Company has established the Plan with the bona fide intention and expectation that it will be permanent, 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. The Company may, through resolution of the Committee, in its sole and absolute discretion, discontinue contributions to or terminate the Plan at any time without liability for such discontinuance or termination.

12.5 **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.

IN WITNESS WHEREOF, the Company has caused this amended and restated Plan, to be executed on its behalf, by its officer duly authorized, this ____ day of _____, 2003.

NISOURCE INC.

By: _____

EXHIBIT A

ADOPTING RELATED EMPLOYERS

NiSource Corporate Services Company

NiSource Development Company, Inc.

NiSource Energy Technologies, Inc.

Northern Indiana Public Service Company (salaried employees only)

Kokomo Gas and Fuel Company (salaried employees only)

Northern Indiana Fuel and Light Company, Inc.

Bay State Gas Company (salaried employees only)

Northern Utilities, Inc. (salaried employees only)

Granite State Gas Transmission, Inc. (salaried employees only)

Columbia Energy Group

Columbia Gas of Kentucky, Inc.

Columbia Gas of Maryland, Inc.

Columbia Gas of Ohio, Inc.

Columbia Gas of Pennsylvania, Inc.

Columbia Gas of Virginia, Inc.

Columbia Gas Transmission Corporation

Columbia Gulf Transmission Company

NiSource Retail Services, Inc.

Northern Indiana Trading Company, Inc.

NI Energy Services, Inc.

EnergyUSA-TPC Corp.

CH2\ 1061842.3

NiSource

POLICY SUBJECT: **Holidays**

EFFECTIVE DATE: **January 1, 2004**

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.

Floating Holidays

Five floating holidays will be granted. Each NiSource subsidiary can assign one or more of the floating holidays to specific days.

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 December 1, granted 1 floating holiday

Provision for Part Time Employees

Part time employees will be paid six hours for any fixed holiday that falls on their regularly scheduled workday. Part time employees are not eligible to receive floating holidays.

Temporary Employees

Temporary employees are not eligible to receive holidays or floating holidays.

NiSource

POLICY SUBJECT: Vacation

EFFECTIVE DATE: January 1, 2004

REVISED: January 1, 2012

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.

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. In order to receive the annual grant, employees must return to work at least one day in the new year. 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.

New Employees

Non-exempt - New employees will be granted 80 hours of vacation on their one-year service anniversary. After 6 months of service, an employee may "borrow" up to 40 of those hours with management approval. Any borrowed hours will be subtracted from the 80 hours granted at the one-year anniversary.

Exempt – New employees will be granted 120 hours of vacation on their one-year service anniversary. After 6 months of service, an employee may "borrow" up to 40 of those hours with management approval. Any borrowed hours will be subtracted from the 120 hours granted at the one-year anniversary.

Employees with less than one year of service who resign or are terminated for cause and have "borrowed" vacation time will be required to reimburse the company for the time taken. By "borrowing" the time, the employee has authorized that the time will be deducted from the final paycheck, in accordance with the law. However, the company reserves the right to obtain reimbursement through other legal channels, if deemed necessary.

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. 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 (or after using a portion of such 80 hours and forfeiting the remainder), 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, or has used a portion of such 80 hours and forfeited the remainder) to the following year.
6. Any employee election referred to in this policy 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 (or after using a portion of such 80 hours and forfeiting the remainder), 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, or has used a portion of such 80 hours and forfeited the remainder), 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 lifetime banking limit. 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 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.

Under the provisions of the federal Family and Medical Leave Act, qualified employees can "unbank" 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

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.

Vacation Paid at Separation

Unused and banked vacation will be paid to employees at separation.

Accrued but not yet earned vacation will be paid to employees at the beginning of long-term disability or 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 – Non-Exempt and 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 – Non-Exempt and Exempt Employees hired or rehired on or after January 1, 2004*

All employees hired or rehired on or after 01/01/04 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 on or after January 1, 2000.
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

All exempt employees hired or rehired on or after 01/01/10 will be covered by the following vacation schedule:

Full Years of Service at 12/31/XX	Vacation Hours Granted the Following Vacation Year
1	120
4	160

Exempt employees hired or rehired on or after January 1, 2010 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 who transfer to an Exempt position will be granted additional vacation hours (if applicable) January 1 of the following year.

Vacation Schedule – Part-Time 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. However, their annual vacation grant will be pro-rated based on the number of hours worked in the previous year. Part-time employees cannot borrow vacation.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-25:

Please provide a description of the Company's merit and cost of living wage rate increase policies.

Response:

Merit (performance adjustment) increases are provided on an annual basis to exempt and non-exempt non-union employees. The increases are normally to base pay. The performance adjustment program is administered through a Lotus Notes-based application that leaders use to recommend performance adjustments and incentives for employees.

The performance adjustment percentage for 2012 was 3 % for all exempt employees and 2.5 % for non-exempt, non-union, non-manual employees. Leaders are provided a specific pool of dollars for this adjustment. If the leader increases the performance adjustment of one employee, they have to decrease the performance adjustment for another or others so that the total increase recommended does not exceed the allotted pool of dollars.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-26:

Please provide the following monthly labor data for the year prior to the HTY, the HTY and the FTY through the most recent date available.

a. number of actual employees broken down between type (e.g., salaried, union, non-union, temporary, etc.);

b. regular payroll broken down between expensed, capitalized and other;

b. overtime payroll broken down between expensed, capitalized and other;

c. temporary payroll broken down between expensed, capitalized and other; and

e. other payroll (specify).

Response:

a.

Description	Pre-HTY 12 Months Ended 5/11	HTY 12 Months Ended 5/12	FTY 12 Months Ended 5/13	FFRY 12 Months Ended 6/14
Total Clerical Labor	48	53	54	54
Total Exempt Labor	74	79	108	108
Total Manual - Non-Union	11	11	11	11
Total Manual - Union	371	367	392	392
	504	510	565	565

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

b., c., d., and e.

Description	Pre-HTY 12 Months Ended 5/11	HTY 12 Months Ended 5/12	FTY 12 Months Ended 5/13	FFRY 12 Months Ended 6/14
Regular Payroll Expense	19,757,119	19,247,962	23,693,163	24,227480
Overtime Payroll Expense	2,256,507	2,253,421	2,525,969	2,581,527
Premium Payroll Expense	315,757	231,024	253,382	253,382
Net Affiliate Labor Transferred Expense	821,061	699,283	782,289	797,297
Subtotal Expense	23,150,445	22,431,690	27,254,804	27,860,316
Regular Payroll Capitalized	9,414,119	12,024,214	12,855,588	13,144,380
Overtime Payroll Capitalized	1,075,209	1,407,713	1,215,895	1,242,681
Premium Payroll Capitalized	150,456	144,321	121,963	121,963
Net Affiliate Labor Transferred Capitalized	391,230	436,843	782,289	384,099
Subtotal Capitalization	11,031,013	14,013,091	14,570,006	14,893,123
Total Labor Expense and Capitalization	34,181,458	36,444,781	41,824,810	42,753,439
Incentive Compensation & Other Expense	2,277,425	1,771,129	1,449,453	1,489,630
Incentive Compensation & Other Capitalized	1,085,176	1,656,307	1,553,828	1,567,385
Total Incentive Compensation	3,362,601	3,427,436	3,003,281	3,057,015

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-27:

Please provide a copy of all incentive compensation and/or bonus plans and provide the level of related payments included in cost of service.

Response:

See Exhibit No. 4, Schedule No. 2, Page 6 and Exhibit No. 104, Schedule No. 2 Pgs. 5 through 9.

Question No. GAS-RR-028
Respondent: J. T. Gore

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-28:

Please provide the percentage wage rate increases granted by the Company by date and employee category for the three most recent calendar years and the current year to date.

Response:

	2009	2010	2011	2012
Exempt	1-Mar 3.00%*	1-Jun 3.50%	1-Jun 3.25%	1-Jun 3.00%
Non-Union, Non-Exempt	1-Mar	1-Jun	1-Jun	1-Jun
	3.00%	3.50%	3.00%	2.50%
United Steelworkers of America	15-Sep	15-Sep	15-Sep	15-Sep
Local 7139-03	3.50%	3.00%	2.00%	2.00%
United Steelworkers of America	15-Sep	15-Sep	15-Sep	15-Sep
Local 13836-14	3.50%	3.00%	2.00%	2.00%
Utility Workers Union of America	30-Sep	30-Sep	30-Sep	30-Sep
Local 475	3.50%	3.00%	2.00%	2.00%
Utility Workers Union of America	1-Nov	1-Nov	1-Nov	1-Nov
Local 479	3.50%	3.00%	2.00%	2.00%
United Steelworkers of America	1-Apr	1-Apr	1-Apr	1-Apr
Local 1852-17	3.00%	3.50%	2.00%	2.00%

* Only exempt employees who were considered to be a field supervisor received an increase of 3% on 3/1/09. This amounts to about 50% of the exempt employees. The remainder of the exempt employees received a one-time, lump sum payment of 2% of their base salary on 9/1/09.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-29:

Please provide an analysis (description, dates and amounts) of any gains or losses on utility property sold for the lesser of the last three years or since the Company's last rate case or anticipated during the FTY. Explain how such amounts have been treated for ratemaking purposes.

Response:

The Company has not sold any utility property since the Company's last rate case and does not anticipate selling any utility property during the FTY.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-30:

Please provide the level of each of the following which is included in the Company's cost of service by separate type and/or payee, which are incurred directly by the Company or are allocated or billed to the Company by affiliates or its parent company.

a. fines and penalties

b. contributions and donations

c. membership dues

d. lobbying expense

e. employee activity costs (e.g., picnics, parties, awards)

f. investor relations expenses

Response:

a. All fines and penalties are booked below the line in account 426-3000.

b. There is $9,161 in charitable organizations and $8,751 in civic contributions included in account 921 Office Supplies and Expenses. While the charitable contributions are recorded in account 921, they have been eliminated from the cost of service claim on Exhibit No. 4, Schedule No. 1, Line 24. There is $483,150 in various charitable organizations booked below the line in account 426. See Exhibit No. 4, Schedule 15, for a listing of the various payees.

c. See Attachment GAS-RR-30, Attachment A.

d. There is $133,494 in lobbying expenses included in operating costs for the fully forecasted rate year (twelve months ended June 30, 2014). This was removed from the cost of service by a ratemaking adjustment on Exhibit No. 104, Schedule No. 1, Page 2 of 2, Line 22.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

e. Columbia Gas of Pennsylvania has discontinued its sponsorship of all athletic associations and employee social clubs. There was $10,340 spent on employee recognition awards.

f. NiSource Corporate Services Company (NCSC) billed Columbia Gas of Pennsylvania $45,705 during the test year for Investor Relations expenses.

Columbia Gas of Pennsylvania, Inc.
Memberships Dues
Booked to Various O&M Accounts
Twelve Months Ended May 31, 2012

Line No.	Description	Amount $
	CIVIC CONTRIBUTIONS	
1	Pittsburgh Region Clean Cities - 2011 Membership Dues	500
2	Central Pennsylvania Convention & Visitors Bureau - 2011 Membership Dues	271
3	Pennsylvania Society - 2011 Entrance Fee & Dues - Mark Kempic	250
4	Pennsylvania Society - 2011 Entrance Fee & Dues - Peter Trufahnestock	250
5	Pennsylvania Society - 2012 Membership Dues - Peter Trufahnestock	50
6	Pennsylvania Society - 2012 Membership Dues - Carol Fox	50
7	Hanover Area Chamber of Commerce - 2012 Membership Dues	1,032
8	Pennsylvania State Association of Boroughs - 2012 Membership Dues	200
9	Beaver County Chamber of Commerce - 2012 Membership Dues	370
10	Warren County Chamber of Business & Industry - 2012 Membership Dues	1,000
11	Southpointe CEO Association - 2012 Membership Dues	2,000
12	Somerset County Economic Development Council - 2012 Membership Dues	1,000
13	Lawrence County Chamber of Commerce - 2012 Membership Dues	425
14	Redbank Valley Chamber of Commerce - 2012 Membership Dues	150
15	Washington County Chamber of Commerce - 2012 Membership Dues	354
16	Beaver County Economic Development - 2012 Membership Dues	200
17	The Chamber Pittsburgh Airport - 2012 Membership Dues	649
18	Total Civic Associations	8,751
	INDUSTRIAL ASSOCIATIONS	
19	American Gas Association - 3rd Quarter Dues 2011	40,573
20	AGA - Sponsorship NARUC Convention	417
21	American Gas Association - 4th Quarter Dues 2011	40,572
22	Association for Iron & Steel Technology - 2010 Membership Dues	100
23	Energy Association of Pennsylvania - 2012 Membership Dues	82,739
24	Pennsylvania Chamber of Business and Industry	18,324
25	American Gas Association - 1st Quarter Dues 2012	34,458
26	SGA Transmission Membership	4,327
27	American Public Works Association - York County Branch Membership Dues	60
28	Common Ground Alliance - 2010 Bronze Sponsorship	1,618
29	American Gas Association - 2nd Quarter Dues 2012	34,458
30	Total Industrial Assocations	257,646
31	Total Membership Dues	266,397

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-31:

Please provide a description and the purpose for membership for each organization listed in the previous response.

Response:

These business and service associations comprise a widely varied group that all contribute either toward helping Columbia personnel perform their jobs more efficiently or to improving the service territories where Columbia facilities are located.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-32:

Please provide the level of payments made to industry organizations included in cost of service along with a description of each payee organization or project.

Response: Please see GAS-RR-032 Attachment A.

Columbia Gas of Pennsylvania, Inc.
Company Memberships - Industrial and Civic Associations
Twelve Months Ended May 31, 2012

Line No.	Description			Amount $
	INDUSTRIAL ASSOCIATIONS			
1	American Gas Association - 3rd Quarter Dues 2011			40,573
2	AGA - Sponsorship NARUC Convention			417
3	American Gas Association - 4th Quarter Dues 2011			40,572
4	Association for Iron & Steel Technology - 2010 Membership Dues			100
5	Energy Association of Pennsylvania - 2012 Membership Dues			82,739
6	Pennsylvania Chamber of Business and Industry			18,324
7	American Gas Association - 1st Quarter Dues 2012			34,458
8	SGA Transmission Membership			4,327
9	American Public Works Association - York County Branch Membership Dues			60
10	Common Ground Alliance - 2010 Bronze Sponsorship			1,618
11	American Gas Association - 2nd Quarter Dues 2012			34,458
12	Total Industrial Organizations			257,646
13	Civic Associations			8,751
14	Company Memberships Per Books			266,397
15	American Gas Association Dues - Per Books	150,061		
16	Annualization of American Gas Associations Dues	137,832	1_/	
17	Adjustment to American Gas Associations Dues	(12,229)		(12,229)
18	Adjusted Company Memberships - See Exhibit No. 4, Schedule 1, Page 2, Line 12			254,168
19	Inflation Adjustment 1.85% - FTY Twelve Months Ended May 31, 2013			4,702
20	Adjusted Company Memberships - See Exhibit No. 104, Schedule 1, Page 2, Line 12			258,870
21	Inflation Adjustment 1.56% - FFRY Twelve Months Ended June 30, 2014			4,038
22	Adjusted Company Memberships - See Exhibit No. 104, Schedule 1, Page 2, Line 12			262,908

1_/ Lobbying Expenses make up 5% of AGA Dues. ($137,832 x 5% = $ 6,892) This amount was included in the adjustment for Lobbying expenses on Exhibit No. 4, Schedule No. 1, Page 2 of 2, Line 22.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-33:

Please provide the following information related to the Company's membership in AGA:

a. Cost included in requested cost of service

b. Cost excluded from requested cost of service

c. Copy of the most recent audit report of AGA expenditures prepared by NARUC.

d. Most recent correspondence received from AGA which addresses the percentage of dues related to lobbying or other separate activities.

e. Policy statement, objective, purpose, etc. of AGA.

Response:

a. AGA costs included in the requested cost of service are $130,940.

b. $6,892 of AGA costs related to lobbying was excluded from the total annual $137,832 AGA dues. This exclusion represents 5.0% of the total dues.

c. NARUC has not audited AGA expenditures for a number of years.

d. Please see GAS-RR-033 Attachment B.

e. The AGA is an advocate for natural gas utility companies providing a range of programs and services for member natural gas companies and industry associates. The AGA serves as the voice and facilitator promoting the safe, reliable and cost effective delivery of natural gas to residential and business customers served by its members. The AGA advocates the interests of its members and their customers and provides information and services promoting efficient demand and supply growth and operational excellence, in the safe, reliable and efficient delivery of natural gas. AGA focuses on the advocacy of natural gas issues that are priorities for the membership and that

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

are achievable in a cost-effective way. The AGA assists members in managing and responding to customer energy needs, regulatory trends, natural gas markets, capital markets and emerging technologies. In addition the AGA collects, analyzes and disseminates information on a timely basis to opinion leaders, policy makers and the public about the benefits provided by energy utilities and the natural gas industry. For the information above and additional details on policy planning and regulatory affairs, please see www.aga.org.

"Public Affairs" provides information about many pertinent items such as: distribution pipeline safety requirements and system compliance, environmental matters, natural gas prices and supply. Many other helpful topics can be found at the website noted above.

The Company believes the AGA provides many useful services and much information, including that noted above, that ultimately is beneficial to the Company's customers. The Company and its customers benefit from the many things that AGA provides that keep members current on a myriad of industry issues, from environmental matters, to pipeline safety issues, to supply availability. For any one company to stay abreast of so many far-ranging topics would be difficult and costly; for AGA to provide members such information and service is extremely cost-effective and efficient. It is for these reasons that the Company believes this portion of the AGA dues should not be excluded from test year expense.

Please see GAS-RR-033 Attachment A for "Definitions of Functional Cost Centers" as provided by the AGA for the year ending December 31, 2008.

AMERICAN GAS ASSOCIATION

Definitions of Functional Cost Centers
For the Year Ended December 31, 2008

Advertisement manages the development and placement of advertisements in national print and electronic media.

Corporate Affairs provides opportunities for interaction between member companies and the financial community. The focus is to promote interest in the investment opportunities in the industry.

General and Administrative includes:

1. Office of the President provides senior management guidance for all AGA activities.
2. Human Resources develops and administers employee programs and provides office and personnel services.
3. Finance and Administration develops and administers financial accounting and treasury services and maintains computer services capability.

General Counsel provides legal counsel to the Association.

Industry Finance and Administration develops and implements programs in such areas as accounting, human resources, and risk management for member companies.

Policy, Planning, and Regulatory Affairs includes:

1. Policy & Analysis identifies the need for and conducts energy analyses and modeling efforts in the areas of gas supply and demand, economics, and the environment.
2. Regulatory Affairs provides members with information on FERC and state regulatory developments; prepares testimony, comments, and filings regarding regulatory activities.

Public Affairs provides members with information on legislative development; prepares testimony, comments, and filings regarding legislative activities, lobbies on behalf of the industry. It also includes Communications, which develops informational material for member companies and consumers and coordinates all media activity.

This document has not been updated since December 31, 2008.

AMERICAN GAS ASSOCIATION
2012 Budget

	2012 Allocation Dollars $	2012 Allocation Percentage %
Communications	2,957,000	10.38%
Corporate Affairs	2,394,000	8.41%
Drive Natural Gas Initiative	900,000	3.16%
General & Administrative	5,643,000	19.81%
General Counsel	1,215,000	4.27%
Government Relations	3,982,000	13.98%
Industry Finance & Administrative Programs	1,060,000	3.72%
Operations & Engineering	5,862,000	20.58%
Policy Analysis	1,749,000	6.14%
Regulatory Affairs	2,717,000	9.54%
Total Expense Budget	28,479,000	100.00%

Note: AGA estimates that lobbying expenses, as define under IRC Section 162, will account for 5% of member dues in 2012.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-34:

Please provide a copy of the most recent FERC audit findings, the Company's response and final disposition of audit exceptions.

Response:

NiSource Inc. (NiSource), including its service company, underwent a FERC audit, Docket No. FA11-5-000, that covered the period January 1, 2009 through December 31, 2010. A DRAFT Audit Report dated August 6, 2012 was sent to NiSource and NiSource sent its Response to the DRAFT Audit Report on August 21, 2012. When the Final Audit Report is issued by the FERC audit staff and reviewed by NiSource, a copy will be provided to the Commission.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-35:

Please provide the annual level of forfeited discounts or late payment charges for the preceding three calendar years. Identify the level of sales revenue with which these are associated.

Response:

Year	Forfeited Discounts $	Revenue $
2009	1,603,924	526,934,826
2010	1,020,698	491,431,759
2011	1,181,506	473,993,713

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-36:

If not reflected in the lead-lag study, please provide a listing of the various types of employee withholdings, garnishments and other employee funds held by the Company for remittance at a later date.

Response:

As noted in response to 53.53 III, 15, Columbia is not making a claim for cash working capital and no lead lag study is included in the filing. The following is a list of miscellaneous employee withholdings and the amount held by the company as of May 31, 2012.

	Balance @ 05/31/2012 $
Charitable Donations primarily United Way	5,455
Union dues	20,174
Garnishments	16,004
NiSource Inc. Political Action Contribution	1,258
Total	42,891

Question No. GAS-RR-037
Respondent: N. J. D. Krajovic
J. T. Gore

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. GAS-RR-037:

Please provide all detailed work papers supporting the adjustments to rate base and operating income.

Response:

Supporting schedules to rate base have been provided in Exhibits No. 8 and No. 108 and supporting schedules to operating income have been provided in Exhibits No. 2 and No. 102. Work papers supporting these exhibits and schedules are detailed and very large and therefore will be made available upon request.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-38:

Please provide a copy of the Company's most recent SFAS 106 plan actuarial study.

Response:

The actuarial study is included as Exhibit No. 4, Schedule 7.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-39:

Please reconcile the historical and future test year SFAS No. 106 expense levels with the amount identified in the actuarial report.

Response:

A. There is a $1,469,171 difference between the gross test year expense recorded on the books and the test year expense identified on the actuarial report as noted below.

SFAS 106 Historical Test Year Expense

Per Books	$1,531,112	
Per Actuarial Report	$61,940	*Attachment A*
Difference	$1,469,171	

This difference is attributable to:

(1) The amortization of the Transition Obligation	$1,541,956
(2) Med D Subsidy for Settled Retirees	$ (72,785)
Total difference from Actuarial Report	**$ 1,469,171**

(1) The transition obligation was established with the adoption of SFAS 106, and it is being amortized over 18 years and 5 months (7/1994 – 12/2012).

(2) The Company receives funds in the form of a Med D Subsidy from the federal government for retirees whose postretirement benefit obligation were transferred to a third-party insurance provider in a prior period, also referred to as settled retirees. Since the purchased insurance was formally paid for using trust funds, it was determined that the Company has a right to retain the funds. The amount received is contributed to the trust to pay for future medical benefits for those

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

individuals not included in this group of settled retirees as the calculation of the Company's OPEB liability does not take settled retirees into consideration.

B. Please refer to the table below for future test year and fully forecasted rate year SFAS 106 expense identified on the actuarial report within Attachment B.

SFAS 106 Expense	Future Test Year		Fully Forecasted Rate Year	
OPEB Medical Expense Accrual	$ (240,000)	Column 5, Row 28	$ (280,000)	Column 7, Row 28
OPEB Life Expense Accrual	$ 56,000	Column 5, Row 32	$ 29,000	Column 7, Row 32
Total Company Expense Level	$ (184,000)		$ (251,000)	

COLUMBIA GAS OF PENNSYLVANIA, INC.
Standard Data Request - Revenue Requirement
SDR 39 Attachment A

Historic Test Year SFAS #106 Expenses

OPEB Medical Expense Accrual	$	(78,131)
OPEB Life Expense Accrual	$	67,287
Transitional Obligation Amortization	$	1,541,956
Total CPA Expense level	$	1,531,112

Historic Test Year Allocated Actuarial Expense from NiSource & Columbia Plans

2011-2012 Actuarial report	Medical	Life	
Service Cost	$ 597,287	$ 131,413	∑A
Interest Cost on APBO	$ 1,393,845	$ 188,113	∑B
Return on Assets	$ (2,065,021)	$ (320,397)	∑C
Transition Obligation	$ -	$ (5)	∑D
Prior Service Cost	$ 68,509	$ (9,805)	∑E
Actuarial (Gain) Loss	$ 40	$ 77,978	∑F
Rounding	$ (7)	$ (8)	
Total Actuarial Expense allocation	$ (5,347)	$ 67,287	∑G

Historic Test Year Allocation Detail

CPA's allocated portion of Retiree Medical plans (reference pg 2 of 5)

2012 Actuarial report (5 mos)	Nisource YTD	Test Year	CPA's Allocation		
Service Cost	$ 5,779,077	$ 2,407,949	0.01%	$ 236	A
Interest Cost on APBO	$ 17,242,539	$ 7,184,391	0.00%	$ 65	B
Return on Assets	$ (380,178)	$ (158,408)	0.00%	$ -	C
Transition Obligation	$ -	$ -	0.00%	$ -	D
Prior Service Cost	$ (1,479,905)	$ (616,627)	0.00%	$ -	E
Actuarial (Gain) Loss	$ 6,828,967	$ 2,845,403	0.00%	$ 25	F
Total	$ 27,990,500	$ 11,662,708		$ 327	G
2012 Actuarial report (5 mos)	Columbia YTD	Test Year	CPA's Allocation		
Service Cost	$ 3,893,588	$ 1,622,328	15.43%	$ 250,350	A
Interest Cost on APBO	$ 12,964,774	$ 5,401,989	10.44%	$ 563,988	B
Return on Assets	$ (19,587,210)	$ (8,161,338)	10.32%	$ (842,005)	C
Transition Obligation	$ -	$ -	0.00%	$ -	D
Prior Service Cost	$ 686,664	$ 286,110	6.33%	$ 18,103	E
Actuarial (Gain) Loss	$ -	$ -	0.00%	$ -	F
Total	$ (2,042,184)	$ (850,910)		$ (9,565)	G

CPA's allocated portion of Retiree Life Insurance plans (reference pg 3 of 5)

2012 Actuarial report (5 mos)	Nisource YTD	Test Year	CPA's Allocation		
Service Cost	$ 186,755	$ 77,815	0.04%	$ 33	A
Interest Cost on APBO	$ 1,556,728	$ 648,637	0.00%	$ 8	B
Return on Assets	$ -	$ -	0.00%	$ -	C
Transition Obligation	$ 77,728	$ 32,387	-0.01%	$ (2)	D
Prior Service Cost	$ -	$ -	0.00%	$ -	E
Actuarial (Gain) Loss	$ 76,024	$ 31,677	0.00%	$ 0	F
Total	$ 1,897,235	$ 790,515		$ 39	G
2012 Actuarial report (5 mos)	Columbia YTD	Test Year	CPA's Allocation		
Service Cost	$ 742,313	$ 309,297	18.58%	$ 57,454	A
Interest Cost on APBO	$ 2,493,633	$ 1,039,014	8.06%	$ 83,764	B
Return on Assets	$ (4,000,867)	$ (1,667,028)	8.06%	$ (134,394)	C
Transition Obligation	$ -	$ -	0.00%	$ -	D
Prior Service Cost	$ (15,811)	$ (6,588)	7.82%	$ (515)	E
Actuarial (Gain) Loss	$ 1,744,014	$ 726,673	8.06%	$ 58,584	F
Total	$ 963,282	$ 401,368		$ 64,893	G

CPA's allocated portion of Retiree Medical plans (reference pg 4 of 5)

2011 Actuarial report (7 mos)	Nisource YTD	Test Year	CPA's Allocation		
Service Cost	$ 4,756,901	$ 2,774,859	0.01%	$ 236	A
Interest Cost on APBO	$ 17,026,156	$ 9,931,924	0.00%	$ 49	B
Return on Assets	$ (450,935)	$ (263,045)	0.00%	$ -	C
Transition Obligation	$ -	$ -	0.00%	$ -	D
Prior Service Cost	$ (1,479,905)	$ (863,278)	0.00%	$ -	E
Actuarial (Gain) Loss	$ 5,303,420	$ 3,093,662	0.00%	$ 15	F
Total	$ 25,155,637	$ 14,674,122		$ 300	G
2011 Actuarial report (7 mos)	Columbia YTD	Test Year	CPA's Allocation		
Service Cost	$ 3,668,852	$ 2,140,164	16.19%	$ 346,465	A
Interest Cost on APBO	$ 14,621,115	$ 8,528,984	9.73%	$ 829,742	B
Return on Assets	$ (19,223,949)	$ (11,213,970)	10.91%	$ (1,223,015)	C
Transition Obligation	$ -	$ -	0.00%	$ -	D
Prior Service Cost	$ 888,226	$ 518,132	9.73%	$ 50,406	E
Actuarial (Gain) Loss	$ -	$ -	7.22%	$ -	F
Total	$ (45,756)	$ (26,691)		$ 3,599	G

CPA's allocated portion of Retiree Life Insurance plans (reference pg 5 of 5)

2011 Actuarial report (7 mos)	Nisource YTD	Test Year	CPA's Allocation		
Service Cost	$ 149,495	$ 87,205	0.03%	$ 27	A
Interest Cost on APBO	$ 1,469,644	$ 857,292	0.00%	$ 5	B
Return on Assets	$ -	$ -	0.00%	$ -	C
Transition Obligation	$ 103,645	$ 60,460	0.00%	$ (3)	D
Prior Service Cost	$ -	$ -	0.00%	$ -	E
Actuarial (Gain) Loss	$ -	$ -	0.00%	$ -	F
Total	$ 1,722,784	$ 1,004,957		$ 30	G
2011 Actuarial report (7 mos)	Columbia YTD	Test Year	CPA's Allocation		
Service Cost	$ 704,116	$ 410,734	17.99%	$ 73,898	A
Interest Cost on APBO	$ 2,287,398	$ 1,334,316	7.82%	$ 104,336	B
Return on Assets	$ (4,077,802)	$ (2,378,718)	7.82%	$ (186,003)	C
Transition Obligation	$ -	$ -	0.00%	$ -	D
Prior Service Cost	$ (203,669)	$ (118,807)	7.82%	$ (9,290)	E
Actuarial (Gain) Loss	$ 425,132	$ 247,994	7.82%	$ 19,392	F
Total	$ (864,825)	$ (504,481)		$ 2,333	G

NiSource, Inc.
2012 ASC 715-60 Expense by Plan
Retiree Medical Plans
d = 4.88%

	Service Cost	Interest Cost	Expected Return on Plan Assets	Amort. Of Transitional Obligation	Amort. Of Prior Service Cost	Recognized Actuarial (gain) loss	Total
NiSource Plan	$ 5,779,077	$ 17,242,539	$ (380,178)	$ 0	$ (1,479,905)	$ 6,828,967	$ 27,990,500
Columbia Plan	3,893,588	12,964,774	(19,587,210)	0	686,664	0	(2,042,184)
Bay State Nonunion Plan	119,080	1,026,874	(499,756)	310,687	83,923	422,621	1,463,429
Bay State Union Plan	381,838	1,326,848	(2,200,477)	637,260	113,493	447,060	706,022
NIFL Plan	38,966	218,962	0	83,665	49,024	(46,064)	344,553
Kokomo Plan	48,059	90,810	0	32,517	70,924	0	242,310
Grand Total	$ 10,260,608	$ 32,870,807	$ (22,667,621)	$ 1,064,129	$ (475,877)	$ 7,652,584	$ 28,704,630

NiSource, Inc.
2012 ASC 715-60 Expense by Plan
Retiree Life Plans
d = 4.88%

	Service Cost	Interest Cost	Expected Return on Plan Assets	Amort. Of Transitional Obligation	Amort. Of Prior Service Cost	Recognized Actuarial (gain) loss	Total
NiSource Plan	$ 186,755	$ 1,556,728	$ 0	$ 77,728	$ 0	$ 76,024	$ 1,897,235
Columbia Plan	742,313	2,493,633	(4,000,867)	0	(15,811)	1,744,014	963,282
Bay State Nonunion Plan	12,880	82,919	(18,476)	20,108	9,114	3,440	109,985
Bay State Union Plan	12,382	51,789	(26,193)	27,325	0	34,064	99,367
NIFL Plan	1,970	17,648	0	0	(6,256)	5,454	18,816
Kokomo Plan	2,128	7,592	0	0	9,797	77	19,594
Grand Total	$ 958,428	$ 4,210,309	$ (4,045,536)	$ 125,161	$ (3,156)	$ 1,863,073	$ 3,108,279

Retiree Medical
2011 Expense by Plan - With Part D Offset
d = 5.29%

	Service Cost	Interest Cost	Expected Return on Plan Assets	Amort. Of Transitional Obligation	Amort. Of Prior Service Cost	Recognized Actuarial (gain) loss	Total
NiSource Plan	$ 4,756,901	$ 17,026,156	$ (450,935)	$ 0	$ (1,479,905)	$ 5,303,420	$ 25,155,637
Columbia Plan	3,668,852	14,621,115	(19,223,949)	0	888,226	0	(45,756)
Bay State Nonunion Plan	101,183	1,156,148	(452,566)	310,687	83,923	452,420	1,651,795
Bay State Union Plan	413,932	1,523,201	(2,375,769)	637,260	113,493	453,223	765,340
NIFL Plan	33,088	238,437	0	111,550	44,591	(45,426)	382,240
Kokomo Plan	36,017	75,945	0	43,364	50,449	0	205,775
Grand Total	$ 9,009,973	$ 34,641,002	$ (22,503,219)	$ 1,102,861	$ (299,223)	$ 6,163,637	$ 28,115,031

Retiree Life Insurance
2011 Expense by Plan
d = 5.29%

	Service Cost	Interest Cost	Expected Return on Plan Assets	Amort. Of Transitional Obligation	Amort. Of Prior Service Cost	Recognized Actuarial (gain) loss	Total
NiSource Plan	$ 149,495	$ 1,469,644	$ 0	$ 103,645	$ 0	$ 0	$ 1,722,784
Columbia Plan	704,116	2,287,398	(4,077,802)	0	(203,669)	425,132	(864,825)
Bay State Nonunion Plan	10,488	78,719	(20,572)	20,108	21,897	0	110,640
Bay State Union Plan	11,206	49,461	(29,756)	27,325	0	27,913	86,149
NIFL Plan	3,188	18,757	0	0	0	1,149	23,094
Kokomo Plan	683	4,161	0	0	2,696	0	7,540
Grand Total	$ 879,176	$ 3,908,140	$ (4,128,130)	$ 151,078	$ (179,076)	$ 454,194	$ 1,085,382

NiSource Inc. Benefit Plans for the Period 2012 through 2014 ($000)
Columbia Gas of Pennsylvania

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
		2012		2013		2014	
1	**Cash Estimates by Plan:**	Prior	Current	Prior	Current	Prior	Current
2	Retirement	$ 6,781	$ 3	$ 5,461	$ 3	$ 4,865	$ 3,254
3	D.C.	1,725	1,997	1,847	2,033	1,903	2,093
4	Medical Active*	3,527	3,423	3,864	3,981	4,244	4,363
5	Medical Retiree	1,558	1,553	132	66	155	75
6	Dental	324	283	344	309	364	323
7	Group Life Active	112	111	116	114	119	118
8	Group Life Retiree	4	5	4	5	4	5
9	Long Term Disability	285	281	294	289	303	298
10	Value Options**	8	8	8	8	8	8
11	Opt Out Credits	125	133	125	145	125	145
12	CPAs 2012 Actuarial Forecast	69	67	71	67	71	67
13	**Total**	$ 14,518	$ 7,864	$ 12,266	$ 7,020	$ 12,161	$ 10,749
14							
15							
16							
17		2012		2013		2014	
18							
19	**Expense Estimates by Plan:**	Prior	Current	Prior	Current	Prior	Current
20	Retirement	$ 3	$ 3	$ 3,432	$ 3	$ 4,865	$ 3,254
21	Qualified	-	-	3,428	-	4,860	3,249
22	SERP	3	3	4	3	5	5
23	D.C.	1,733	1,792	1,857	2,042	1,912	2,102
24	Savings Plan Match	1,428	1,486	1,542	1,727	1,588	1,778
25	Profit Sharing	305	306	315	315	324	324
26	Medical	3,313	3,401	3,497	3,741	3,735	4,083
27	Active*	3,527	3,423	3,864	3,981	4,244	4,363
28	Retiree	(214)	(22)	(367)	(240)	(509)	(280)
29	Dental	324	283	344	309	364	323
30	Group Life	172	267	145	170	115	147
31	Active	112	111	116	114	119	118
32	Retiree	60	156	29	56	(4)	29
33	Long Term Disability	285	281	294	289	303	298
34	Value Options**	8	8	8	8	8	8
35	Opt Out Credits	125	133	125	145	125	145
36	Vision	69	67	71	67	71	67
37	**TOTAL**	$ 6,032	$ 6,235	$ 9,773	$ 6,774	$ 11,498	$ 10,427
38							

* Includes Rx, HSA, mental health and administrative expenses.

** Where applicable, includes EAP and Work Life costs.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-40:

Please identify the actual or projected amounts contributed to SFAS No. 106 funds for the historic and future test years. Identify the actual or projected dates and amounts of the contributions.

Response:

Please refer to GAS RR-40 Attachment A for the actual and projected SFAS No. 106 contributions to the VEBA trust fund.

Columbia Gas of Pennysvlania, Inc.
Actual and Projected OPEB Contributions
For the Years 2011 to 2014
SDR 40 Attachment A

Retiree Medical and Life Contributions

Actual Cash Contributions

Month	Jun-11	Jul-11	Aug-11	Sep-11	Dec-11	Mar-12	Jun-12
Date	6/30/11	7/31/2011	8/31/2011	9/30/2011	12/31/2011	3/31/2012	6/30/12
Contributions	$ 11,090	$ 11,091	$ 11,091	$ 11,091	$ 33,273	$ 33,273	$ 488,909

Projected Cash Contributions

Month	Sep-12	Dec-12	Mar-13	Jun-13	Sep-13	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14
Date	9/30/2012	12/31/2012	3/31/2013	6/30/2013	9/30/2013	12/31/2013	3/31/2014	6/30/2014	9/30/2014	12/31/2014
Contributions	$ 488,909	$ 488,909	$ 17,750	$ 17,750	$ 17,750	$ 17,750	$ 20,000	$ 20,000	$ 20,000	$ 20,000

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-41

Please explain the funding options or plans which are being used for SFAS No. 106 costs. Identify the portion of the costs which are eligible for tax preferred funding.

Response:

A §401(h) account and Union and Non-Union VEBAs were established in December 1992 for the express purpose of prefunding OPEB health benefits. The employment of these funding vehicles affords some of the most tax efficient means available for prefunding OPEB health benefits. The Company's retiree life insurance plan was funded through a Special Insurance Continuation Account beginning in 1974 and converted during 1992 to a VEBA, separate from the OPEB health VEBAs and §401(h) account.

Like the NiSource Master Retirement Trust, the §401(h) account, the Union Medical VEBA, and the Union Life VEBA are fully tax-advantaged funding vehicles. Tax advantages result from (1) expected future medical inflation or salary growth rates, as applicable, being permitted by the IRC in determining current contribution amounts, (2) employer contributions being tax deductible (subject to statutory limits), and (3) investment earnings permitted to grow tax-free. Contributions made to the §401(h) account are subordinate to those made to NiSource Master Retirement Trust and are generally limited to one-third of the annual contribution made to master retirement trust. Thus, at times the §401(h) may not be able to accept contributions.

The Non-Union VEBA's are less tax efficient. Expected future medical inflation rates are not permitted in determining current contribution amounts and investment earnings are typically subject to tax. Still, it is one of the most tax efficient funding vehicles available today after the §401(h) account and Union VEBA funding alternatives for OPEB health care benefits.

For the 2011 tax year, Columbia Pennsylvania deposited $800,000 into its OPEB trusts; of this amount, approximately $800,000 was deductible on a current basis.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-42:

Is the Company studying and/or anticipating any changes to its postretirement benefits offered to employees as a result of SFAS No. 106 or for other reasons? If yes, please provide such study and/or explain the anticipated change.

Response:

The Company will not offer postretirement medical benefits for nonexempt nonunion and Columbia union employee new hires beginning on or after January 1, 2013.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-43:

Please state whether the Company has included expenses related to SFAS No. 112 in its test year claim. If so, please provide complete details and include a copy of the actuarial study.

Response:

The Company has included $138,824 for SFAS 112 expenses in its claim based on a 5 year average of on-going expense and continued amortization of the transition obligation as follows:

SFAS 112 Expense Claim

Twelve Months Ended	Expense
May-08	($64,887)
May-09	($305,142)
May-10	$217,328
May-11	$945,949
May-12	($516,008)
5 Year Average	**$55,448**
Amortization	$83,376
Total Claim	$138,824

Please refer to GAS-RR-43 Attachment A for the support regarding the on-going SFAS 112 expense amounts recorded in the last 5 years and GAS-RR-43 Attachment B for the transition obligation amortization.

NiSource
Delivering life's essential resources

December 27, 2007
No. 2007-35

From: J. Grossman

To:	R. Kriner K. Townsend	M. Hershberger	L. Miller	S. Taylor	G. Bane
CC:	K. Blissmer	L. Ford	K. Johnson	L. Olson	J. Shikany
	C. Delany	K. Fritts	L. Koh	T. Pemberton	J. Siegle
	T. Dillinger	L. Francisco	P. LaCroix	R. Plantz	B. Vangen
	B. Douce	J. Gore	D. Loudermilk	E. Postma	J. Witwer
	D. Djokic	R. Grzywana	T. Napiwocki	K. Richardson	J. Wood
	B. Elliot	T. Harmon	P. Newman	S. Rippy	
	G. Fisher	M. Holland	J. O'Brien	A. Romero	

Re: **FAS-112 Post-Employment Benefits Accrual Adjustment.**

The accompanying Excel worksheet reflects the FAS-112 estimated liability to be accrued as of December 31, 2007 and the adjustments to be recorded by entity in the fourth quarter of 2007. Please make the necessary adjustments to the accrual in December business.

Please use the following accounts for the FAS 112 liability:
Short-term FAS 112 Liability: Hyperion account # 304224242
Long-term FAS 112 Liability: Hyperion account # 361300253

If you have any questions regarding the required entries, please contact Kevin Blissmer at (219) 647-5690 or Vicky Flesher at (219) 647-4113.

	COMP	BALANCE AS OF 12-31-07			BALANCE AS OF 12-31-06			ADJUSTMENT		
CO #	NAME	Current	Long-Term	Total	Current	Long-Term	Total	Current	Long-Term	Total
37	CPA	149,482	1,455,953	1,605,435	146,105	1,524,217	1,670,322	3,377	(68,264)	(64,887)

Columbia Gas of Pennsylvania
FAS 112 Calculation
Assumptions: Lesser of 15 years or until age 65

								DAP		CMEP		GLIP			TOTAL
Discount Rate	6.00%		Years	# of LTD's	# of LTD's	Running		Future Cost (Discounted)	Future Cost (Discounted)	Future Cost (Discounted)	Future Cost (Discounted)	Life	GLIP	Future Cost (Discounted)	Future Cost (Discounted)
Trend Assumption	5.00%	LTD Age	Eligible	by age	by yrs elg	Total	Year	total	per empl	total	per empl	Insurance	Total	total	total
DAP															
Monthly	46.91	69													
Annual	562.94	68													
CMEP		67													
Monthly	670.02	66													
Annual	8,040.20	65	0												
GLIP		64	1	1	1	17	2008	9,570	563	138,683	8,040	64,000	2,360,000	3,228	149,482
Monthly	0.11	63	2	1	1	16	2009	8,922	591	127,430	8,442	168,000	2,296,000	2,963	139,315
Annual	1.37	62	3		0	15	2010	8,286	621	118,338	8,864		2,128,000	2,591	129,215
		61	4		0	15	2011	8,207	652	117,222	9,308		2,128,000	2,444	127,873
		60	5		0	15	2012	8,130	684	116,116	9,773		2,128,000	2,306	126,552
		59	6		0	15	2013	8,053	718	115,021	10,262		2,128,000	2,175	125,249
		58	7		0	15	2014	7,977	754	113,935	10,775		2,128,000	2,052	123,965
		57	8		0	15	2015	7,902	792	112,861	11,313		2,128,000	1,936	122,699
		56	9	1	1	15	2016	7,827	832	111,796	11,879	38,000	2,128,000	1,826	121,450
		55	10	2	2	14	2017	7,237	873	103,358	12,473	439,000	2,090,000	1,692	112,287
		54	11	3	3	12	2018	6,144	917	87,757	13,097	440,000	1,651,000	1,261	95,163
		53	12	2	2	9	2019	4,565	963	65,197	13,751	263,000	1,211,000	873	70,634
		52	13		0	7	2020	3,517	1,011	50,230	14,439		948,000	645	54,392
		51	14		0	7	2021	3,484	1,062	49,756	15,161		948,000	608	53,848
		50 and unde	15	7	7	7	2022	3,451	1,115	49,287	15,919	948,000	948,000	574	53,312
		Total		17	17			103,272		1,474,988				27,175	1,605,435
		Current Portion						9,570		138,683				3,228	149,482
		Noncurrent Portion						93,702		1,338,304				23,946	1,455,953
		Total						103,272		1,474,988				27,175	1,605,435

NiSource
Delivering life's essential resources

January 5, 2009
No. 2008-40

From: J. Grossman

To:	R. Kriner	M. Hershberger	W. Telzerow	S. Taylor	G. Bane
CC:	K. Blissmer	L. Ford	K. Johnson	L. Olson	J. Shikany
	C. Delany	K. Fritts	L. Koh	T. Pemberton	J. Siegle
	T. Dillinger	L. Francisco	P. LaCroix	R. Plantz	K. Townsend
	B. Douce	J. Gore	D. Loudermilk	E. Postma	B. Vangen
	D. Djokic	R. Grzywana	T. Napiwocki	S. Rippy	J. Gambone
	B. Elliot	T. Harmon	P. Newman	A. Romero	J. Wood
	G. Fisher	M. Holland	J. O'Brien		

Re: **FAS-112 Post-Employment Benefits Accrual Adjustment.**

The accompanying Excel worksheet reflects the FAS-112 estimated liability to be accrued as of December 31, 2008 and the adjustments to be recorded by entity in the fourth quarter of 2008. Please make the necessary adjustments to the accrual in December business.

Please use the following accounts for the FAS 112 liability:
Short-term FAS 112 Liability: Hyperion account # 304224242
Long-term FAS 112 Liability: Hyperion account # 361300253

If you have any questions regarding the required entries, please contact Kevin Blissmer at (219) 647-5690 or Vicky Flesher at (219) 647-4113.

	COMP	BALANCE AS OF 12-31-08			BALANCE AS OF 12-31-07			ADJUSTMENT		
CO #	NAME	Current	Long-Term	Total	Current	Long-Term	Total	Current	Long-Term	Total
37	CPA	132,127	1,168,166	1,300,293	149,482	1,455,953	1,605,435	(17,354)	(287,787)	(305,142)

Columbia Gas of Pennsylvania
FAS 112 Calculation
Assumptions: Lesser of 15 years or until age 65

Discount Rate	6.92%							DAP		CMEP		GLIP			TOTAL
Trend Assumption	5.00%	LTD Age	Years Eligible	# of LTD's by age	# of LTD's by yrs elg	Running Total	Year	Future Cost (Discounted) total	Future Cost (Discounted) per empl	Future Cost (Discounted) total	Future Cost (Discounted) per empl	Life Insurance	GLIP Total	Future Cost (Discounted) total	Future Cost (Discounted) total
DAP															
Monthly	47.42	69													
Annual	569.00	68													
CMEP		67													
Monthly	665.79	66													
Annual	7,989.42	65	0												
GLIP		64	1		0	15	2009	8,535	569	119,841	7,989	168,000	2,742,000	3,751	132,127
Monthly	0.11	63	2		0	15	2010	8,362	597	117,689	8,399		2,574,000	3,293	129,384
Annual	1.37	62	3		0	15	2011	8,231	627	115,576	8,808		2,574,000	3,080	126,887
		61	4	1	1	15	2012	8,083	659	113,500	9,249		2,574,000	2,881	124,466
		60	5	1	1	14	2013	7,409	692	104,031	9,711	112,000	2,574,000	2,694	114,135
		59	6		0	13	2014	6,756	726	94,866	10,197		2,462,000	2,410	104,033
		58	7	1	1	13	2015	6,635	763	93,162	10,707	223,000	2,462,000	2,254	102,052
		57	8	1	1	12	2016	6,015	801	84,452	11,242	38,000	2,239,000	1,917	92,384
		56	9	1	1	11	2017	5,414	841	76,024	11,804	439,000	2,201,000	1,763	83,201
		55	10	2	2	10	2018	4,834	883	67,872	12,394	440,000	1,762,000	1,320	74,025
		54	11	2	2	8	2019	3,798	927	53,322	13,014	263,000	1,322,000	926	58,046
		53	12		0	6	2020	2,797	973	39,274	13,665		1,059,000	694	42,765
		52	13		0	6	2021	2,747	1,022	38,568	14,348		1,059,000	649	41,964
		51	14	1	1	6	2022	2,697	1,073	37,876	15,065	200,000	1,059,000	607	41,180
		50 and unde	15	5	5	5	2023	2,208	1,127	30,996	15,819	859,000	859,000	461	33,664
		Total		15	15			84,541		1,187,051				28,702	1,300,293
		Current Portion						8,535		119,841				3,751	132,127
		Noncurrent Portion						76,006		1,067,209				24,951	1,168,166
		Total						84,541		1,187,051				28,702	1,300,293

NiSource
Delivering life's essential resources

December 23, 2009
No. 2009-43

From: J. Grossman

To:	R. Kriner J. Veurink	M. Hershberger	W. Telzerow	S. Taylor	G. Bane
CC:	K. Blissmer	L. Francisco	K. Isley	L. Pilof	T. Stanton
	M. Casey	J. Gambone	K. Johnson	R. Plantz	M. Tapp
	C. Delany	B. Golding	L. Koh	G. Plesac	K. Townsend
	B. Douce	J. Gore	P. LaCroix	E. Postma	B. Vangen
	J. Eing	R. Grzywana	C. Misirly	S. Rippy	J. Wood
	B. Elliot	T. Harmon	P. Newman	A. Romero	A. Zientara
	G. Fisher	R. Harper	J. O'Brien	R. Rudenga	
	L. Ford	A. Hazen	L. Olson	J. Shikany	
	K. Fritts	K. Humrichouse	T. Pemberton	J. Siegle	

Re: **ASC 712 (FAS-112) Post-Employment Benefits Accrual Adjustment.**

The accompanying Excel worksheet reflects the ASC 712 (FAS-112) estimated liability to be accrued as of December 31, 2009 and the adjustments to be recorded by entity in the fourth quarter of 2009. Please make the necessary adjustments to the accrual in December business.

Please use the following accounts for the ASC 712 (FAS 112) liability:
Short-term FAS 112 Liability: Hyperion account # 304224242
Long-term FAS 112 Liability: Hyperion account # 361300253

If you have any questions regarding the required entries, please contact Kevin Blissmer at (219) 647-5690 or Vicky Flesher at (219) 647-4113.

NISOURCE INC
December 31, 2009
ADJUSTMENT TO SFAS 112 LIABILITIES

	COMP	BALANCE AS OF 12-31-09			BALANCE AS OF 12-31-08			ADJUSTMENT		
CO #	NAME	Current	Long-Term	Total	Current	Long-Term	Total	Current	Long-Term	Total
37	CPA	140,132	1,377,489	1,517,621	132,127	1,168,166	1,300,293	8,005	209,323	217,328

Columbia Gas of Pennsylvania
FAS 112 Calculation
Assumptions: Lesser of 15 years or until age 65

Discount Rate	5.50%
Trend Assumption	5.00%
DAP	
Monthly	46.38
Annual	556.59
CMEP	
Monthly	711.21
Annual	8,534.49
GLIP	
Monthly	0.11
Annual	1.37

						DAP		CMEP		GLIP			TOTAL
LTD Age	Years Eligible	# of LTD's by age	# of LTD's by yrs e/g	Running Total	Year	Future Cost (Discounted) total	Future Cost (Discounted) per empl	Future Cost (Discounted) total	Future Cost (Discounted) per empl	Life Insurance	GLIP Total	Future Cost (Discounted) total	Future Cost (Discounted) total
69													
68													
67													
66													
65	0												
64	1		0	15	2010	8,349	557	128,017	8,534		2,753,000	3,766	140,132
63	2		0	15	2011	8,309	584	127,411	8,961		2,753,000	3,570	139,290
62	3		0	15	2012	8,270	614	126,807	9,409		2,753,000	3,384	138,460
61	4	1	1	15	2013	8,231	644	126,206	9,880	112,000	2,753,000	3,207	137,644
60	5		0	14	2014	7,646	677	117,234	10,374		2,641,000	2,916	127,796
59	6	1	1	14	2015	7,609	710	116,678	10,892	223,000	2,641,000	2,764	127,052
58	7	1	1	13	2016	7,032	746	107,831	11,437	38,000	2,418,000	2,399	117,262
57	8	1	1	12	2017	6,461	783	99,064	12,009	439,000	2,380,000	2,238	107,763
56	9	2	2	11	2018	5,894	822	90,378	12,609	440,000	1,941,000	1,730	98,003
55	10	1	1	9	2019	4,800	863	73,596	13,240	222,000	1,501,000	1,268	79,663
54	11		0	8	2020	4,246	907	65,106	13,902		1,279,000	1,024	70,379
53	12	1	1	8	2021	4,226	952	64,800	14,597	293,000	1,279,000	971	69,997
52	13	1	1	7	2022	3,680	1,000	56,431	15,327	200,000	986,000	709	60,821
51	14		0	6	2023	3,140	1,050	48,140	16,093		786,000	536	51,816
50 and unde	15	6	6	6	2024	3,125	1,102	47,912	16,898	786,000	786,000	508	51,545
Total		15	15			91,017		1,395,612				30,992	1,517,621
Current Portion						**8,349**		**128,017**				**3,766**	**140,132**
Noncurrent Portion						**82,668**		**1,267,595**				**27,226**	**1,377,489**
Total						**91,017**		**1,395,612**				**30,992**	**1,517,621**

NiSource
Delivering life's essential resources

December 17, 2010
No. 2010-41

From: J. Veurink

To:	R. Kriner	M. Hershberger	W. Telzerow	S. Taylor	G. Bane
	J. Veurink				
CC:	K. Blissmer	L. Francisco	K. Isley	L. Pilof	T. Stanton
	M. Casey	J. Gambone	K. Johnson	R. Plantz	M. Tapp
	C. Delany	B. Golding	L. Koh	G. Plesac	K. Townsend
	B. Douce	J. Gore	P. LaCroix	E. Postma	B. Vangen
	J. Eing	R. Grzywana	C. Misirly	S. Rippy	J. Wood
	B. Elliot	T. Harmon	P. Newman	A. Romero	A. Zientara
	G. Fisher	R. Harper	J. O'Brien	R. Rudenga	
	L. Ford	A. Hazen	L. Olson	J. Shikany	
	K. Fritts	K. Humrichouse	T. Pemberton	J. Siegle	

Re: **ASC 712 (FAS-112) Post-Employment Benefits Accrual Adjustment.**

The accompanying Excel worksheet reflects the ASC 712 (FAS-112) estimated liability to be accrued as of December 31, 2010 and the adjustments to be recorded by entity in the fourth quarter of 2010. Please make the necessary adjustments to the accrual in December business.

Please use the following accounts for the ASC 712 (FAS 112) liability:
Short-term FAS 112 Liability: Hyperion account # 304224242
Long-term FAS 112 Liability: Hyperion account # 361300253

If you have any questions regarding the required entries, please contact Kevin Blissmer at (219) 647-5690 or Diana Baldwin at (614) 460-4656.

NISOURCE INC
December 31, 2010
ADJUSTMENT TO SFAS 112 LIABILITIES

	COMP	BALANCE AS OF 12-31-10			BALANCE AS OF 12-31-09			ADJUSTMENT		
CO #	NAME	Current	Long-Term	Total	Current	Long-Term	Total	Current	Long-Term	Total
37	CPA	226,147	2,237,422	2,463,570	140,132	1,377,489	1,517,621	86,015	859,934	945,949

Columbia Gas of Pennsylvania
FAS 112 Calculation
Assumptions: Losser of 15 years or until age 65

							DAP		CMEP		GLIP		TOTAL	
Discount Rate	4.61%						*Future Cost*	*Future Cost*	*Future Cost*	*Future Cost*			*Future Cost*	*Future Cost*
Trend Assumption	5.00%	LTD Age	Years Eligible	# of LTD's by age	# of LTD's by yrs elg	Running Total	Year	(Discounted) total	(Discounted) per empl	(Discounted) total	(Discounted) per empl	Life Insurance	GLIP Total	(Discounted) total	(Discounted) total
DAP															
Monthly	49.74	69													
Annual	596.92	68													
CMEP		67													
Monthly	747.58	66													
Annual	8,971.01	65	0												
GLIP		64	1		0	23	2011	13,729	597	206,333	8,971		4,448,000	6,085	226,147
Monthly	0.11	63	2		0	23	2012	13,780	627	207,102	9,420		4,448,000	5,817	226,700
Annual	1.37	62	3	1	1	23	2013	13,832	658	207,875	9,891	112,000	4,448,000	5,560	227,267
		61	4		0	22	2014	13,280	691	199,578	10,385		4,336,000	5,182	218,039
		60	5	1	1	22	2015	13,329	726	200,322	10,904	223,000	4,336,000	4,953	218,604
		59	6	1	1	21	2016	12,771	762	191,929	11,450	38,000	4,113,000	4,491	209,191
		58	7	1	1	20	2017	12,208	800	183,471	12,022	439,000	4,075,000	4,254	199,933
		57	8	3	3	19	2018	11,641	840	174,947	12,623	614,000	3,636,000	3,628	190,217
		56	9	2	2	16	2019	9,839	882	147,873	13,254	281,000	3,022,000	2,883	160,595
		55	10	1	1	14	2020	8,641	926	129,872	13,917	116,000	2,741,000	2,499	141,013
		54	11	2	2	13	2021	8,054	972	121,046	14,613	590,000	2,625,000	2,288	131,387
		53	12	3	3	11	2022	6,840	1,021	102,804	15,343	788,000	2,035,000	1,696	111,340
		52	13		0	8	2023	4,993	1,072	75,045	16,111		1,247,000	993	81,032
		51	14	4	4	8	2024	5,012	1,126	75,325	16,916	561,000	1,247,000	950	81,287
		50 and unde	15	4	4	4	2025	2,515	1,182	37,803	17,762	686,000	686,000	499	40,818
		Total		23	23			150,466		2,261,326				51,778	2,463,570
		Current Portion						13,729		206,333				6,085	226,147
		Noncurrent Portion						136,737		2,054,992				45,693	2,237,422
		Total						150,466		2,261,326				51,778	2,463,570

NiSource
Delivering life's essential resources

December 1, 2011
No. 2011-52

From: J. Veurink

To: J. Konold, R. Plantz, S. Taylor, W. Telzerow

CC:

A. Abram	S. Diener	B. Golding	R. Markosky	A. Romero
S. Anderson	C. Dixon	T. Harmon	T. Napiwocki	R. Rudenga
G. Bane	D. Dorsch	D. Hasson	N. Maynard	S. Sagun
C. Berberich	B. Douce	K. Humrichouse	C. Misirly	S. Schmal
C. Holmquest	J. Eing	D. Isensee	D. Monk	B. Sedlock
K. Blissmer	B. Elliot	K. Isley	C. Moore	J. Shikany
N. Bly	K. Figg	K. Johnson	J. O'Brien	D. Speas
D. Bruno	L. Fitzgerald	M. Katko	L. Olson	T. Stanton
M. Casey	K. Ford	E. Kendall	T. Pemberton	M. Tapp
A. Chen	L. Ford	R. Kriner	L. Pilof	K. Townsend
K. Cochran	L. Francisco	P. LaCroix	E. Postma	B. Vangen
S. Cogar	J. Gambone	D. Loudermilk	C. Rider	J. Wood
C. Delany				J. Wozniak

Re: **ASC 712 (FAS-112) Post-Employment Benefits Accrual Adjustment.**

The accompanying Excel worksheet reflects the ASC 712 (FAS-112) estimated liability to be accrued as of December 31, 2011 by entity. Please make the necessary adjustments to the accrual in November business. This accrual is adjusted annually and represents the estimated cost of providing medical, dental and life insurance to those individuals on disability up until they are age 65.

In total, the 2011 adjustment resulted in a $1.1 million decrease to the consolidated liability. This decrease is mainly attributable to a movement of several long-term disability individuals to a less costly medical plan, as well as an overall reduction in the number of individuals on long-term disability.

Please use the following accounts for the ASC 712 (FAS 112) liability:
Short-term FAS 112 Liability: Hyperion account # 304224242
Long-term FAS 112 Liability: Hyperion account # 361300253
Please note the offset to the liability should be recorded to the FAS 112 expense account, unless you have specific regulatory treatment.

If you have any questions regarding the required entries, please contact Diana Baldwin at (614) 460-4656 or Kevin Blissmer at (219) 647-5690.

NISOURCE INC
December 31, 2011
ADJUSTMENT TO SFAS 112 LIABILITIES

	COMP	BALANCE AS OF 12-31-11			BALANCE AS OF 12-31-10			ADJUSTMENT		
CO #	NAME	Current	Long-Term	Total	Current	Long-Term	Total	Current	Long-Term	Total
37	CPA	200,607	1,746,954	1,947,562	226,147	2,237,422	2,463,570	(25,540)	(490,468)	(516,008)

Columbia Gas of Pennsylvania
FAS 112 Calculation
Assumptions: Lesser of 15 years or until age 65

								DAP		CMEP		GLIP			TOTAL
Discount Rate	5.29%							Future Cost	Future Cost	Future Cost	Future Cost			Future Cost	Future Cost
Trend Assumption	5.00%	LTD Age	Years Eligible	# of LTD's by age	# of LTD's by yrs elg	Running Total	Year	(Discounted) total	(Discounted) per empl	(Discounted) total	(Discounted) per empl	Life Insurance	GLIP Total	(Discounted) total	(Discounted) total
DAP															
Monthly	50.25	69													
Annual	602.97	68													
CMEP		67													
Monthly	760.48	66													
Annual	9,125.71	65	0												
GLIP		64	1		0	20	2012	12,059	603	182,514	9,126		4,190,000	6,034	200,607
Monthly	0.12	63	2		0	20	2013	12,026	633	182,011	9,582		4,190,000	5,730	199,768
Annual	1.44	62	3		0	20	2014	11,993	665	181,510	10,061		4,190,000	5,443	198,946
		61	4		0	20	2015	11,960	698	181,010	10,564		4,190,000	5,169	198,139
		60	5	1	1	20	2016	11,927	733	180,512	11,092	38,000	4,190,000	4,909	197,348
		59	6	2	2	19	2017	11,300	770	171,014	11,647	567,000	4,152,000	4,620	188,934
		58	7	3	3	17	2018	10,082	808	152,591	12,229	636,000	3,585,000	3,789	166,462
		57	8	3	3	14	2019	8,280	848	125,317	12,841	411,000	2,949,000	2,960	136,557
		56	9	1	1	11	2020	6,488	891	98,192	13,483	116,000	2,538,000	2,420	107,100
		55	10	1	1	10	2021	5,882	935	89,020	14,157	590,000	2,422,000	2,193	97,095
		54	11	2	2	9	2022	5,279	982	79,897	14,865	701,000	1,832,000	1,575	86,752
		53	12		0	7	2023	4,095	1,031	61,971	15,608		1,131,000	924	66,989
		52	13	4	4	7	2024	4,083	1,083	61,800	16,388	561,000	1,131,000	877	66,761
		51	14	2	2	3	2025	1,745	1,137	26,413	17,208	334,000	570,000	420	28,578
		50 and unde	15	1	1	1	2026	580	1,194	8,780	18,068	236,000	236,000	185	9,525
		Total		20	20			117,780		1,782,552				47,229	1,947,562
		Current Portion						12,059		182,514				6,034	200,607
		Noncurrent Portion						105,721		1,600,038				41,196	1,746,954
		Total						117,780		1,782,552				47,229	1,947,562

Columbia Gas of Pennsylvania
SFAS 112 - Post Employment Benefit Amortization

		Monthly Amortization	Unamortized Balance
	May-12		180,676
2012	Jun-12	(6,948)	173,728
	Jul-12	(6,948)	166,780
	Aug-12	(6,948)	159,832
	Sep-12	(6,948)	152,884
	Oct-12	(6,948)	145,936
	Nov-12	(6,948)	138,988
2013	Dec-12	(6,948)	132,040
	Jan-13	(6,948)	125,092
	Feb-13	(6,948)	118,144
	Mar-13	(6,948)	111,196
	Apr-13	(6,948)	104,248
	May-13	(6,948)	97,300
	Jun-13	(6,948)	90,352
	Jul-13	(6,948)	83,404
	Aug-13	(6,948)	76,456
	Sep-13	(6,948)	69,508
	Oct-13	(6,948)	62,560
	Nov-13	(6,948)	55,612
2014	Dec-13	(6,948)	48,664
	Jan-14	(6,948)	41,716
	Feb-14	(6,948)	34,768
	Mar-14	(6,948)	27,820
	Apr-14	(6,948)	20,872
	May-14	(6,948)	13,924
	Jun-14	(6,948)	6,976
	Jul-14	(6,948)	28
	Aug-14	(28)	-

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-44:

Please provide all documentation supporting the uncollectible accrual rate reflected in the Company's filing.

Response:

Columbia did not use an uncollectible accrual rate in this filing but instead used an actual uncollectible experienced rate. Data and documentation supporting the development of this 1.458% rate is provided on Exhibit No. 4, Schedule No. 2, Page 13. This reference provides the following:

Total 3 Year Billed Revenue (line 4)	$1,195,279,975
Total 3 Year Net Write-offs (line 9)	$17,422,031
Uncollectible Rate (line 9 / line 4)	1.458%

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. GAS-RR-045:

Please provide all work papers and documentation supporting the Company's claimed balance of gas stored underground - current. Include support for the monthly injections and withdrawals and the gas cost rate.

Response:

Please see Exhibit No. 108, Schedule No. 7, Page 1 for the monthly injections and withdrawals and the gas cost rate claimed by the Company.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-46:

Please provide a comparison between actual and budgeted O&M expenses by budget cost element for the historical test year and explain any budget variances of 10 percent or more.

Response:

Columbia did not use budgeted O&M expenses in its cost of service request but instead used a build-up approach as described in Columbia Statement No. 4, J. T. Gore's testimony. A comparison of the cost elements used to determine Columbia's claim has been provided as Exhibit No. 4, Schedule No. 3, and Pages 1 through 3.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-47:

Please provide the most recent actual number of eligible participants in each of the employee medical and dental plans reflected in the Company's filing.

Response:

There are 510 eligible participants currently in each of the employee medical and dental plans reflected in the Company's filing, see Exhibit No. 4, Schedule No. 2, Page 4. There are an additional 55 eligible participants included in the forecasted annualization of benefits expense included in Exhibit No. 104, Schedule No. 2, Page 11, Column 9.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-48:

Please provide workpapers showing the derivation of future test year Social Security and Medicare FICA taxes based on future test year labor expense. Identify both the total and O&M amounts.

Response:

The future test year Social Security and Medicare FICA taxes are derived using a build-up approach starting with the historic test year. A work paper for the historic test year Social Security and Medicare FICA taxes is provided as Exhibit No. 6, Schedule No. 2, and Page 2. A work paper for the future test year and fully forecasted rate year for Social Security and Medicare FICA taxes is provided as Exhibit No. 106, Schedule No. 2, and Page 2.

The O&M amounts are as follows:

12 Months Ended May 31, 2012 Per Books	$ 1,799,731
Adjustment to historic test year per books (Exh. No. 6, Sch. No. 2, Pg 2)	$ 208,216
Normalized 12 Months Ended Historic Test Year	$ 2,007,947
Adjustment to Normalized Historic Test Year (Exh. No. 106, Sch 2, Pg 2)	$ 133,856
Future Test Year FICA Taxes	$2,141,802
Adjustment to Future Test Year (Exh. No. 106, Sch 2, Pg 2)	$ 49,067
Fully Forecasted Rate Year FICA Taxes	$2,190,689

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-49:

Please provide work papers showing the derivation of future test year federal and state unemployment taxes. Show both the total and O&M amounts.

Response:

The historic federal and state unemployment taxes were adjusted to eliminate an out-of-period balance sheet reconciliation adjusting entry. The impact of this adjustment is detailed on Exhibit 6, Schedule No. 2, Page 2 of 5.

The future test year and fully forecasted rate year federal and state nemployment taxes are unchanged from the historic test year amounts after allowing for the elimination of the out-of-period items. Both years are as follows:

Federal Unemployment Tax	$ 45,196
State Unemployment Tax	$ 161,920

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-50:

Please provide work papers showing the derivation of future test year capital stock taxes.

Response:

Refer to Standard Filing Requirement, Exhibit 106, Schedule No. 2, Page 5.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-51:

If applicable, please provide a copy of the billing and payment terms for all contracts between the Company and its parent or an affiliated company for services. Further, to the extent that the parent or affiliated company provides service to non-affiliated companies, please provide the corresponding billing and payment terms.

Response:

GAS RR-51 Attachment A is the Service Agreement between the Company and NiSource Corporate Services Company ("NCSC") dated December 15, 2005. Per Article 2, Compensation, Section 2.3, NCSC renders a monthly report known as a "contract bill" to the Company. The Company reviews the bills and identifies any questions or concerns it has regarding the bill. If no issues are identified, the Company remits all charges billed within 30 days of receipt of the contract bill. The billing and payment terms for the NCSC contract bill are the same for all affiliate companies. NCSC does not provide services to non-affiliated companies.

Service Agreement

BETWEEN

NISOURCE CORPORATE SERVICES COMPANY

AND

COLUMBIA GAS OF PENNSYLVANIA, INC.

Dated December 15, 2005

(To Take Effect Pursuant to Article 3 Hereof)

SERVICE AGREEMENT

This SERVICE AGREEMENT (the "Service Agreement" or "Agreement") is made and entered into this 17th day of December, 2005 by and between Columbia Gas of Pennsylvania, Inc., its subsidiaries, affiliates and associates ("Client", and together with other associate companies that have or may in the future execute this form of Service Agreement, the "Clients") and NiSource Corporate Services Company ("Company").

WITNESSETH:

WHEREAS, the Securities and Exchange Commission ("SEC") has approved and authorized as meeting the requirements of Section 13(b) of the Public Utility Holding Company Act of 1935 ("Act") the organization and conduct of the business of the Company, in accordance herewith, as a wholly-owned subsidiary service company of NiSource Inc. ("NiSource), including the allocation of all Company costs by using the methods approved by the Securities and Exchange Commission ("SEC Method");

WHEREAS, Client is an affiliate of the Company; and

WHEREAS, the Company and Client agree to enter into this Service Agreement whereby the Client may seek certain services from the Company and the Company agrees to provide such services upon request and upon the Company's conclusion that it is able to perform such services. Further, the Client agrees to pay for the services as provided herein at cost, with cost determined in accordance with applicable rules and regulations under the Act, which require the Company to fairly and equitably allocate costs among all Clients to which it renders services; and

WHEREAS, the rendition of such services set forth in Article 2 of Appendix A on a centralized basis enables the Clients to realize economic and other benefits through (1) efficient use of personnel and equipment, (2) coordination of analysis and planning, and (3) availability of specialized personnel and equipment which the Clients cannot economically maintain on an individual basis.

NOW THEREFORE, in consideration of the premises and the mutual agreements herein contained, the parties to this Service Agreement covenant and agree as follows:

ARTICLE 1

SERVICES

1.1 The Company shall furnish to Client, as requested by Client, upon the terms and conditions hereinafter set forth, such of the services described in Section 2 of Appendix A hereto (the "Services"), at such times, for such periods and in such manner as Client may from time to time request and that the Company concludes it is able to perform. The Company shall also provide Client with such services, in addition to those services described in Appendix A hereto, as may be requested by Client and that the Company concludes it is able to perform. In supplying such services, the Company may arrange, where it deems appropriate in consultation with Client,

for the services of such experts, consultants, advisers, and other persons with necessary qualifications as are required for or pertinent to the provision of such services ("Additional Services").

1.2 Client shall take from the Company such of the Services, and such Additional Services, whether or not now contemplated, as are requested from time to time by Client and that the Company concludes it is able to perform.

1.3 The cost of the Services described herein or contemplated to be performed hereunder shall be allocated to Client in accordance with the SEC Method. Client shall have the right from time to time to amend or alter any activity, project, program or work order provided that (i) Client pays and remunerates the Company the full cost for the services covered by the activity, project, program or work order, including therein any expense incurred by the Company as a direct result of such amendment or alteration of the activity, project, program or work order, and (ii) Client accepts that no amendment or alteration of an activity, project, program or work order shall release Client from liability for all costs already incurred by or contracted for by the Company pursuant to the activity, project, program or work order, regardless of whether the services associated with such costs have been completed.

1.4 The Company shall hire, train and maintain an experienced staff able to perform the Services, or shall obtain experience through third-party resources, as it shall determine in consultation with Client.

ARTICLE 2

COMPENSATION

2.1 As compensation for the Services to be rendered hereunder, Client shall compensate and pay to the Company all costs, reasonably identifiable and related to particular Services performed by the Company for or on Client's behalf. The methods for allocating the Company costs to Client, as well as to other associate companies, are set forth in Appendix A.

2.2 It is the intent of this Service Agreement that charges for Services shall be billed, to the extent possible, directly to the Client or Clients benefiting from such Service. Any amounts remaining after such direct billing shall be allocated using the methods identified in Appendix A. The methods of allocation of cost shall be subject to review annually, or more frequently if appropriate. Such methods of allocation of costs may be modified or changed by the Company without the necessity of an amendment to this Service Agreement; provided that, in each instance, all services rendered hereunder shall be at actual cost thereof, fairly and equitably allocated, all in accordance with the requirements of the Act and any orders promulgated thereunder. The Company shall review with the Client any proposed change in the methods of allocation of costs hereunder and the parties must agree to any such changes before they are implemented.

2.3 The Company shall render a monthly report to Client that shall reflect all information necessary to identify the costs charged and Services rendered for that month. Client shall undertake an immediate review of the report and identify all questions or concerns

regarding the charges reflected within ten (10) days of receipt of the report. If no concerns are identified within that time, Client shall remit to the Company all charges billed to it within 30 days of receipt of the monthly report.

2.4 Client agrees to provide the Company, from time to time, as requested such financial and statistical information as the Company may need to compute the charges payable by Client consistent with the method of allocation set forth on Appendix A.

2.5 It is the intent of this Service Agreement that the payment for services rendered by the Company to Client under this Service Agreement shall cover all the costs of its doing business including, but not limited to, salaries and wages, office supplies and expenses, outside services employed, insurance, injuries and damages, employee and retiree pensions and benefits, miscellaneous general expenses, rents, maintenance of structures and equipment, depreciation and amortization, and compensation for use of capital as permitted under the Act.

ARTICLE 3

TERM

3.1 This Service Agreement shall become effective as of the date first written above, subject only to the receipt of any required regulatory approvals from the State Commissions and the SEC, and shall continue in force until terminated by the Company or Client, upon not less than one year's prior written notice to the other party. This Service Agreement shall also be subject to termination or modification at any time, without notice, if and to the extent performance under this Service Agreement may conflict with (1) the Act or with any rule, regulation or order of the SEC adopted before or after the date of this Service Agreement, or (2) any state or federal statute, or any rule, decision, or order of any state or federal regulatory agency having jurisdiction over one or more Clients. Further, this Service Agreement shall be terminated with respect to the Client immediately upon the Client ceasing to be an associate company of the Company. The parties' obligations under this Service Agreement which by their nature are intended to continue beyond the termination or expiration of this Service Agreement shall survive such termination or expiration.

ARTICLE 4

SERVICE REVIEW

4.1 On an annual basis, the Company and Client shall meet to assess the quality of the Services being provided pursuant to this Service Agreement and to determine the continued need therefor and shall, subject to Section 1.1, above, amend the scope of services, delete services entirely from this Service Agreement, and/or decline services as they determine to be necessary or desirable.

4.2 NiSource maintains an Internal Audit Department that will conduct periodic audits of the Company administration and accounting processes ("Audits"). The Audits will include examinations of Service Agreements, accounting systems, source documents, methods of allocation of costs and billings to ensure all Services are properly accounted for and billed to the appropriate Client. In addition, the Company's policies, operating procedures and controls will be evaluated annually. Copies of the reports generated by the Company as part of the Audits will be provided to Client upon request.

ARTICLE 5

MISCELLANEOUS

5.1 All accounts and records of the Company shall be kept in accordance with the General Rules and Regulations promulgated by the SEC pursuant to the Act, in particular, the Uniform System of Accounts for Mutual Service Companies and Subsidiary Service Companies in effect from and after the date hereof.

5.2 New direct or indirect subsidiaries of NiSource Inc., which may come into existence after the effective date of this Service Agreement, may become additional Clients of the Company and subject to a service agreement with the Company. The parties hereto shall make such changes in the scope and character of the services to be rendered and the method of allocating costs of such services as specified in Appendix A, subject to the requirements of Section 2.2, as may become necessary to achieve a fair and equitable allocation of the Company's costs among all Clients including any new subsidiaries. The parties shall make similar changes if any Client ceases to be associated with the Company.

5.3 The Company shall permit Client reasonable access to its accounts and records including the basis and computation of allocations.

5.4 The Company and Client shall comply with the terms and conditions of all applicable contracts managed by the Company for the Client, individually, or for one or more Clients, collectively, including without limitation terms and conditions preserving the confidentiality and security of proprietary information of vendors.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the date and year first above written.

NISOURCE CORPORATE SERVICES COMPANY

By: Susanne M. Taylor
Name: Susanne M. Taylor
Its: Controller

COLUMBIA GAS OF PENNSYLVANIA, INC.

By: Terrence J. Murphy
Name: Terrence J. Murphy
Its: President

APPENDIX A

NISOURCE CORPORATE SERVICES COMPANY

Services Available to Clients
Methods of Charging Therefor and
Miscellaneous Terms and Conditions of Service Agreement

ARTICLE 1

DEFINITIONS

1 The term "Company" shall mean NiSource Corporate Services Company and its successors.

2 The term "Service Agreement" shall mean an agreement, of which this Appendix A constitutes a part, for the rendition of services by the Company.

3 The term "Client" shall mean any corporation to which services may be rendered by the Company under a Service Agreement.

ARTICLE 2

DESCRIPTION OF SERVICES

Descriptions of the expected services to be provided by the Company are detailed below. The descriptions are deemed to include services associated with, or related or similar to, the services contained in such descriptions. The details listed under each heading are intended to be illustrative rather than inclusive and are subject to modification from time to time in accordance with the state of the art and the needs of the Clients.

1 *Accounting and Statistical Services.* The Company will advise and assist the Clients in all aspects of accounting, including financial accounting, plant accounting, regulatory accounting, tax accounting, maintenance of books and records, safeguarding of assets, accounts payable, accounts receivable, reconciliations, accounting research, reporting, operations and maintenance analysis, and related accounting functions. The Company will also provide services related to developing, analyzing and interpreting financial statements, directors' reports, regulatory reports, operating statistics and other financial reports. The Company will ensure compliance with generally accepted accounting principles and provide guidance on exposure drafts, financial accounting standards, and interpretations issued by the Financial Accounting Standards Board. The Company will advise and assist the Clients in the formulation of accounting practices and policies and will conduct special studies as may be requested by the Clients.

2 *Auditing Services.* The Company will conduct periodic audits of the general records of the Clients, will supervise the auditing of local and field office records of the Client, and will coordinate the audit programs of the Clients with those of the independent accountants in the annual examination of their accounts.

3 *Budget Services.* The Company will advise and assist the Clients in matters involving the preparation and development of budgets and budgetary controls.

4 *Business Promotion Services.* The Company will advise and assist the Clients in the preparation and use of advertising, in the development of residential, commercial and industrial business, and in the rendering of aid to local appliance distributors and dealers in the advertising and promotion of appliance sales.

5 *Corporate Services.* The Company will advise and assist the Clients in connection with corporate matters and with proceedings involving regulatory bodies.

6 *Depreciation Services.* The Company will advise and assist the Clients in matters pertaining to depreciation practices, including (1) the making of studies to determine the estimated service life of various types of plant, annual depreciation accrual rates, salvage experience, and trends in depreciation reserves indicated by such studies; (2) assistance in the organization and training of the depreciation departments of the Clients; and (3) dissemination to the Clients of information concerning current developments in depreciation practices.

7 *Economic Services.* The Company will advise and assist the Clients in matters involving economic research and planning and in the development of specific economic studies.

8 *Electronic Communications Services.* The Company will advise and assist the Clients in connection with the planning, installation and operation of radio networks, remote control and telemetering devices, microwave relay systems and all other applications of electronics to the fields of communication and control.

9 *Employee Services.* The Company will advise and assist the Clients in connection with employee relations matters, including recruitment, employee placement, training, compensation, safety, labor relations and health, welfare and employee benefits. The Company will also advise and assist the Clients in connection with temporary labor matters, including assessment, selection, contract negotiation, administration, service provider relationships, compliance, review and reporting.

10 *Engineering and Research Services.* The Company will advise and assist the Clients in connection with the engineering phases of all construction and operating matters, including estimates of costs of construction, preparation of plans and designs, engineering and supervision of the fabrication of natural gas facilities, standardization of engineering procedures, and supervision and inspection of construction. The Company will also conduct both basic and specific research in fields related to the operations of the Clients.

11 *Gas Dispatching Services.* The Company will advise and assist the Clients in the dispatching of the gas supplies available to the Clients, and in determining and effecting the most efficient routing and distribution of such supplies in the light of the respective needs therefor and the applicable laws and regulations of governmental bodies. If requested by the Clients, the Company will provide a central dispatcher or dispatchers to handle the routing and dispatching of gas.

12 *Information Technology Services.* The Company will advise and assist Clients in matters involving information technology, including management, operations, control, monitoring, testing, evaluation, data access security, disaster recovery planning, technical research, and support services. The Company will also provide and assist the Client with application development, maintenance, modifications, upgrades and ongoing production support for a portfolio of systems and software that are used by the Clients. In addition, the Company will identify and resolve problems, ensure efficient use of software and hardware, and ensure that timely upgrades are made to meet the demands of the Clients. The Company will also maintain information concerning the disposition and location of Information Technology assets.

13 *Information Services.* The Company will advise and assist the Clients in matters involving the furnishing of information to customers, employees, investors and other interested groups, and to the public generally, including the preparation of booklets, photographs, motion pictures and other means of presentation, and assistance to Clients in their advertising programs.

14 *Insurance Services.* The Company will advise and assist the Clients in general insurance matters, in obtaining policies, making inspections and settling claims.

15 *Legal Services.* The Company will provide Clients with legal services (including legal services, as necessary or advisable, in connection with or in support of any of the other services provided hereunder), including, but not limited to, general corporate matters and internal corporate maintenance, contract drafting and negotiation, litigation, liability and risk assessment, financing, securities offerings, state and federal regulatory compliance, state and federal regulatory support and rule interpretation and advice (relating to the all aspects of SEC compliance, PUHCA, FERC, FPA, PURPA), bankruptcy and collection matters, employment and labor relations investigations, union contracting, EEOC issues, and all other matters for which Clients require such legal services.

16 *Office Space.* As may from time to time be available, the Company will provide suitable space in its offices for the use of the Clients and their officers and employees.

17 *Officers.* Any Client may, with the consent of the Company, elect to any office of the Client any officer or employee of the Company whose compensation is paid, in whole or in part, by the Company. Services rendered to the Client by such person as an officer shall be billed by the Company to the Client and paid for as provided in Articles 3 and 4, and the Client shall not be required to pay any compensation directly to any such person.

18 *Operations Support and Planning Services.* The Company will advise and assist the Clients in connection with operations support and planning, including logistics and scheduling; workforce planning; corrosion and leakage programs; estimates of gas requirements and gas availability; gas transmission, measurement, storage and distribution; construction requirements; construction management; operating standards and practices; regulatory compliance; training; management of transportation and sales programs; negotiation of gas purchase and sale contracts; energy marketing and trading; security services; measurement, regulation and conditioning equipment; meter testing, calibration and repair; hydraulic gas network modeling, facility mapping and GIS technologies; and other operating matters.

19 *Purchasing, Storage and Disposition Services.* The Company will render advice and assistance to the Clients in connection with supply chain activities, including the standardization, purchase, lease, license and acquisition of equipment, materials, supplies, services, software, intellectual property and other assets, as well as shipping, storage and disposition of same. The Company will also render advice and assistance to the Client in connection with the negotiation of the purchase, sale, acquisition or disposition of assets and services and the placing of purchase orders for the account of the Client.

20 *Rate Services.* The Company will advise and assist the Clients in all rate matters, including the design and preparation of schedules and tariffs, the analysis of rate filings of producers and pipeline suppliers, and the preparation and presentation of testimony and exhibits to regulatory authorities.

21 *Tax Services.* The Company will advise and assist the Clients in tax matters, in the preparation of tax returns and in connection with proceedings relating to taxes.

22 *Transportation Services.* The Company will advise and assist the Clients in connection with the purchase, lease, operation and maintenance of motor vehicles and the operation of aircraft owned or leased by the Company or the Clients.

23 *Treasury Services.* The Company provides services such as cash management, long and short term financing for NiSource and all Clients, investment of temporarily available cash, retirement of long term debt, investment management oversight of all benefits plans, special economic studies as requested, and support for various regulatory proceedings, as requested.

24 *Land/Surveying Services.* The Company will provide land asset management, land contract management, and surveying services in connection with Clients' acquisition, leasing, maintenance, and disposal of interests in real property, including the maintenance of land records and the recording of instruments relating to such interests in real property, where necessary.

25 *Customer Billing, Collection, and Contact Services.* The Company will render calculating, bill exception processing, back office processing, posting, printing, inserting, mailing and related services to Client associated with the preparation and issuance of customer bills, notices, inserts and similar mailings. The Company will provide cash processing, revenue recovery, account reconciliations and adjustments, and related services to Client associated with the collection of revenue and management of accounts receivable. The Company will provide customer contact and related services to Client, including customer contact center management, operation and administration; management of key customer relationships; communications associated with the commencement, transfer, maintenance and disconnection of service; sales of optional products and services; the receipt and processing of emergency calls; the handling of customer complaints; and responses to customer billing, credit, collection, order take and inquiry, outage, meter reading, retail choice and other inquiries.

26 *Miscellaneous Services.* The Company will render to any Client such other services, not hereinabove described, as may properly be rendered by the Company to such Client

within the meaning and intent of the Public Utility Holding Company Act of 1935 and any other applicable statutes and the orders, rules and regulations of the Securities and Exchange Commission and any other governmental bodies having jurisdiction, as from time to time the Company may be equipped to render and such Client may desire to have performed.

ARTICLE 3

ALLOCATION METHODS

1 *Specific Direct Salary Charges to Clients.* To the extent that time spent by the officers and employees of the Company rendering services hereunder is related to services rendered to a specific Client, a direct salary charge, computed as provided in Article 4, shall be made to such Client.

2 *Apportioned Direct Salary Charges to Clients.* To the extent that the time spent by such officers and employees is related to services rendered to the Clients generally, or to any specified group of the Clients, a direct salary charge, computed as provided in Article 4, shall be made to the Clients generally, or to such specified group of the Clients, and allocated to each such Client using an allocation method approved by the Securities and Exchange Commission as set forth on Exhibit A hereto.

3 *Direct Salary Charges for Services to the Company.* To the extent that time spent by any officer or employee of the Company is related to services rendered to the Company, a direct salary charge computed as provided in Article 4 shall be allocated among the Clients in the same proportions which the direct salary charges to such Clients made pursuant to Sections 1 and 2 of this Article III, for services of officers and employees, bear to the aggregate of such direct salary charges.

4 *Apportionment of Employee Benefits.* The employee benefit expenses which are related to direct salary charges made pursuant to sub-paragraphs (1), (2) and (3) of Article 3 shall be apportioned among the Clients, as applicable, in the proportions which the respective direct salary charges made pursuant to the rendering of such services to each such Client bear to the aggregate of such direct salary charges.

5 *Other Expenses.* All expenses, other than salaries and employee benefit expenses incurred by the Company in connection with services rendered to a specific Client shall be charged directly to such Client. All such expenses incurred by the Company in connection with services rendered to the Clients generally or to any specified group of Clients shall be apportioned in the manner set forth in Section 2 of this Article 3 for the apportionment of salary charges. All such expenses incurred by the Company in connection with services rendered to the Company shall be apportioned in the manner set forth in Section 3 of this Article 3 for the apportionment of salary charges.

ARTICLE 4

COMPUTATION OF SALARY CHARGES

Direct Salary Charges The direct salary charge per hour which shall be made for the time of any officer or employee for services rendered in any calendar month shall be computed by dividing his total compensation for such month by the aggregate of (1) the number of scheduled working hours for which he was compensated, including hours paid for but not worked, and (2) hours worked in excess of his regular work schedule, whether or not compensated for.

Exhibit A

BASES OF ALLOCATION

The SEC approved Bases of Allocation shown below will be used by the Corporate Services Accounting Department for apportioning Job Order charges to affiliates. Any change in an allocation method that causes either a $50,000 or 5% change in the cost that would be charged to a company must be brought to the SEC for approval under the 60-Day Letter process.

BASIS 1

GROSS FIXED ASSETS AND TOTAL OPERATING EXPENSES

- Fifty percent of the total job order charges will be allocated on the basis of the relation of the affiliate's gross fixed assets to the total gross fixed assets of all benefited affiliates; the remaining 50% will be allocated on the basis of the relation of the affiliate's total operating expenses to the total operating expenses of all benefited affiliates. All companies may be included in this allocation.

BASIS 2

GROSS FIXED ASSETS

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its total gross fixed assets to the sum of the total gross fixed assets of all benefited affiliates. All companies may be included in this allocation.

BASIS 7

GROSS DEPRECIABLE PROPERTY AND TOTAL OPERATING EXPENSE

- Fifty percent of the total job order charges will be allocated on the basis of the relation of the affiliate's total operating expenses to the total of all the benefited affiliates' total operating expense; the remaining 50% will be allocated on the basis of the relation of the affiliate's gross depreciable property to the gross depreciable property of all benefited affiliates. All companies may be included in this allocation.

BASIS 8

GROSS DEPRECIABLE PROPERTY

- Job order charges will be allocated to each benefited affiliate on the basis of the relationship of its total depreciable property to the sum of the total depreciable property of all benefited affiliates. All companies may be included in this allocation.

BASIS 9

AUTOMOBILE UNITS

- Job order charges will be allocated to each benefited affiliate on the basis of its number of automobile units to the total number of all automobile units of the benefited affiliates. All companies may be included in this allocation.

BASIS 10

NUMBER OF RETAIL CUSTOMERS

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its number of retail customers to the total number of all retail customers of the benefited affiliates. All companies may be included in this allocation.

BASIS 11

NUMBER OF REGULAR EMPLOYEES

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its number of regular employees to the total number of all regular employees of the benefited affiliates. All companies may be included in this allocation.

BASIS 13

FIXED ALLOCATION

- Job order charges will be allocated to each benefitted affiliate on the basis of fixed percentages on an individual project basis. All companies may be included in this allocation.

BASIS 14

NUMBER OF TRANSPORTATION CUSTOMERS

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its Transportation Customers to the total of all Transportation Customers of the benefited affiliates. This allocation is only used by the following companies: Columbia Gas of Virginia, Columbia Gas of Kentucky, Columbia Gas of Ohio, Columbia Gas of Pennsylvania and Columbia Gas of Maryland.

BASIS 15

NUMBER OF COMMERCIAL CUSTOMERS

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its Commercial Customers to the total of all Commercial Customers of the benefited affiliates. This allocation is only used by the following companies: Columbia Gas of Virginia, Columbia Gas of Kentucky, Columbia Gas of Ohio, Columbia Gas of Pennsylvania and Columbia Gas of Maryland.

BASIS 16

NUMBER OF RESIDENTIAL CUSTOMERS

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its Residential Customers to the total of all Residential Customers of the benefited affiliates. This allocation is only used by the following companies: Columbia Gas of Virginia, Columbia Gas of Kentucky, Columbia Gas of Ohio, Columbia Gas of Pennsylvania and Columbia Gas of Maryland.

BASIS 17

NUMBER OF HIGH PRESSURE CUSTOMERS

- Job order charges will be allocated to each benefited affiliate on the basis of the relation of its High Pressure Customers to the total of all High Pressure Customers of the benefited affiliates. This allocation is only used by the following companies: Columbia Gas of Virginia, Columbia Gas of Kentucky, Columbia Gas of Ohio, Columbia Gas of Pennsylvania and Columbia Gas of Maryland.

BASIS 20

DIRECT COSTS

- Job order charges will be allocated to each benefitted affiliate on the basis of the relation of its direct costs billed by Service Corporation to the total of all direct costs billed by Service Corporation. All companies may be included in this allocation.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-52:

Please provide the annual level of outside services employed for the preceding three calendar years. Include in your response a breakdown of the test year amount indicating the service provider and the type of service performed.

Response:

Attachment GAS-RR-52 provides details regarding outside services costs incurred for calendar years 2009, 2010 and 2011 as well as the historic test year ended May, 2012. Attachment A provides the information of costs charged to Operation and Maintenance expense and Attachment B provides information on costs charged to capital and other accounts (or stated another way charged to non-operation and maintenance accounts).

Columbia Gas of Pennsylvania
Outsides Services Detailed by Cost Account
Amounts Charged to Operation and Maintenance Expense

Line No.	Cost Activity Description	Twelve Months Ended December 2009	Twelve Months Ended December 2010	Twelve Months Ended December 2011	Twelve Months Ended May 2012
1	CURRENT COLLECTION FEES	984.86	62.33	7.48	13.23
2	CHECKFREE SERVICE CHARGE	8.75			
3	DELINQUENT COLLECTION FEES	260,520.96	2,173.43	(7,156.00)	(5,453.63)
4	CREDIT REPORTS AND INVESTIGATIONS	38,411.58			
5	LOCKBOX SERVICE CHARGES	216,922.44			
6	OTHER SERVICE CHARGES	31,124.42	5,452.23	1,691.00	2,872.67
7	COURIER SERVICES(UPS, FEDEX, ETC.)	23,578.47	24,194.32	35,390.47	36,980.42
8	DESTRUCTION OF COMPANY RECORDS		545.00		
9	STORAGE SERVICES			1,175.00	1,650.00
10	CUSTOMER SATISFACTION TRACKING	7,740.00	10,756.00	9,248.00	9,248.00
11	CONTRACT METER READING	1,176,191.05	1,177,206.99	1,594,716.60	1,245,440.92
12	MAIN LINE INSTALLATION	62,402.21	27,634.78	35,632.95	81,688.14
13	SERVICE LINE INSTALLATION	34,293.57	13,604.08	43,218.02	29,589.60
14	CORROSION - CAPITAL	9,400.00	6,470.00	2,872.20	1,393.20
15	METERS AND REGULATORS	1,151.96	323.50		(552.00)
16	CAPITAL PROJ NOT OTHERWISE IDENTIFD	62,528.93	118,028.28	818,616.85	558,319.45
17	INSPECTION	630,540.81	567,529.88	586,177.34	690,261.72
18	LOCATING	1,011,665.97	1,314,087.35	1,272,200.00	931,120.63
19	ONE - CALL SYSTEM	147,859.38	132,032.10	131,262.25	118,550.05
20	INSIDE LEAKAGE & CORROSION INSPECT	135,859.25	129,879.50	103,430.00	237,815.25
21	LABORATORY TESTING	2,074.72	9,390.06	40,900.00	41,192.48
22	OPER ACTIV NOT OTHERWISE IDENTIFIED	32,336.45	37,365.28	62,367.86	50,668.72
23	LEAK REPAIR	595,245.65	815,462.60	986,246.44	637,831.57
24	REGULATOR BUILDINGS AND LOTS	6,291.74	90,404.43	69,227.25	71,345.25
25	CORROSION - MAINTENANCE	170,535.30	612,911.18	323,179.43	217,322.68
26	CLEAR RIGHT - OF - WAY	613,261.93	649,527.39	90,357.20	117,040.85
27	RECONNECT SERVICE LINES	51,642.08	91,029.18	180,563.13	140,720.48
28	MAINT ACTIV NOT OTHERWISE IDENTIFID	109,380.63	203,308.40	177,825.84	82,837.73
29	APPLIANCE REPAIR	873.75	165.00		(163.41)
30	CUST SERV NOT OTHERWISE IDENTIFIED	19,755.98	26,437.86	738,471.06	727,904.54
31	PAVING RESTORATION	3,227,985.68	2,372,773.94	2,466,937.50	2,842,633.07
32	SEED AND SOD	183,076.89	210,786.51	244,273.80	220,881.79
33	TRAFFIC CONTROL	4,696.54	8,038.29	16,091.80	37,447.30
34	DAMAGE TO PROPERTY OF OTHERS	9,076.50	9,637.90	13,293.64	14,924.80
35	COMP FACILITIES DAMAGED BY OTHERS	11,302.92	9,067.40	8,703.50	7,739.91
36	PROPANE PLANT -OPERATION AND MAINTE			106.40	106.40
37	OPERATIONS MAPPING	490.76	476.13		
38	OPER SVCS NOT OTHERWISE IDENTIFIED	5,052.41	49,237.93	60,683.51	31,860.48
39	ENVIRONMENTAL LAB ANALYSIS&EPA FEES	37,132.19	34,049.98	45,341.87	37,511.66
40	ECONOMIC FORECASTING SERVICE	10,090.39	9,133.47	1,793.73	1,793.73
41	ENVIRONMENTL HAZ/SPE WASTE DISPOSAL	21,488.53	11,959.46	4,511.53	8,220.75
42	FINANCIAL STATEMENT REVIEW	470,379.96	500,493.75	391,585.73	446,136.23
43	SPECIAL STUDY	5,705.00	11,370.03	7,195.24	9,888.74
44	CONSULTANT EXPENSES	220,487.10	587,002.61	414,000.38	395,664.88
45	BENEFITS ADMINISTRATION	310,985.79	312,449.00	376,800.02	354,744.67
46	ENVIRONMENTAL CONSULTING	77,314.31	38,238.97	47,519.29	42,948.02
47	REGULATORY LEGAL EXPENSES	2,630.00	8,095.30	654,537.79	501,173.47
48	LEGAL OUTSIDE FEES - NON REGULATORY		4,977.18	(7,594.13)	(7,594.13)
49	LEGAL NOTICES		50,893.36		
50	EXPERT WITNESSES & CONSULTANTS		10,872.90		
51	MEDICAL EXAMINATIONS	46,284.50	68,468.17	99,113.85	77,999.85
52	PRE-EMPLOYMENT PHYSICAL EXAMINATION	1,348.95			2,001.92
53	EMPLOYEE HEARING TESTS	150.00	164.50		
54	DRIVERS D.O.T.PHYSICAL EXAMINATIONS	35,386.75	33,816.99	2,661.00	2,504.00
55	DRUG TESTING		20.00	20.00	8,493.22
56	SHORT TERM TEMPORARY EMPLOYEES	343,635.48	300,543.02	148,799.38	172,223.25
57	SEASONAL TEMPORARY EMPLOYEES	31,448.62	101,328.18	143,981.14	137,989.30
58	SPECIAL DUTY POLICE OFFICERS	12,984.10	19,014.68	10,590.74	17,307.43
59	CONTRACT EMPLOYEE SERVICES	6,192.74	7,974.50	9,832.25	12,131.75
60	OUTSIDE FOOD SERVERS		219.38		

Columbia Gas of Pennsylvania
Outsides Services Detailed by Cost Account
Amounts Charged to Operation and Maintenance Expense

Line No.	Cost Activity Description	Twelve Months Ended December 2009	Twelve Months Ended December 2010	Twelve Months Ended December 2011	Twelve Months Ended May 2012
61	EMPLOYEE TRAINING	80,737.65	71,010.17	138,347.59	131,569.12
62	EMPLOYMENT ADVERTISING	1,096.00	2,962.93	6,618.91	12,981.54
63	EMPLOYMENT CONSULTANTS	2,728.38		1,137.50	1,137.50
64	PRINTING	233,546.94	139,322.05	124,539.94	73,755.37
65	GRAPHIC DESIGN	176,308.43	13,915.45		
66	BLUEPRINT DUPLICATION	0.49			
67	LITERATURE DISTRIBUTION	81,294.68	22,346.63	91,663.15	107,766.91
68	NEWS MONITORING	(29,049.98)	501.86	169.00	
69	FILM, VIDEO AND AUDIO SERVICES	(41,060.34)	72,615.91	11,772.10	10,840.66
70	GRAPHIC PRESENTATIONS			800.00	
71	ENGRAVING	3,415.43			
72	DISPATCH PRINTING	3,180.00			
73	MKT ADMINISTRATIVE EXPENSES	251.60	826.32		
74	DATA TRACKING & UPDATE	2,000.48	1,561.33	2,217.74	2,654.84
75	PROGRAMS & PROMOTIONS	1,820.68			
76	CAP ADMINISTRATION COSTS	210,553.00	274,509.00	197,200.00	266,295.00
77	CAP INITIAL APPLICATION	138,955.00	121,020.00	166,432.00	122,463.00
78	CAP REVERIFICATION		8,800.00		3,060.00
79	CAP EDUCATION	8,380.66	6,186.00	5,120.94	3,640.00
80	CONSERVATION CONSULTANTS ADMIN COST	4,333.62	15,084.42	20,810.10	7,533.08
81	CCI INSTALLATION				
82	WEATHERIZATION/RCS EXPENSES	3,216,206.39	3,232,876.01	3,277,317.95	2,760,717.22
83	R & D CONTRACT SERVICES		135,000.00		165,000.00
84	COMMUNICATION TOWER MAINTENANCE	477.00			
85	JANITOR SERVICES	117,021.69	98,392.54	121,625.42	105,254.60
86	WASTE MANAGEMENT SERVICES	45,265.29	41,169.40	45,007.64	40,358.49
87	SNOW REMOVAL	828.08	4,044.00	2,545.00	
88	OPERATION (LAWN CARE, SNOW REMOVAL)	64,582.91	26,890.72	21,342.80	20,934.42
89	MAINTENANCE	113,005.96	172,423.32	160,205.63	163,881.91
90	BUILDING AND PROPERTY SECURITY	4,237.04	11,333.21	10,916.19	5,172.44
91	OUTSIDE FOOD SERVICE	6,270.13	13,157.73	11,355.04	11,840.59
92	OUTSIDE LAUNDRY SERVICES	3,155.96	14,187.88	15,153.58	10,492.90
93	RELOCATION OF COMPANY FACILITIES	1,012.94	742.15		
94	MATERIAL HANDLING SERVICES	540.19	16.24	13,644.21	15,155.78
95	REPAIR OF FURNISHINGS	9,400.46	11,015.94	14,004.80	12,853.12
96	REPAIR OF INSTRUMENTS	19,469.61	23,907.70	10,771.32	16,490.72
97	REPAIR OF TOOLS	71,029.18	53,241.90	33,632.03	34,541.55
98	REPAIR OF OFFICE MACHINES	1,343.50	579.37	2,989.80	2,423.23
99	EDP MAINTENANCE AGREEMENTS	22,174.55	15,130.31	96.93	96.93
100	DUPLICATING MAINTENANCE AGREEMENTS	11.13	9.90		
101	OFFICE MACHINES MAINT AGREEMENTS	57,360.95	65,629.68	48,618.19	38,323.88
102	COMPANY VEHICLE TOWING COSTS			250.00	440.00
103	SERVICE/REPAIRS TO COMPANY VEHICLES	481.06	1,192.84	8,147.23	
104	SERVICE/REPAIRS TO CUST VEHICLE				291.35
105	STATE INSPECTION CLASS A		600.00		
106	DOT INSPECTION		243.50		
107	PROGRAMMING SERVICES	11,968.57			
108	EXTERNAL COMPUTING SERVICES	7,281.83	7,145.80	20,205.80	20,335.43
109	CONTRACTS (UNDETERMINED)	6,944.19			
110					
111	Total	15,186,470.28	15,516,676.89	17,043,058.86	15,570,672.61

Columbia Gas of Pennsylvania
Outsides Services Detailed by Cost Account
Amounts Charged to Capital and Other Accounts

Line No.	Cost Activity Description	Twelve Months Ended December 2009	Twelve Months Ended December 2010	Twelve Months Ended December 2011	Twelve Months Ended May 2012
1	CURRENT COLLECTION FEES	2.14	10.99	0.27	2.33
2	CHECKFREE SERVICE CHARGE	1.15			
3	DELINQUENT COLLECTION FEES		25.00		
4	OTHER SERVICE CHARGES	45.24	97,348.03	81,951.60	20,472.37
5	COURIER SERVICES(UPS, FEDEX, ETC.)	(8.19)	179.34	427.16	248.24
6	STORAGE SERVICES				110,500.00
7	MAIN LINE INSTALLATION	16,115,648.52	19,878,508.79	36,169,458.43	38,760,619.47
8	SERVICE LINE INSTALLATION	5,649,517.04	6,734,172.67	9,402,672.53	10,576,435.28
9	CORROSION - CAPITAL	13,212.65	44,685.93	561.12	3,267.33
10	METERS AND REGULATORS	350,501.80	406,263.71	788,206.15	800,449.39
11	TELECOMMUNICTN CAPITAL INSTALLATN	1,997.69	230.00	432.00	432.00
12	CAPITAL PROJ NOT OTHERWISE IDENTIFD	1,466,239.05	1,245,259.34	3,319,617.10	3,884,473.83
13	INSPECTION	27,307.74	21,876.08	106,441.65	138,328.06
14	LOCATING	224,921.92	156,798.49	209,967.19	167,950.15
15	ONE - CALL SYSTEM	45,609.05	15,840.34	28,960.01	40,780.63
16	LABORATORY TESTING	5,489.51	55.48	21,226.14	2,824.10
17	OPER ACTIV NOT OTHERWISE IDENTIFIED	1,140.02	2,470.21		235.00
18	LEAK REPAIR	9,259.70	39,951.57	79,280.14	73,127.89
19	REGULATOR BUILDINGS AND LOTS	70,651.73	18,248.18	25,536.75	11,007.75
20	CORROSION - MAINTENANCE	250.00	457.25		
21	CLEAR RIGHT - OF - WAY	51,528.92	52,712.01	44,699.26	18,152.70
22	RECONNECT SERVICE LINES	2,808,001.16	2,994,672.10	5,932,043.73	6,264,195.52
23	MAINT ACTIV NOT OTHERWISE IDENTIFID	12,966.54	54,189.57	23,120.68	21,420.33
24	APPLIANCE REPAIR			269.90	253.31
25	CUST SERV NOT OTHERWISE IDENTIFIED	209,221.63	10,152.00	162,939.30	276,456.76
26	PAVING RESTORATION	10,189,530.66	7,943,261.83	18,255,100.29	22,157,843.54
27	SEED AND SOD	876,323.67	527,372.43	487,793.80	715,750.08
28	TRAFFIC CONTROL	149,611.98	56,492.20	140,166.29	296,275.89
29	DAMAGE TO PROPERTY OF OTHERS	29,398.21	29,637.87	26,020.54	25,328.24
30	COMP FACILITIES DAMAGED BY OTHERS			1,170.91	
31	GAS AIR BLENDING	1,219.23			
32	OPERATIONS MAPPING	490.76			
33	OPER SVCS NOT OTHERWISE IDENTIFIED	2,371.56	7,578.89	31,158.75	942.49
34	ENVIRONMENTAL LAB ANALYSIS&EPA FEES	13,105.02	11,160.21	6,934.90	6,965.10
35	ENVIRONMENTL HAZ/SPE WASTE DISPOSAL	6,546.57	3,080.44	4,854.70	6,075.06
36	CONSULTANT EXPENSES	114,081.81	122,812.86	75,528.48	570,864.56
37	ENVIRONMENTAL CONSULTING	85,585.31	7,071.48	6,944.60	5,899.60
38	LEGAL NOTICES	545.00			
39	EXPERT WITNESSES & CONSULTANTS	(3,379.29)			
40	SHORT TERM TEMPORARY EMPLOYEES	467,697.51	131,662.29	90,282.26	62,765.12
41	SEASONAL TEMPORARY EMPLOYEES	10,992.47	2,071.50	4,696.96	4,696.96
42	SPECIAL DUTY POLICE OFFICERS	5,252.92	24,289.56	20,952.83	36,975.01
43	CONTRACT EMPLOYEE SERVICES			2,780,395.85	3,143,870.72
44	OUTSIDE FOOD SERVERS		73.12		
45	EMPLOYEE TRAINING	1,189.71	5,148.58	27,488.62	36,328.58
46	EMPLOYMENT ADVERTISING	844.58	100.00		
47	PRINTING	22,439.09	16,234.44	6,766.65	3,538.69

Columbia Gas of Pennsylvania
Outsides Services Detailed by Cost Account
Amounts Charged to Capital and Other Accounts

Line No.	Cost Activity Description	Twelve Months Ended December 2009	Twelve Months Ended December 2010	Twelve Months Ended December 2011	Twelve Months Ended May 2012
48	BLUEPRINT DUPLICATION	23.25			
49	FILM, VIDEO AND AUDIO SERVICES	3.86			
50	MKT ADMINISTRATIVE EXPENSES	44.40			
51	TELEPHONE ANSWERING SERVICES			1,170.18	1,170.18
52	JANITOR SERVICES	521.26	192.37	216.00	216.00
53	WASTE MANAGEMENT SERVICES	5,073.10	5,286.79	21,047.02	31,064.12
54	SNOW REMOVAL	38.48			
55	OPERATION (LAWN CARE, SNOW REMOVAL)	6,996.83	7,947.39	4,381.02	4,645.75
56	MAINTENANCE	159,697.41	103,878.33	689,912.13	665,689.01
57	BUILDING AND PROPERTY SECURITY	11,689.87	153,615.45	29,833.18	22,571.97
58	OUTSIDE FOOD SERVICE	12.60	1,912.83		226.11
59	OUTSIDE LAUNDRY SERVICES	460.80	1,371.10	1,742.69	1,556.12
60	RELOCATION OF COMPANY FACILITIES	178.76	65,314.19	9.17	
61	MATERIAL HANDLING SERVICES	90.75		464.18	4,958.00
62	REPAIR OF FURNISHINGS	349.50	112.63	3,319.53	13.26
63	REPAIR OF INSTRUMENTS		255.55	213.50	
64	REPAIR OF TOOLS	3,578.25	3,220.24	1,866.49	1,852.05
65	REPAIR OF OFFICE MACHINES	324.67	102.24	99.98	
66	EDP MAINTENANCE AGREEMENTS	6,613.12	5,800.00	10,578.64	4,216.79
67	DUPLICATING MAINTENANCE AGREEMENTS	510.33	514.21		
68	OFFICE MACHINES MAINT AGREEMENTS				28,008.30
69	COMPANY VEHICLE TOWING COSTS	3,547.00	1,160.68		
70	SERVICE/REPAIRS TO COMPANY VEHICLES	1,774,842.46	1,402,721.10	1,596,966.24	1,663,536.71
71	ARI FLEET SERVICE FEE	39,505.71	51,931.39	90,247.98	91,869.43
72	STATE INSPECTION CLASS A	1,637.57	1,018.37	9,841.09	9,782.88
73	DOT INSPECTION				120.28
74	SYSTEM DEVELOPMENT COSTS		140,412.21	80,995.75	22,237.05
75	PROGRAMMING SERVICES	6,855.30	290,894.78	30,855.95	11,098.48
76	PERSONAL COMPUTER INSTALLATION SERV			14,035.69	
77					
78	Total	41,059,947.06	42,899,816.63	80,951,863.95	90,810,584.57

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-53:

Please describe each budgeted or planned cost savings program to be implemented during the historic or future year. Please identify the cost of implementing the program and the anticipated annual savings.

Response:

The utility neither experienced nor does it anticipate implementation of cost saving programs in either the historic or future years. The company has not identified any specific costs of implementation of such programs or anticipated savings in this filing. Columbia does implement process improvements gained through technology or other efficiencies as a course of business when found not to jeopardize the delivery of safe and reliable service.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-54:

Please explain how the Company has treated reserve accruals and balances for ratemaking purposes and provide the requested level of any self-funded reserve accruals by type of item.

Response:

The Company has not made any rate making adjustments based on self funded reserve accruals.

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-55:

Please provide a copy of the corporate federal tax returns and supporting schedules for the preceding three years and, if applicable, a copy of the calculation work papers for the Company's consolidated tax savings adjustment.

Response:

Enclosed are copies of the corporate federal tax returns for 2008 (GAS-RR-55 Attachment A), 2009 (GAS-RR-55 Attachment B) and 2010 (GAS-RR-55 Attachment C). Workpapers relating to the Company's consolidated tax savings are included in the Standard Filing Requirements as Exhibit No. 7 (26) Pages 2-4.

Form **1120**

Department of the Treasury
Internal Revenue Service

U.S. Corporation Income Tax Return

For calendar year 2008 or tax year beginning _____ ending _____

▶ See separate instructions.

OMB No. 1545-0123

2008

A Check if:
1a Consolidated return (attach Form 851) . ☐
b Life/nonlife consolidated return . . . ☐
c Personal holding co. (attach Sch. PH) . ☐
3 Personal service corp. (see instr) . . ☐
4 Schedule M-3 attached . . . . . ☒

Use IRS label. Other-wise, print or type.

Name: COLUMBIA GAS OF PENNSYLVANIA INC

Number, street, and room or suite no. If a P.O. box, see instructions.: 200 CIVIC CENTER DRIVE

City or town, state, and ZIP code: COLUMBUS OH 43215

B Employer identification number: 25-1100252

C Date incorporated: 06/23/1960

D Total assets (see instructions): $ 1,109,226,841

E Check if: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change

Income	1a	Gross receipts or sales 778,642,852 b Less returns and allowances _____ c Bal ▶	1c	778,642,852
	2	Cost of goods sold (Schedule A, line 8)	2	579,115,304
	3	Gross profit. Subtract line 2 from line 1c	3	199,527,548
	4	Dividends (Schedule C, line 19)	4	0
	5	Interest See Stmt 1	5	5,747,687
	6	Gross rents	6	154,707
	7	Gross royalties	7	
	8	Capital gain net income (attach Schedule D (Form 1120))	8	0
	9	Net gain or (loss) from Form 4797, Part II, line 17 (attach Form 4797)	9	-3,030,110
	10	Other income (see instructions - attach schedule) See Stmt 2	10	6,282,623
	11	**Total income.** Add lines 3 through 10 ▶	11	208,682,455
Deductions (See instructions for limitations)	12	Compensation of officers (Schedule E, line 4) ▶	12	0
	13	Salaries and wages (less employment credits)	13	23,697,234
	14	Repairs and maintenance	14	56,172,987
	15	Bad debts	15	37,854,480
	16	Rents See Stmt 3	16	3,608,293
	17	Taxes and licenses See Stmt 4	17	3,207,162
	18	Interest See Stmt 5	18	16,436,426
	19	Charitable contributions	19	
	20	Depreciation from Form 4562 not claimed on Schedule A or elsewhere on return (attach Form 4562)	20	31,283,230
	21	Depletion	21	
	22	Advertising	22	1,119,926
	23	Pension, profit-sharing, etc., plans	23	2,534,885
	24	Employee benefit programs	24	3,941,255
	25	Domestic production activities deduction (attach Form 8903)	25	
	26	Other deductions (attach schedule) See Stmt 6	26	201,647,242
	27	**Total deductions.** Add lines 12 through 26 ▶	27	381,503,120
	28	Taxable income before net operating loss deduction and special deductions. Subtract line 27 from line 11	28	-172,820,665
	29	Less: a Net operating loss deduction (see instructions) 29a _____		
		b Special deductions (Schedule C, line 20) 29b 0	29c	0
	30	**Taxable income.** Subtract line 29c from line 28 (see instructions)	30	-172,820,665
Tax, Refundable Credits, and Payments	31	**Total tax** (Schedule J, line 10)	31	
	32a	2007 overpayment credited to 2008 32a _____		
	b	2008 estimated tax payments 32b _____		
	c	2008 refund applied for on Form 4466 32c ( ) d Bal ▶ 32d _____		
	e	Tax deposited with Form 7004 32e _____		
	f	Credits: (1) Form 2439 _____ (2) Form 4136 _____ 32f _____		
	g	Refundable credits from Form 3800, line 19c, and Form 8827, line 8c 32g _____	32h	
	33	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐	33	
	34	**Amount owed.** If line 32h is smaller than the total of lines 31 and 33, enter amount owed	34	
	35	**Overpayment.** If line 32h is larger than the total of lines 31 and 33, enter amount overpaid	35	
	36	Enter amt from line 35 you want: **Credited to 2009 estimated tax** ▶ **Refunded** ▶	36	

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature of officer _____ Date _____ Title _____

May the IRS discuss this return with the preparer shown below (see instr)? ☐ Yes ☐ No

Paid Preparer's Use Only

Preparer's signature _____ Date _____ Check if self-employed ☐ Preparer's SSN or PTIN _____

Firm's name (or yours if self-employed), address, and ZIP code _____ EIN _____ Phone no. _____

Schedule A Cost of Goods Sold (see instructions)

1	Inventory at beginning of year	1	66,974,998
2	Purchases	2	609,128,137
3	Cost of labor	3	
4	Additional section 263A costs (attach schedule)	4	0
5	Other costs (attach schedule)	5	0
6	Total. Add lines 1 through 5	6	676,103,135
7	Inventory at end of year	7	96,987,831
8	Cost of goods sold. Subtract line 7 from line 6. Enter here and on page 1, line 2	8	579,115,304

9 a Check all methods used for valuing closing inventory:
- (i) ☒ Cost
- (ii) ☐ Lower of cost or market
- (iii) ☐ Other (Specify method used and attach explanation.) ▶

b Check if there was a writedown of subnormal goods ▶ ☐

c Check if the LIFO inventory method was adopted this tax year for any goods (if checked, attach Form 970) ▶ ☐

d If the LIFO inventory method was used for this tax year, enter percentage (or amounts) of closing inventory computed under LIFO — 9d

e If property is produced or acquired for resale, do the rules of section 263A apply to the corporation? ☒ Yes ☐ No

f Was there any change in determining quantities, cost, or valuations between opening and closing inventory? If "Yes," attach explanation ☐ Yes ☒ No

Schedule C Dividends and Special Deductions (see instructions)

		(a) Dividends received	(b) %	(c) Special deductions (a) x (b)
1	Dividends from less-than-20%-owned domestic corporations (other than debt-financed stock)		70	
2	Dividends from 20%-or-more-owned domestic corporations (other than debt-financed stock)		80	
3	Dividends on debt-financed stock of domestic and foreign corporations		see instructions	
4	Dividends on certain preferred stock of less-than-20%-owned public utilities		42	
5	Dividends on certain preferred stock of 20%-or-more-owned public utilities		48	
6	Dividends from less-than-20%-owned foreign corporations and certain FSCs		70	
7	Dividends from 20%-or-more-owned foreign corporations and certain FSCs		80	
8	Dividends from wholly owned foreign subsidiaries		100	
9	Total. Add lines 1 through 8. See instructions for limitation			0
10	Dividends from domestic corporations received by a small business investment company operating under the Small Business Investment Act of 1958		100	
11	Dividends from affiliated group members		100	
12	Dividends from certain FSCs		100	
13	Dividends from foreign corporations not included on lines 3, 6, 7, 8, 11, or 12			
14	Income from controlled foreign corporations under subpart F (attach Form(s) 5471)			
15	Foreign dividend gross-up			
16	IC-DISC and former DISC dividends not included on lines 1, 2, or 3			
17	Other dividends			
18	Deduction for dividends paid on certain preferred stock of public utilities			
19	Total dividends. Add lines 1 through 17. Enter here and on page 1, line 4 ▶	0		
20	Total special deductions. Add lines 9, 10, 11, 12, and 18. Enter here and on page 1, line 29b ▶			0

Schedule E Compensation of Officers (see instructions for page 1, line 12)

Note: Complete Schedule E only if total receipts (line 1a plus lines 4 through 10 on page 1) are $500,000 or more.

	(a) Name of officer	(b) Social security number	(c) Percent of time devoted to business	Percent of corporation stock owned (d) Common	(e) Preferred	(f) Amount of compensation
1			%	%	%	
			%	%	%	
			%	%	%	
			%	%	%	
			%	%	%	
2	Total compensation of officers					0
3	Compensation of officers claimed on Schedule A and elsewhere on return					
4	Subtract line 3 from line 2. Enter the result here and on page 1, line 12					0

Schedule J Tax Computation (see instructions)

1	Check if the corporation is a member of a controlled group (attach Schedule O (Form 1120)) ▶ ☐			
2	Income tax. Check if a qualified personal service corporation (see instructions) ▶ ☐		2	
3	Alternative minimum tax (attach Form 4626)		3	
4	Add lines 2 and 3		4	
5a	Foreign tax credit (attach Form 1118)	5a		
b	Credit from Form 8834	5b		
c	General business credit (attach Form 3800)	5c		
d	Credit for prior year minimum tax (attach Form 8827)	5d		
e	Bond credits from Form 8912	5e		
6	**Total credits.** Add lines 5a through 5e		6	
7	Subtract line 6 from line 4		7	
8	Personal holding company tax (attach Schedule PH (Form 1120))		8	
9	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Form 8902 ☐ Other (attach schedule)		9	
10	**Total tax.** Add lines 7 through 9. Enter here and on page 1, line 31		10	

Schedule K Other Information (see instructions)

		Yes	No
1	Check accounting method: a ☐ Cash b ☒ Accrual c ☐ Other (specify) ▶		
2	See the instructions and enter the:		
a	Business activity code no. ▶ 221210		
b	Business activity ▶ NATURAL GAS DISTRIBUTION		
c	Product or service ▶ NATURAL GAS DISTRIBUTION		
3	Is the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group?	X	
	If "Yes," enter name and EIN of the parent corporation ▶ NiSource Inc 35-2108964		
4	At the end of the tax year:		
a	Did any foreign or domestic corporation, partnership (including any entity treated as a partnership), or trust own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of the corporation's stock entitled to vote? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v).	X	

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Percentage Owned in Voting Stock
[redacted]bia Energy Group	13-1594808	C-Corp	US	100.0000%

b	Did any individual or estate own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of the corporation's stock entitled to vote? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (iv).		X

(i) Name of Individual or Estate	(ii) Identifying Number (if any)	(iii) Country of Citizenship (see instructions)	(iv) Percentage Owned in Voting Stock

Schedule K Continued

		Yes	No
5	At the end of the tax year, did the corporation:		
a	Own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of stock entitled to vote of any foreign or domestic corporation not included on **Form 851**, Affiliations Schedule? For rules of constructive ownership, see instructions		X

If "Yes," complete (i) through (iv).

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage Owned in Voting Stock

b	Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in any foreign or domestic partnership *(including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions*		X

If "Yes," complete (i) through (iv).

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Country of Organization	(iv) Maximum Percentage Owned in Profit, Loss, or Capital

6	During this tax year, did the corporation pay dividends (other than stock dividends and distributions in exchange for stock) in excess of the corporation's current and accumulated earnings and profits? (See sections 301 and 316.)		X
	If "Yes," file **Form 5452,** Corporate Report of Nondividend Distributions.		
	If this is a consolidated return, answer here for the parent corporation and on Form 851 for each subsidiary.		
7	At any time during the tax year, did one foreign person own, directly or indirectly, at least 25% of (a) the total voting power of all classes of the corporation's stock entitled to vote or (b) the total value of all classes of the corporation's stock?		X
	For rules of attribution, see section 318. If "Yes," enter:		
	(i) Percentage owned ▶ _____ and (ii) Owner's country ▶ _____		
	(c) The corporation may have to file **Form 5472,** Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business. Enter the number of Forms 5472 attached ▶ _____		
8	Check this box if the corporation issued publicly offered debt instruments with original issue discount . . . . . ▶ ☐		
	If checked, the corporation may have to file **Form 8281,** Information Return for Publicly Offered Original Issue Discount Instruments.		
9	Enter the amount of tax-exempt interest received or accrued during the tax year ▶$ NONE		
10	Enter the number of shareholders at the end of the tax year (if 100 or fewer) ▶ 1		
11	If the corporation has an NOL for the tax year and is electing to forego the carryback period, check here . . . . . ▶ ☐		
	If the corporation is filing a consolidated return, the statement required by Regulations section 1.1502-21(b)(3) must be attached or the election will not be valid.		
12	Enter the available NOL carryover from prior tax years (do not reduce it by any deduction on line 29a.) ▶$ _____		
13	Are the corporation's total receipts (line 1a plus lines 4 through 10 on page 1) for the tax year **and** its total assets at the end of the tax year less than $250,000?		X
	If "Yes," the corporation is not required to complete Schedules L, M-1, and M-2 on page 5. Instead, enter the total amount of cash *distributions and the book value of property distributions (other than cash) made during the tax year.* ▶$		

Schedule L Balance Sheets per Books

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
1 Cash		13,152,100		25,367,865
2 a Trade notes and accounts receivable	64,376,917		83,153,867	
b Less allowance for bad debts	(4,201,614)	60,175,303	(5,497,257)	77,656,610
3 Inventories		56,840,279		85,537,825
4 U.S. government obligations				
5 Tax-exempt securities (see instructions)				
6 Other current assets (attach schedule) See Stmt 7		64,855,569		76,469,694
7 Loans to shareholders				
8 Mortgage and real estate loans				
9 Other investments (attach schedule)		0		0
10 a Buildings and other depreciable assets	823,070,976		889,483,215	
b Less accumulated depreciation	(255,883,862)	567,187,114	(260,568,993)	628,914,222
11 a Depletable assets				
b Less accumulated depletion	( )		( )	
12 Land (net of any amortization)		1,959,505		2,030,678
13 a Intangible assets (amortizable only)	5,973,134		5,055,213	
b Less accumulated amortization	(3,773,581)	2,199,553	(3,327,631)	1,727,582
14 Other assets (attach schedule) See Stmt 8		135,426,827		211,522,365
15 Total assets		901,796,250		1,109,226,841
Liabilities and Shareholders' Equity				
16 Accounts payable		49,367,845		61,635,256
17 Mortgages, notes, bonds payable in less than 1 year				
18 Other current liabilities (attach schedule) See Stmt 9		111,940,917		196,047,552
19 Loans from shareholders See Stmt 10				
20 Mortgages, notes, bonds payable in 1 yr or more		263,215,000		285,215,000
21 Other liabilities (attach schedule) See Stmt 11		188,129,268		247,437,666
22 Capital stock: a Preferred stock				
b Common stock	45,127,800	45,127,800	45,127,800	45,127,800
23 Additional paid-in capital		7,223,795		7,466,504
24 Retained earnings - Appropriated (attach schedule)		0		0
25 Retained earnings - Unappropriated		236,791,625		266,297,063
26 Adjustments to shareholders' equity (attach schedule)		0		0
27 Less cost of treasury stock		( )		( )
28 Total liabilities and shareholders' equity		901,796,250		1,109,226,841

Schedule M-1 Reconciliation of Income (Loss) per Books With Income per Return

Note: Schedule M-3 required instead of Schedule M-1 if total assets are $10 million or more - see instructions

1 Net income (loss) per books		7 Income recorded on books this year not included on this return (itemize): Tax-exempt interest $	
2 Federal income tax per books			
3 Excess of capital losses over capital gains			
4 Income subject to tax not recorded on books this year (itemize):		8 Deductions on this return not charged against book income this year (itemize):	
5 Expenses recorded on books this year not deducted on this return (itemize):		a Depreciation $	
a Depreciation $		b Charitable contributions $	
b Charitable contributions $			
c Travel and entertainment $			
6 Add lines 1 through 5		9 Add lines 7 and 8	
		10 Income (page 1, line 28) - line 6 less line 9	

Schedule M-2 Analysis of Unappropriated Retained Earnings per Books (Line 25, Schedule L)

1 Balance at beginning of year	236,791,625	5 Distributions: a Cash	
2 Net income (loss) per books	29,505,438	b Stock	
3 Other increases (itemize):		c Property	
		6 Other decreases (itemize):	0
	0	7 Add lines 5 and 6	0
4 Add lines 1, 2, and 3	266,297,063	8 Balance at end of year (line 4 less line 7)	266,297,063

SCHEDULE B
(Form 1120)
(December 2008)
Department of the Treasury
Internal Revenue Service

Additional Information for Schedule M-3 Filers

▶ See Instructions
▶ Attach to Form 1120.

OMB No. 1545-0123

Name: COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number (EIN): 25-1100252

		Yes	No
1	Do the amounts reported on Schedule M-3 (Form 1120), Part II, lines 9 or 10, column (d), reflect allocations to this corporation from a partnership of income, gain, loss, deduction, or credit that are disproportionate to this corporation's capital contribution to the partnership or its ratio for sharing other items of the partnership?		X
2	At any time during the tax year, did the corporation sell, exchange, or transfer any interest in an intangible asset to a related person as definited in section 267(b)?		X
3	At any time during the tax year, did the corporation acquire any interest in an intangible asset from a related person as definited in section 267(b)?		X
4a	During the tax year, did the corporation enter into a cost-sharing arrangement with any related foreign party on whose behalf the corporation did not file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations?		X
b	At any time during the tax year, was the corporation a participant in a cost-sharing arrangement with any related foreign party on whose behalf the corporation did not file Form 5471?		X
5	At any time during the tax year, did the corporation make any change in accounting principle for financial accounting purposes? See Instructions for the definition of change in account principle		X
6	At any time during the tax year, did the corporation make any change in a method of accounting for U.S. income tax purposes?	X	
7	At any time during the tax year, did the corporation own any voluntary employees' beneficiary association (VEBA) trusts that were used to hold funds designated for employee benefits?	X	
8	At any time during the tax year, did the corporation use an allocation method for mixed-service costs that varied from the Federal Energy Regulatory Commission method of accounting?		X

Form **4136**
Department of the Treasury
Internal Revenue Service

Credit for Federal Tax Paid on Fuels

▶ See the separate instructions.
▶ Attach this form to your income tax return.

OMB No. 1545-0162

2008
Attachment Sequence No. 23

Name (as shown on your income tax return)

OLUMBIA GAS OF PENNSYLVANIA INC

Taxpayer identification number

25-1100252

Caution. Claimant has the name and address of the person who sold the fuel to the claimant and the dates of purchase. For claims on lines 1c and 2b (type of use 13 and 14), 3d, 4c, and 5, claimant has not waived the right to make the claim. For claims on lines 1c and 2b (type of use 13 and 14), claimant certifies that a certificate has not been provided to the credit card issuer.

1 Nontaxable Use of Gasoline

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Off-highway business use		$ .183		$	
b Use on a farm for farming purposes		.183			362
c Other nontaxable use (see Caution above line 1)		.183			
d Exported		.184			411

2 Nontaxable Use of Aviation Gasoline

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Use in commercial aviation (other than foreign trade)		$ .15/.000*		$	354
b Other nontaxable use (see Caution above line 1)		.193/.043*			324
c Exported		.194/.044*			412
d LUST tax on aviation fuels used in foreign trade		.001			433

*This rate applies after March 31, 2009.

3 Nontaxable Use of Undyed Diesel Fuel

Claimant certifies that the diesel fuel did not contain visible evidence of dye.
Exception. If any of the diesel fuel included in this claim **did** contain visible evidence of dye, attach an explanation and check here ▶ ☐

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of Credit	(e) CRN
a Nontaxable use	02	$ .243	42,251	$	360
b Use on a farm for farming purposes		.243		10,267	
c Use in trains		.243			353
d Use in certain intercity and local buses (see Caution above line 1)		.17			350
e Exported		.244			413

4 Nontaxable Use of Undyed Kerosene (Other Than Kerosene Used in Aviation)

Claimant certifies that the kerosene did not contain visible evidence of dye.
Exception. If any of the kerosene included in this claim **did** contain visible evidence of dye, attach an explanation and check here ▶ ☐

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Nontaxable use taxed at $.244		$ .243		$	346
b Use on a farm for farming purposes		.243			
c Use in certain intercity and local buses (see Caution above line 1)		.17			347
d Exported		.244			414
e Nontaxable use taxed at $.044		.043			377
f Nontaxable use taxed at $.219		.218			369

5 Kerosene Used in Aviation (see Caution above line 1)

		(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Kerosene used in commercial aviation (other than foreign trade) taxed at $.244		$ .200		$	417
b	Kerosene used in commercial aviation (other than foreign trade) taxed at $.219/.044*		.175/.000*			355
c	Nontaxable use (other than use by state or local government) taxed at $.244		.243			346
d	Nontaxable use (other than use by state or local government) taxed at $.219/.044*		.218/.043*			369
e	LUST tax on aviation fuels used in foreign trade		.001			433

*This rate applies after March 31, 2009.

6 Sales by Registered Ultimate Vendors of Undyed Diesel Fuel Registration No. ▶

Claimant certifies that it sold the diesel fuel at a tax-excluded price, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. Claimant certifies that the diesel fuel did not contain visible evidence of dye.

Exception. If any of the diesel fuel included in this claim did contain visible evidence of dye, attach an explanation and check here . . . . ▶ ☐

		(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Use by a state or local government	$ .243		$	360
b	Use in certain intercity and local buses	.17			350

7 Sales by Registered Ultimate Vendors of Undyed Kerosene (Other Than Kerosene For Use in Aviation) Registration No. ▶

Claimant certifies that it sold the kerosene at a tax-excluded price, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. Claimant certifies that the kerosene did not contain visible evidence of dye.

Exception. If any of the kerosene included in this claim did contain visible evidence of dye, attach an explanation and check here . . . . ▶

		(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Use by a state or local government	$ .243		$	346
b	Sales from a blocked pump	.243			
c	Use in certain intercity and local buses	.17			347

8 Sales by Registered Ultimate Vendors of Kerosene For Use in Aviation Registration No. ▶

Claimant sold the kerosene for use in aviation at a tax-excluded price and has not collected the amount of tax from the buyer, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. See the instructions for additional information to be submitted.

		(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Use in commercial aviation (other than foreign trade) taxed at $.219/.044*		$ .175/.000*		$	355
b	Use in commercial aviation (other than foreign trade) taxed at $.244		.200			417
c	Nonexempt use in noncommercial aviation		.025/.200*			418
d	Other nontaxable uses taxed at $.244		.243			346
e	Other nontaxable uses taxed at $.219/.044*		.218/.043*			369
f	LUST tax on aviation fuels used in foreign trade		.001			433

*This rate applies after March 31, 2009.

9 Alcohol Fuel Mixture Credit Registration No. ▶

Claimant produced an alcohol fuel mixture by mixing taxable fuel with alcohol. The alcohol fuel mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant.

		(b) Rate	(c) Gallons of alcohol	(d) Amount of credit	(e) CRN
a	Alcohol fuel mixtures containing ethanol	$ .51/.45*		$	393
b	Alcohol fuel mixtures containing alcohol (other than ethanol)	.60			394

*This rate applies after December 31, 2008.

10 Biodiesel or Renewable Diesel Mixture Credit Registration No. ▶

Biodiesel mixtures. Claimant produced a mixture by mixing biodiesel with diesel fuel. The biodiesel used to produce the mixture met ASTM D6751 and met EPA's registration requirements for fuels and fuel additives. The mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant. Claimant has attached the Certificate for Biodiesel and, if applicable, the Statement of Biodiesel Reseller. **Renewable diesel mixtures.** Claimant produced a mixture by mixing renewable diesel with diesel fuel (other than renewable diesel). The renewable diesel used to produce the renewable diesel mixture was derived from biomass (as defined in section 45K(c)(3)) using a thermal depolymerization process, met EPA's registration requirements for fuels and fuel additives, and met ASTM D975 or D396. The mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant. Claimant has attached the Certificate for Biodiesel and, if applicable, the Statement of Biodiesel Reseller, both of which have been edited as discussed in the instructions for Form 4136. See the instructions for line 10 for details.

		(b) Rate	(c) Gallons of biodiesel or renewable diesel	(d) Amount of credit	(e) CRN
a	Biodiesel (other than agri-biodiesel) mixtures	$ .50/1.00*		$	388
b	Agri-biodiesel mixtures	1.00			390
c	Renewable diesel mixtures	1.00			307

*This rate applies after December 31, 2008.

11 Nontaxable Use of Alternative Fuel

Caution. There is a reduced credit rate for use in certain intercity and local buses (type of use 5). See Instructions for Form 4136 for the credit rate.

		(a) Type of use	(b) Rate	(c) Gallons or gasoline gallon equivalents (GGE)	(d) Amount of credit	(e) CRN
a	Liquefied petroleum gas (LPG)		$ .183		$	419
b	"P Series" fuels		.183			420
c	Compressed natural gas (CNG) (GGE = 126.67 cu. ft.)		.183			421
d	Liquefied hydrogen		.183			422
e	Any liquid fuel derived from coal (including peat) through the Fischer-Tropsch process		.243			423
f	Liquid fuel derived from biomass		.243			424
g	Liquefied natural gas (LNG)		.243			425
h	Liquefied gas derived from biomass		.183			435

12 Alternative Fuel Credit and Alternative Fuel Mixture Credit Registration No. ▶

		(b) Rate	(c) Gallons or gasoline gallon equivalents (GGE)	(d) Amount of credit	(e) CRN
a	Liquefied petroleum gas (LPG)	$ .50		$	426
b	"P Series" fuels	.50			427
c	Compressed natural gas (CNG) (GGE = 121 cu. ft.)	.50			428
d	Liquefied hydrogen	.50			429
e	Any liquid fuel derived from coal (including peat) through the Fischer-Tropsch process	.50			430
f	Liquid fuel derived from biomass	.50			431
g	Liquefied natural gas (LNG)	.50			432
h	Liquefied gas derived from biomass	.50			436
i	Compressed natural gas derived from biomass (GGE = 121 cu. ft.)	.50			437

13 Registered Credit Card Issuers — Registration No. ▶

		(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Diesel fuel sold for the exclusive use of a state or local government	$ .243		$	360
b	Kerosene sold for the exclusive use of a state or local government	.243			346
c	Kerosene for use in aviation sold for the exclusive use of a state or local government taxed at $.219/.044*. *This rate applies after March 31, 2009.	.218/.043*			369

14 Nontaxable Use of a Diesel-Water Fuel Emulsion

Caution. There is a reduced credit rate for use in certain intercity and local buses (type of use 5). See Instructions for Form 4136 for the credit rate.

		(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Nontaxable use		$ .197		$	309
b	Exported		.198			306

15 Diesel-Water Fuel Emulsion Blending — Registration No. ▶

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
Blender credit	$ .046		$	310

16 Exported Dyed Fuels and Exported Gasoline Blendstocks

		(b) Rate	(c) Gallons	(d) Amount of Credit	(e) CRN
a	Exported dyed diesel fuel and exported gasoline blendstocks taxed at $.001	$ .001		$	415
b	Exported dyed kerosene	.001			416

17	**Total income tax credit claimed.** Add lines 1 through 16, column (d). Enter here and on Form 1040, line 68 (also check box b on line 68); Form 1120, line 32f(2); Form 1120S, line 23c; Form 1041, line 24g; or the proper line of other returns. ▶	17	$ 10,267	

Form **4626**

Department of the Treasury
Internal Revenue Service

Alternative Minimum Tax - Corporations

▶ See separate instructions.
▶ Attach to the corporation's tax return.

OMB No. 1545-0175

2008

[redacted]UMBIA GAS OF PENNSYLVANIA INC

Employer identification number
25-1100252

Part II Alternative Minimum Tax Computation

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1	Taxable income or (loss) before net operating loss deduction			1	-172,820,665
2	**Adjustments and preferences:**				
a	Depreciation of post-1986 property			2a	3,300,150
b	Amortization of certified pollution control facilities			2b	
c	Amortization of mining exploration and development costs			2c	
d	Amortization of circulation expenditures (personal holding companies only)			2d	
e	Adjusted gain or loss			2e	-844,977
f	Long-term contracts			2f	
g	Merchant marine capital construction funds			2g	
h	Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only)			2h	
i	Tax shelter farm activities (personal service corporations only)			2i	
j	Passive activities (closely held corporations and personal service corporations only)			2j	
k	Loss limitations			2k	
l	Depletion			2l	
m	Tax-exempt interest income from specified private activity bonds			2m	
n	Intangible drilling costs			2n	
o	Other adjustments and preferences			2o	-39,192,585
3	Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o			3	-209,558,077
4	**Adjusted current earnings (ACE) adjustment:**				
a	ACE from line 10 of the ACE worksheet in the instructions	4a	-256,038,619		
b	Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions)	4b	-46,480,542		
c	Multiply line 4b by 75% (.75). Enter the result as a positive amount	4c	34,860,407		
d	Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). **Note:** You **must** enter an amount on line 4d (even if line 4b is positive)	4d	75,407,659		
e	ACE adjustment. • If line 4b is zero or more, enter the amount from line 4c • If line 4b is less than zero, enter the **smaller** of line 4c or line 4d as a negative amount			4e	-34,860,407
5	Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT			5	-244,418,484
6	Alternative tax net operating loss deduction (see instructions)			6	
7	**Alternative minimum taxable income.** Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions			7	
8	**Exemption phase-out** (If line 7 is $310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):				
a	Subtract $150,000 from line 7 (If completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-	8a			
b	Multiply line 8a by 25% (.25)	8b			
c	Exemption. Subtract line 8b from $40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-			8c	
9	Subtract line 8c from line 7. If zero or less, enter -0-			9	
10	If the corporation had qualified timber gain, complete Part II and enter the amount from line 24 here. Otherwise, multiply line 9 by 20% (.20)			10	
11	Alternative minimum tax foreign tax credit (AMTFTC) (see instructions)			11	
12	Tentative minimum tax. Subtract line 11 from line 10			12	
13	Regular tax liability before applying all credits except the foreign tax credit			13	
14	**Alternative minimum tax.** Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on [redacted]rm 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return			14	

Part II **Alternative Tax for Corporations with Qualified Timber Gain.** Complete Part II only if the corporation had qualified timber gain under section 1201(b). See instructions.

15	Enter qualified timber gain from Schedule D (Form 1120), line 15, as refigured for the AMT, if necessary. If you are filing Form 1120-RIC, see instructions for the amount to enter	15	0
16	Enter the amount from Schedule D (Form 1120), line 13, as refigured for the AMT, if necessary	16	0
17	Enter the amount from Part I, line 9	17	0
18	Enter the **smallest** of the amount on line 15, line 16, or line 17	18	0
19	Multiply line 18 by 15% (.15)	19	
20	Subtract line 18 from line 17	20	
21	Multiply line 20 by 20% (.20)	21	
22	Enter the total of line 19 and line 21	22	
23	Multiply line 17 by 20% (.20)	23	
24	Enter the smaller of line 22 or line 23 here and on Part I, line 10	24	

Adjusted Current Earnings (ACE) Worksheet

▶ See ACE Worksheet Instructions. (which begin on page 8).

1	Pre-adjustment AMTI. Enter the amount from line 3 of Form 4626				1	-209,558,077
2	ACE depreciation adjustment:					
a	AMT depreciation			2a 27,983,080		
b	ACE depreciation.					
	(1) Post-1993 property	2b(1)	24,392,165			
	(2) Post-1989, pre-1994 property	2b(2)	2,054,080			
	(3) Pre-1990 MACRS property	2b(3)	1,559,137			
	(4) Pre-1990 original ACRS property	2b(4)	1,563,059			
	(5) Property described in sections 168(f)(1) through (4)	2b(5)				
	(6) Other property	2b(6)	317,205			
	(7) Total ACE depreciation. Add lines 2b(1) through 2b(6)			2b(7) 29,885,646		
c	ACE depreciation adjustment. Subtract line 2b(7) from line 2a				2c	-1,902,566
3	Inclusion in ACE of items included in earnings and profits (E&P):					
a	Tax-exempt interest income			3a		
b	Death benefits from life insurance contracts			3b		
c	All other distributions from life insurance contracts (including surrenders)			3c		
d	Inside buildup of undistributed income in life insurance contracts			3d		
e	Other items (see Regulations sections 1.56(g)-1(c)(6)(iii) through (ix) for a partial list)			3e		
f	Total increase to ACE from inclusion in ACE of items included in E&P. Add lines 3a through 3e				3f	0
4	Disallowance of items not deductible from E&P:					
a	Certain dividends received			4a		
b	Dividends paid on certain preferred stock of public utilities that are deductible under section 247			4b		
c	Dividends paid to an ESOP that are deductible under section 404(k)			4c		
d	Nonpatronage dividends that are paid and deductible under section 1382(c)			4d		
e	Other items (see Regulations sections 1.56(g)-1(d)(3)(i) and (ii) for a partial list)			4e		
f	Total increase to ACE because of disallowance of items not deductible from E&P. Add lines 4a through 4e				4f	0
5	Other adjustments based on rules for figuring E&P:					
a	Intangible drilling costs			5a		
b	Circulation expenditures			5b		
c	Organizational expenditures			5c		
d	LIFO inventory adjustments			5d -44,240,715		
e	Installment sales			5e		
f	Total other E&P adjustments. Combine lines 5a through 5e				5f	-44,240,715
6	Disallowance of loss on exchange of debt pools				6	
7	Acquisition expenses of life insurance companies for qualified foreign contracts				7	
8	Depletion				8	
9	Basis adjustments in determining gain or loss from sale or exchange of pre-1994 property				9	-337,261
10	**Adjusted current earnings.** Combine lines 1, 2c, 3f, 4f, and 5f through 9. Enter the result here and on line 4a of Form 4626				10	-256,038,619

For Paperwork Reduction Act Notice, See Instructions.

JXB F 02/10/05

SCHEDULE M-3 (Form 1120)

Department of the Treasury
Internal Revenue Service

Net Income (Loss) Reconciliation for Corporations With Total Assets of $10 Million or More

▶ Attach to Form 1120 or 1120-C.
▶ See separate instructions.

OMB No. 1545-0123

2008

Name of corporation (common parent, if consolidated return)

DLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number

25-1100252

Check applicable box(es): (1) ☐ Non-consolidated return (2) ☐ Consolidated return (Form 1120 only)
(3) ☐ Mixed 1120/L/PC group (4) ☐ Dormant subsidiaries schedule attached

Part I Financial Information and Net Income (Loss) Reconciliation (see instructions)

1 a Did the corporation file SEC Form 10-K for its income statement period ending with or within this tax year?
☐ Yes. Skip lines 1b and 1c and complete lines 2a through 11 with respect to that SEC Form 10-K.
☒ No. Go to line 1b. See instructions if multiple non-tax-basis income statements are prepared.

b Did the corporation prepare a certified audited non-tax-basis income statement for that period?
☐ Yes. Skip line 1c and complete lines 2a through 11 with respect to that income statement.
☒ No. Go to line 1c.

c Did the corporation prepare a non-tax-basis income statement for that period?
☒ Yes. Complete lines 2a through 11 with respect to that income statement.
☐ No. Skip lines 2a through 3c and enter the corporation's net income (loss) per its books and records on line 4a.

2 a Enter the income statement period: Beginning 01/01/2008 Ending 12/31/2008

b Has the corporation's income statement been restated for the income statement period on line 2a?
☐ Yes. (If "Yes," attach an explanation and the amount of each item restated.)
☒ No.

c Has the corporation's income statement been restated for any of the five income statement periods preceding the period on line 2a?
☐ Yes. (If "Yes," attach an explanation and the amount of each item restated.)
☒ No.

3 a Is any of the corporation's voting common stock publicly traded?
☐ Yes.
☒ No. *If "No," go to line 4a.*

b Enter the symbol of the corporation's primary U.S. publicly traded voting common stock

c Enter the nine-digit CUSIP number of the corporation's primary publicly traded voting common stock

4 a	Worldwide consolidated net income (loss) from income statement source identified in Part I, line 1	4a	29,505,438
b	Indicate accounting standard used for line 4a (see instructions): (1) ☒ GAAP (2) ☐ IFRS (3) ☐ Statutory (4) ☐ Tax-basis (5) ☐ Other (specify)		
5 a	Net income from nonincludible foreign entities (attach schedule)	5a	( )
b	Net loss from nonincludible foreign entities (attach schedule and enter as a positive amount)	5b	
6 a	Net income from nonincludible U.S. entities (attach schedule)	6a	( )
b	Net loss from nonincludible U.S. entities (attach schedule and enter as a positive amount)	6b	
7 a	Net income (loss) of other includible foreign disregarded entities (attach schedule)	7a	
b	Net income (loss) of other includible U.S. disregarded entities (attach schedule)	7b	
c	Net income (loss) of other includible entities (attach schedule)	7c	
8	Adjustment to eliminations of transactions between includible entities and nonincludible entities (attach schedule)	8	
9	Adjustment to reconcile income statement period to tax year (attach schedule)	9	
10 a	Intercompany dividend adjustments to reconcile to line 11 (attach schedule)	10a	
b	Other statutory accounting adjustments to reconcile to line 11 (attach schedule)	10b	
c	Other adjustments to reconcile to amount on line 11 (attach schedule)	10c	
11	**Net income (loss) per income statement of includible corporations.** Combine lines 4 through 10	11	29,505,438

Note. Part I, line 11, must equal the amount on Part II, line 30, column (a), and Schedule M-2, line 2.

12 *Enter the total amount (not just the corporation's share) of the assets and liabilities of all entities included or removed on the following lines.*

		Total Assets	Total Liabilities
a	Included on Part I, line 4 ▶	1,109,226,841	790,335,474
b	Removed on Part I, line 5 ▶		
c	Removed on Part I, line 6 ▶		
d	Included on Part I, line 7 ▶		

Schedule M-3 (Form 1120) 2008

Name of corporation (common parent, if consolidated return) | Employer identification number

COLUMBIA GAS OF PENNSYLVANIA INC | 25-1100252

Check applicable box(es): (1) ☐ Consolidated group (2) ☐ Parent corp (3) ☐ Consolidated eliminations (4) ☒ Subsidiary corp (5) ☐ Mixed 1120/L/PC group

Check if a sub-consolidated: (6) ☐ 1120 group (7) ☐ 1120 eliminations

e of subsidiary (if consolidated return) | Employer identification number

Part II Reconciliation of Net Income (Loss) per Income Statement of Includible Corporations With Taxable Income per Return (see instructions)

Income (Loss) Items (Attach schedules for lines 1 through 11)	(a) Income (Loss) per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Income (Loss) per Tax Return
1 Income (loss) from equity method foreign corporations				
2 Gross foreign dividends not previously taxed				
3 Subpart F, QEF, and similar income inclusions				
4 Section 78 gross-up				
5 Gross foreign distributions previously taxed				
6 Income (loss) from equity method U.S. corporations				
7 U.S. dividends not eliminated in tax consolidation				
8 Minority interest for includible corporations				
9 Income (loss) from U.S. partnerships				
10 Income (loss) from foreign partnerships				
11 Income (loss) from other pass-through entities				
12 Items relating to reportable transactions (attach details)				
13 Interest income (attach Form 8916-A)	7,755,064	-2,007,377		5,747,687
14 Total accrual to cash adjustment				
15 Hedging transactions	-14,437,475			-14,437,475
16 Mark-to-market income (loss)				
17 Cost of goods sold (attach Form 8916-A)	(562,886,002)	-16,229,302		(579,115,304)
18 Sale versus lease (for sellers and/or lessors)				
19 Section 481(a) adjustments		-141,988,397		-141,988,397
20 Unearned/deferred revenue	361,425	-361,425		
21 Income recognition from long-term contracts				
22 Original issue discount and other imputed interest				
23 a Income statement gain/loss on sale, exchange, abandonment, worthlessness, or other disposition of assets other than inventory and pass-through entities	-708	708		
b Gross capital gains from Schedule D, excluding amounts from pass-through entities				
c Gross capital losses from Schedule D, excluding amounts from pass-through entities, abandonment losses, and worthless stock losses				
d Net gain/loss reported on Form 4797, line 17, excluding amounts from pass-through entities, abandonment losses, and worthless stock losses		2,730,255		2,730,255
e Abandonment losses		-5,760,365		-5,760,365
f Worthless stock losses (attach details)				
g Other gain/loss on disposition of assets other than inventory				
24 Capital loss limitation and carryforward used See Stmt 12				
25 Other income (loss) items with differences (attach schedule)	10,167,912	-3,429,898		6,738,014
26 **Total income (loss) items.** Combine lines 1 through 25	-559,039,784	-167,045,801	0	-726,085,585
27 **Total expense/deduction items** (from Part III, line 36)	-108,899,692	-51,604,407	16,324,105	-144,179,994
28 Other items with no differences	697,444,914			697,444,914
29 a Mixed groups, see instructions. All others, combine lines 26 through 28	29,505,438	-218,650,208	16,324,105	-172,820,665
b PC insurance subgroup reconciliation totals				
c Life insurance subgroup reconciliation totals				
Reconciliation totals. Combine lines 29a through 29c	29,505,438	-218,650,208	16,324,105	-172,820,665

Note. Line 30, column (a), must equal the amount on Part I, line 11, and column (d) must equal Form 1120, page 1, line 28.

Name of corporation (common parent, if consolidated return) | Employer identification number

COLUMBIA GAS OF PENNSYLVANIA INC | 25-1100252

Check applicable box(es): (1) ☐ Consolidated group (2) ☐ Parent corp (3) ☐ Consolidated eliminations (4) ☒ Subsidiary corp (5) ☐ Mixed 1120/L/PC group

Check if a sub-consolidated: (6) ☐ 1120 group (7) ☐ 1120 eliminations

Name of subsidiary (if consolidated return) | Employer identification number

Part II Reconciliation of Net Income (Loss) per Income Statement of Includible Corporations With Taxable Income per Return - Expense/Deduction Items (see instructions)

Expense/Deduction Items	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1 U.S. current income tax expense	-9,592,905		9,592,905	
2 U.S. deferred income tax expense	25,495,890		-25,495,890	
3 State and local current income tax expense	145,152	-162,617		-17,465
4 State and local deferred income tax expense	2,791,310	-2,791,310		
5 Foreign current income tax expense (other than foreign withholding taxes)				
6 Foreign deferred income tax expense				
7 Foreign withholding taxes				
8 Interest expense (attach Form 8916-A)	18,464,078	-2,027,652		16,436,426
9 Stock option expense				
10 Other equity-based compensation	83,399	-79,184	-58	4,157
11 Meals and entertainment	449,601		-224,801	224,800
12 Fines and penalties	5,100		-5,100	
13 Judgements, damages, awards, and similar costs				
14 Parachute payments				
15 Compensation with section 162(m) limitation				
16 Pension and profit-sharing	1,321,892	1,212,993		2,534,885
17 Other post-retirement benefits	1,974,794	222,192	56,581	2,253,567
18 Deferred compensation	3,484,287	-109,350		3,374,937
19a Charitable contribution of cash and tangible property	928,202	-928,202		
b Charitable contribution of intangible property				
21 Charitable contribution limitation/carryforward				
22 Domestic production activities deduction				
23 Current year acquisition or reorganization investment banking fees				
24 Current year acquisition or reorganization legal and accounting fees				
25 Current year acquisition/reorganization other costs				
26 Amortization/impairment of goodwill				
27 Amortization of acquisition, reorganization, and start-up costs				
28 Other amortization or impairment write-offs		126		126
29 Section 198 environmental remediation costs				
30 Depletion				
31 Depreciation	20,084,725	11,198,505		31,283,230
32 Bad debt expense	33,222,348	4,632,132		37,854,480
33 Corporate owned life insurance premiums				
34 Purchase versus lease (for purchasers and/or lessees)				
35 Other expense/deduction items with differences (attach schedule) See Stmt 13	10,041,819	40,436,774	-247,742	50,230,851
36 **Total expense/deduction items.** Combine lines 1 through 35. Enter here and on Part II, line 27, reporting positive amounts as negative and negative amounts as positive	108,899,692	51,604,407	-16,324,105	144,179,994

Form **8916-A**
Department of the Treasury
Internal Revenue Service

Supplemental Attachment to Schedule M-3

▶ Attach to Schedule M-3 for Form 1065, 1120, 1120-L, 1120-PC, or 1120S.

OMB No. 1545-2061

2008

Name of common parent
COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number
25-1100252

Name of subsidiary

Employer identification number

Part I Cost of Goods Sold

Cost of Goods Sold Items	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1 Amounts attributable to cost flow assumptions		-1,639,999		-1,639,999
2 Amounts attributable to:				
a Stock option expense				
b Other equity based compensation		-1		-1
c Meals and entertainment				
d Parachute payments				
e Compensation with section 162(m) limitation				
f Pension and profit sharing		-448		-448
g Other post-retirement benefits		-398		-398
h Deferred compensation		-582		-582
i Section 198 environmental remediation costs				
j Amortization				
k Depletion				
l Depreciation				
m Corporate owned life insurance premiums				
n Other section 263A costs		-21,478		-21,478
3 Inventory shrinkage accruals				
4 Excess inventory and obsolescence reserves				
5 Lower of cost or market write-downs				
6 Other items with differences (attach schedule). See Stmt 14	-17,892,208	17,892,208		
7 Other items with no differences	580,778,210			580,778,210
Total cost of goods sold. Add lines 1 through 7, columns a, b, c, and d	562,886,002	16,229,302		579,115,304

Part II Interest Income

	Interest Income Item	(a) Income (Loss) per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Income (Loss) per Tax Return
1	Tax-exempt interest income				
2	Interest income from hybrid securities				
3	Sale/lease interest income				
4 a	Intercompany interest income - From outside tax affiliated group				
4 b	Intercompany interest income - From tax affiliated group	1,989,415			1,989,415
5	Other interest income	5,765,649	-2,007,377		3,758,272
6	Total interest income. Add lines 1 through 5. Enter total on Schedule M-3 (Forms 1120, 1120-PC, and 1120-L), Part II, line 13 or Schedule M-3 (Forms 1065 and 1120-S) Part II, line 11.	7,755,064	-2,007,377		5,747,687

Part III Interest Expense

	Interest Expense Item	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1	Interest expense from hybrid securities				
2	Lease/purchase interest expense				
3 a	Intercompany interest expense - Paid to outside tax affiliated group				
3 b	Intercompany interest expense - Paid to tax affiliated group	16,313,705			16,313,705
4	Other interest expense	2,150,373	-2,027,652		122,721
5	Total interest expense. Add lines 1 through 4. Enter total on Schedule M-3 (Form 1120) Part III, line 8; Schedule M-3 (Forms 1120-PC and 1120-L), Part III, line 36; Schedule M-3 (Form 1065) Part III, line 27; or Schedule M-3 (Form 1120-S) Part III, line 26.	18,464,078	-2,027,652		16,436,426

Form **4562**

Department of the Treasury
Internal Revenue Service

Depreciation and Amortization
(Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

OMB No. 1545-0172

2008

Attachment Sequence No. 67

Name(s) shown on return	Business or activity to which this form relates	Identifying number
COLUMBIA GAS OF PENNSYLVANIA INC	NATURAL GAS DISTRIBUTION	25-1100252

Part I Election To Expense Certain Property Under Section 179

Note: If you have any listed property, complete Part V before you complete Part I.

1	Maximum amount. See the instructions for a higher limit for certain businesses	1	$250,000
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	$800,000
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	0
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	250,000

	(a) Description of property	(b) Cost (business use only)	(c) Elected cost
6			

7	Listed property. Enter the amount from line 29	7		
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	8		0
9	Tentative deduction. Enter the **smaller** of line 5 or line 8	9		0
10	Carryover of disallowed deduction from line 13 of your 2007 Form 4562	10		
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions)	11		0
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11	12		0
13	Carryover of disallowed deduction to 2009. Add lines 9 and 10, less line 12 ▶	13	0	

Note: Do not use Part II or Part III below for listed property. Instead, use Part V.

Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	16,061,710
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	672,640

Part III MACRS Depreciation (Do not include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2008	17	13,470,897
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B - Assets Placed in Service During 2008 Tax Year Using the General Depreciation System

	(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19 a	3-year property						
b	5-year property		411,947	5.0	HY	200 DB	82,389
c	7-year property						
d	10-year property						
e	15-year property		19,833,277	15.0	HY	150 DB	991,664
f	20-year property						
g	25-year property			25 yrs.		S/L	
h	Residential rental property			27.5 yrs.	MM	S/L	
				27.5 yrs.	MM	S/L	
i	Nonresidential real property		317,790	39 yrs.	MM	S/L	3,930
					MM	S/L	

Section C - Assets Placed in Service During 2008 Tax Year Using the Alternative Depreciation System

20 a	Class life					S/L	
b	12-year			12 yrs.		S/L	
c	40-year			40 yrs.	MM	S/L	

Part IV Summary (See instructions)

21	Listed property. Enter amount from line 28	21	
22	**Total.** Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instr.	22	31,283,230
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	114,836

Part V Listed Property (Include automobiles, certain other vehicles, cellular telephones, certain computers, and property used for entertainment, recreation, or amusement.)

Note: For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete only 24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.

Section A - Depreciation and Other Information (Caution: See the instructions for limits for passenger automobiles.)

24a Do you have evidence to support the business/investment use claimed? [X] Yes [ ] No 24b If "Yes," is the evidence written? [X] Yes [ ] No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ Investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use (see instructions)						25		
26 Property used more than 50% in a qualified business use:								
See Stmt 15		%	82,810					
		%						
		%						
27 Property used 50% or less in a qualified business use:								
		%				S/L-		
		%				S/L-		
		%				S/L-		
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1						28	0	
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1							29	0

Section B - Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other "more than 5% owner," or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
30 Total business/investment miles driven during the year (do not include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
Total miles driven during the year. Add lines 30 through 32												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
34 Was the vehicle available for personal use during off-duty hours?												
35 Was the vehicle used primarily by a more than 5% owner or related person?												
36 Is another vehicle available for personal use?												

Section C - Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who are not more than 5% owners or related persons (see instructions).

	Yes	No
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		X
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners	X	
39 Do you treat all use of vehicles by employees as personal use?		X
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?	X	
41 Do you meet the requirements concerning qualified automobile demonstration use? (See instructions.)		X

Note: If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles.

Part VI Amortization

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2008 tax year (see instructions):					
43 Amortization of costs that began before your 2008 tax year				43	126
44 Total. Add amounts in column (f). See the instructions for where to report				44	126

Form **4797**

Department of the Treasury
Internal Revenue Service (99)

Sales of Business Property
(Also Involuntary Conversions and Recapture Amounts Under Sections 179 and 280F(b)(2))

▶ Attach to your tax return. ▶ See separate instructions.

OMB No. 1545-0184

2008

Attachment Sequence No. 27

Name(s) shown on return: COLUMBIA GAS OF PENNSYLVANIA INC

Identifying number: 25-1100252

1	Enter the gross proceeds from sales or exchanges reported to you for 2008 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions)	1

Part I Sales or Exchanges of Property Used In a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year (see instructions)

2 (a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)

3	Gain, if any, from Form 4684, line 45	3	
4	Section 1231 gain from installment sales from Form 6252, line 26 or 37	4	
5	Section 1231 gain or (loss) from like-kind exchanges from Form 8824	5	
6	Gain, if any, from line 32, from other than casualty or theft	6	
7	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows: **Partnerships (except electing large partnerships) and S corporations.** Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below. **Individuals, partners, S corporation shareholders, and all others.** If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.	7	0
8	Nonrecaptured net section 1231 losses from prior years (see instructions)	8	
9	Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions)	9	

Part II Ordinary Gains and Losses (see instructions)

10 Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):

Abandonment of Land	Various	Various			708	(708)
Public Utility	Various	Various	198,242	5,059,916	8,287,560	(3,029,402)

11	Loss, if any, from line 7	11	( )
12	Gain, if any, from line 7 or amount from line 8, if applicable	12	
13	Gain, if any, from line 31	13	
14	Net gain or (loss) from Form 4684, lines 37 and 44a	14	
15	Ordinary gain from installment sales from Form 6252, line 25 or 36	15	
16	Ordinary gain or (loss) from like-kind exchanges from Form 8824	16	
17	Combine lines 10 through 16	17	(3,030,110)
18	For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:		
a	If the loss on line 11 includes a loss from Form 4684, line 41, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions	18a	
b	Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14	18b	

Part III Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255

(see instructions)

		(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
19	(a) Description of section 1245, 1250, 1252, 1254, or 1255 property:		
	B		
	C		
	D		

These columns relate to the properties on lines 19A through 19D. ▶		Property A	Property B	Property C	Property D
20 Gross sales price (Note: See line 1 before completing.)	20				
21 Cost or other basis plus expense of sale	21				
22 Depreciation (or depletion) allowed or allowable	22				
23 Adjusted basis. Subtract line 22 from line 21	23				
24 Total gain. Subtract line 23 from line 20	24				
25 **If section 1245 property:**					
a Depreciation allowed or allowable from line 22	25a				
b Enter the smaller of line 24 or 25a	25b				
26 **If section 1250 property:** If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.					
a Additional depreciation after 1975 (see instructions)	26a				
b Applicable percentage multiplied by the smaller of line 24 or line 26a (see instructions)	26b				
c Subtract line 26a from line 24. If residential rental property or line 24 is not more than line 26a, skip lines 26d and 26e	26c				
d Additional depreciation after 1969 and before 1976	26d				
e Enter the smaller of line 26c or 26d	26e				
f Section 291 amount (corporations only)	26f				
Add lines 26b, 26e, and 26f	26g				
27 **If section 1252 property:** Skip this section if you did not dispose of farmland or if this form is being completed for a partnership (other than an electing large partnership).					
a Soil, water, and land clearing expenses	27a				
b Line 27a multiplied by applicable percentage (see instructions)	27b				
c Enter the smaller of line 24 or 27b	27c				
28 **If section 1254 property:**					
a Intangible drilling and development costs, expenditures for development of mines and other natural deposits, and mining exploration costs (see instructions)	28a				
b Enter the smaller of line 24 or 28a	28b				
29 **If section 1255 property:**					
a Applicable percentage of payments excluded from income under section 126 (see instructions)	29a				
b Enter the smaller of line 24 or 29a (see instructions)	29b				

Summary of Part III Gains. Complete property columns A through D through line 29b before going to line 30.

30	Total gains for all properties. Add property columns A through D, line 24	30	0
31	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32	Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 39. Enter the portion from other than casualty or theft on Form 4797, line 6	32	0

Part IV Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50% or Less

(see instructions)

		(a) Section 179	(b) Section 280F(b)(2)
33	Section 179 expense deduction or depreciation allowable in prior years	33	
34	Recomputed depreciation (see instructions)	34	
35	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35	0

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2008

EIN: 25-1100252

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Form 1120, Page 1, Line 5, Interest income — **Statement: 1**

Description	Amount
INTERCOMPANY INT INCOME FROM TAX AFFILIATED GROUP	1,989,415
OTHER INTEREST INCOME	3,758,272
Total	5,747,687

Form 1120, Page 1, Line 10, Other income — **Statement: 2**

Description	Amount
CUSTOMER ADVANCES RECEIVED	2,530,408
CONTRIBUTION IN AID OF CONSTRUCTION	954,960
MISC NON-OPERATING INCOME	2,797,255
Total	6,282,623

Form 1120, Page 1, Line 16, Rent expense — **Statement: 3**

Description	Amount
A&G - RENT EXPENSE	2,992,294
BUILDING LEASE WRITEDOWN/BUYOUTS	(164,186)
RENT EXPENSE: LEASED AUTOMOBILE	(817)
UTILITY RENT EXPENSE	781,002
Total	3,608,293

Form 1120, Page 1, Line 17, Taxes and licenses — **Statement: 4**

Description	Amount
STATE TAXES BASED ON INCOME	(17,465)
NET WORTH OR CAPITAL STOCK TAXES	589,138
REAL ESTATE / PERSONAL PROPERTY TAXES	373,423
GROSS RECEIPTS/STORAGE	2,199
PAYROLL TAXES	1,784,316
LICENSE / FRANCHISE	23,783
SALES/USE	444,404
OTHER TAXES	7,364
Total	3,207,162

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2008

EIN: 25-1100252

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Form 1120, Page 1, Line 18, Interest expense — **Statement: 5**

Description	Amount
INTEREST EXPENSE	237,557
INTERECOMPANY INT EXP - PAID TO TAX AFFILIATED GROUP	16,313,705
OTHER INTEREST EXPENSE	(114,836)
Total	16,436,426

Form 1120, Page 1, Line 26, Other deductions — **Statement: 6**

Description	Amount
BOOK HEDGING INCOME/LOSS	14,437,475
ENVIRONMENTAL COSTS	166,986
TAX AMORTIZATION: SEC 167	126
EXPENSE ACCRUED ON REGULATORY ASSET	4,092
PROPERTY COST OF REMOVAL	788,189
SEC 481 RELOCATION EXPENSE: REPAIRS OF GAS PIPELINE	141,988,397
UNDERGROUND STORAGE OPERATING EXPENSES	162,882
GAS DISTRIBUTION OPERATING EXP	21,547,678
CUSTOMER ACCOUNTS EXPENSE	6,576,131
CUSTOMER SERVICE AND INFORMATIONAL EXPENSE	2,278,536
SALES EXPENSE	260,573
OFFICE SUPPLIES & EXP- NET OF ADMIN EXP TRNF	1,793,867
BUSINESS MEALS & ENTERTAINMENT	224,800
OUTSIDE SERVICES EMPLOYED	6,223,489
PROPERTY INSURANCE	377,236
INJURIES & DAMAGES	3,074,197
REGULATORY COMMISSION EXPENSE	1,609,517
MISCELLANEOUS GENERAL EXPENSES	133,071
Total	201,647,242

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2008

EIN: 25-1100252

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Form 1120, Page 5, Schedule L, Line 6, Other current assets — **Statement: 7**

Description	Beginning Amount	Ending Amount
ACCTS REC - ASSOCIATES	9,221,589	1,054,284
PREPAYMENTS	2,284,054	2,402,838
INTEREST & DIVIDENDS REC	41	0
ACCRUED UTILITY REVENUES	52,924,693	71,636,552
MISC CURR & ACCR ASSETS	425,192	1,376,020
Total	64,855,569	76,469,694

Form 1120, Page 5, Schedule L, Line 14, Other assets — **Statement: 8**

Description	Beginning Amount	Ending Amount
CONSTRUCTION WORK IN PROGRESS	10,728,479	14,824,174
CUSHION GAS	895,339	895,339
REGULATORY ASSETS	79,250,218	133,181,030
PRELIM GAS SURVEY & INVES	(134,186)	(202,717)
MISCELLANEOUS DFD DEBITS	3,016,846	5,566,314
UNRECOVERED PURCHSED GAS	41,670,131	57,258,225
Total	135,426,827	211,522,365

Form 1120, Page 5, Schedule L, Line 18, Other current liabilities — **Statement: 9**

Description	Beginning Amount	Ending Amount
ACCT PAYABLE-ASSOCIATES	11,447,894	89,659,515
ACCRUED TAXES	3,490,016	3,772,880
ACCRUED INTEREST	187,232	179,997
TAX COLLECTIONS PAYABLE	1,053,688	1,420,369
ACCRUED VACATIONS	3,087,598	3,480,309
CMEP-MAP MEDICAL RESERVE	188,846	123,750
OPEB LIABILITY-CUR	149,482	132,128
OTHER ACCRUED LIABILITIES	91,739,077	96,882,778
ACCRUED RATE REFUNDS	597,084	395,826
Total	111,940,917	196,047,552

Form 1120, Page 5, Schedule L, Line 20, Mortgages, notes, bonds payable in 1 year or more — **Statement: 10**

Description	Beginning Amount	Ending Amount

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2008 EIN: 25-1100252

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NOTES PAYABLE	263,215,000	285,215,000
Total	263,215,000	285,215,000

Form 1120, Page 5, Schedule L, Line 21, Other liabilities **Statement: 11**

Description	Beginning Amount	Ending Amount
ASSET RETIREMENT OBLIGATIONS	9,327,057	8,658,204
OTHER DEFERRED CREDITS	9,529,962	39,084,409
OPEB LIABILITY-DEFERRED	10,875,478	14,653,705
OUTSTANDING LOSS RESERVES	2,666,764	2,785,040
POST EMPL. BENEFTI OBLIG	641,089	528,336
REGULATORY LIABILITIES NONCURRENT	10,289,565	6,263,898
ACCUM DFD INCOME TAXES	144,799,353	175,464,074
Total	188,129,268	247,437,666

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2008

EIN: 25-1100252

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Form 1120, Schedule M-3, Page 2, Part II, Line 25, Other income (loss) items with differences

Statement: 12

Description	Income (Loss) per Income Statement	Temporary Difference	Permanent Difference	Income (Loss) per Tax Return
MISC NON-OPERATING INCOME	2,601,175	196,080	0	2,797,255
CONTRIBUTION IN AID OF CONSTRUCTION	0	954,960	0	954,960
INCOME ACCRUED ON REGULATORY LIABILITY	7,165,345	(7,165,345)	0	0
INCOME ACCRUED ON REGULATORY ASSET	(60,005)	60,005	0	0
CUSTOMER ADVANCES RECEIVED	0	2,530,408	0	2,530,408
RATE REFUND	461,397	(6,006)	0	455,391
Total	10,167,912	(3,429,898)	0	6,738,014

Form 1120, Schedule M-3, Page 3, Part III, Line 35, Other expense/deduction items with differences

Statement: 13

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
INJURIES & DAMAGES	3,192,473	(118,276)	0	3,074,197
PROPERTY INSURANCE	258,452	118,784	0	377,236
PROPERTY COST OF REMOVAL	0	788,189	0	788,189
LOBBYING EXPENSES	246,925	0	(246,925)	0
EXPENSE ACCRUED ON REGULATORY LIABILITY	2,303,474	(2,303,474)	0	0
EXPENSE ACCRUED ON REGULATORY ASSET	302,640	(298,548)	0	4,092
ENVIRONMENTAL COSTS	0	166,986	0	166,986
EMPLOYEE INSURANCE PLANS	889,910	117,111	0	1,007,021
SALES/USE	546,404	(102,000)	0	444,404
PAYROLL TAXES	1,852,717	(68,401)	0	1,784,316
REAL ESTATE / PERSONAL PROPERTY TAXES	448,824	(75,401)	0	373,423
RENT EXPENSE: LEASED AUTOMOBILE	0	0	(817)	(817)
BUILDING LEASE WRITEDQWN/BUYOUTS	0	(164,186)	0	(164,186)
REPAIRS OF GAS PIPELINE	0	42,375,990	0	42,375,990
Total	10,041,819	40,436,774	(247,742)	50,230,851

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2008

EIN: 25-1100252

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Form 8916-A, Line 6, Other items with differences — Statement: 14

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
SYSTEM GAS LOSSES	8,561	(8,561)	0	0
PURCHSE GAS ADJUSTMENT	(18,188,677)	18,188,677	0	0
EXCESS BANK PURCHASES	287,908	(287,908)	0	0
Total	(17,892,208)	17,892,208	0	0

Statement: 15

Form 4562, Page 2, Part V, Section A, Line 26, Listed property used more than 50%

Row ID	Type of Property	Date Placed in Service	Business Use Percentage	Cost	Basis for Depreciation	Recovery Period	Method (200 DB) (150 DB) (DB) (S/L) Convention (HY) (MM) (MQ) (S/L) (PRE)	Depreciation Deduction	Elected Sec 179 Cost
1	Leased Vehicles	07/01/2003	100.000000%	70					
2	Leased Vehicles	07/01/2004	100.000000%	22,209					
3	Leased Vehicles	07/01/2005	100.000000%	8,799					
4	Leased Vehicles	07/01/2006	100.000000%	18,724					
5	Leased Vehicles	07/01/2007	100.000000%	14,958					
6	Leased Vehicles	07/01/2008	100.000000%	18,050					
Total				82,810					

Form **1120**

Department of the Treasury
Internal Revenue Service

U.S. Corporation Income Tax Return

For calendar year 2009 or tax year beginning _____ ending _____

▶ See separate instructions.

OMB No. 1545-0123

2009

A Check if:
1a Consolidated return (attach Form 851) . ☐
b Life/nonlife consolidated return . . . ☐
2 Personal holding co. (attach Sch. PH) . ☐
3 Personal service corp. (see instr) . . ☐
4 Schedule M-3 attached . . . . . ☒

Use IRS label. Otherwise, print or type.

Name
COLUMBIA GAS OF PENNSYLVANIA INC

Number, street, and room or suite no. If a P.O. box, see instructions.
200 CIVIC CENTER DRIVE

City or town, state, and ZIP code
COLUMBUS OH 43215

B Employer identification number
25-1100252

C Date incorporated
06/23/1960

D Total assets (see instructions)
$ 1,156,146,126

E Check if: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change

Income	1a	Gross receipts or sales 541,175,728 b Less returns and allowances _____ c Bal ▶	1c	541,175,728
	2	Cost of goods sold (Schedule A, line 8)	2	269,006,622
	3	Gross profit. Subtract line 2 from line 1c	3	272,169,106
	4	Dividends (Schedule C, line 19)	4	0
	5	Interest See Stmt 1	5	5,804,156
	6	Gross rents	6	123,686
	7	Gross royalties	7	
	8	Capital gain net income (attach Schedule D (Form 1120))	8	0
	9	Net gain or (loss) from Form 4797, Part II, line 17 (attach Form 4797)	9	-2,934,458
	10	Other income (see instructions - attach schedule) See Stmt 2	10	6,022,123
	11	**Total income.** Add lines 3 through 10 ▶	11	281,184,613
Deductions (See Instructions for Limitation on deductions.)	12	Compensation of officers (Schedule E, line 4) ▶	12	0
	13	Salaries and wages (less employment credits)	13	24,362,209
	14	Repairs and maintenance	14	44,772,595
	15	Bad debts	15	33,503,108
	16	Rents See Stmt 3	16	3,615,711
	17	Taxes and licenses See Stmt 4	17	6,752,764
	18	Interest See Stmt 5	18	21,249,926
	19	Charitable contributions	19	1,375,676
	20	Depreciation from Form 4562 not claimed on Schedule A or elsewhere on return (attach Form 4562)	20	34,541,553
	21	Depletion	21	
	22	Advertising	22	678,728
	23	Pension, profit-sharing, etc., plans	23	8,994,146
	24	Employee benefit programs	24	2,742,337
	25	Domestic production activities deduction (attach Form 8903)	25	
	26	Other deductions (attach schedule) See Stmt 6	26	80,503,619
	27	**Total deductions.** Add lines 12 through 26 ▶	27	263,092,372
	28	Taxable income before net operating loss deduction and special deductions. Subtract line 27 from line 11	28	18,092,241
	29	Less: a Net operating loss deduction (see instructions) 29a _____		
		b Special deductions (Schedule C, line 20) 29b 0	29c	0
	30	**Taxable income.** Subtract line 29c from line 28 (see instructions)	30	18,092,241
Tax, Refundable Credits, and Payments	31	**Total tax** (Schedule J, line 10)	31	
	32a	2008 overpayment credited to 2009 32a _____		
	b	2009 estimated tax payments 32b _____		
	c	2009 refund applied for on Form 4466 32c ( ) d Bal ▶	32d	
	e	Tax deposited with Form 7004	32e	
	f	Credits: (1) Form 2439 _____ (2) Form 4136 _____	32f	
	g	Refundable credits from Form 3800, line 19c, and Form 8827, line 8c	32g	
			32h	
	33	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐	33	
	34	**Amount owed.** If line 32h is smaller than the total of lines 31 and 33, enter amount owed	34	
	35	**Overpayment.** If line 32h is larger than the total of lines 31 and 33, enter amount overpaid	35	
	36	Enter amt from line 35 you want: Credited to 2010 estimated tax ▶ Refunded ▶	36	

Sign

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature of officer _____ Date _____ ▶ Title _____

May the IRS discuss this return with the preparer shown below (see instr)? ☐ Yes ☐ No

Paid Preparer's Use Only

Preparer's signature _____ Date _____ Check if self-employed ☐ Preparer's SSN or PTIN _____

Firm's name (or yours if self-employed), address, and ZIP code _____ EIN _____ Phone no. _____

Schedule A Cost of Goods Sold (see instructions)

1	Inventory at beginning of year	1	96,987,831
2	Purchases	2	238,747,583
3	Cost of labor	3	
4	Additional section 263A costs (attach schedule)	4	0
5	Other costs (attach schedule)	5	0
6	**Total.** Add lines 1 through 5	6	335,735,414
7	Inventory at end of year	7	66,728,792
8	**Cost of goods sold.** Subtract line 7 from line 6. Enter here and on page 1, line 2	8	269,006,622

9 a Check all methods used for valuing closing inventory:
- (i) ☒ Cost
- (ii) ☐ Lower of cost or market
- (iii) ☐ Other (Specify method used and attach explanation.) ▶

b Check if there was a writedown of subnormal goods ▶ ☐

c Check if the LIFO inventory method was adopted this tax year for any goods (if checked, attach Form 970) ▶ ☐

d If the LIFO inventory method was used for this tax year, enter percentage (or amounts) of closing inventory computed under LIFO 9d

e If property is produced or acquired for resale, do the rules of section 263A apply to the corporation? ☒ Yes ☐ No

f Was there any change in determining quantities, cost, or valuations between opening and closing inventory? If "Yes," attach explanation ☐ Yes ☒ No

Schedule C Dividends and Special Deductions (see instructions)

		(a) Dividends received	(b) %	(c) Special deductions (a) x (b)
1	Dividends from less-than-20%-owned domestic corporations (other than debt-financed stock)		70	
2	Dividends from 20%-or-more-owned domestic corporations (other than debt-financed stock)		80	
3	Dividends on debt-financed stock of domestic and foreign corporations		see instructions	
4	Dividends on certain preferred stock of less-than-20%-owned public utilities		42	
5	Dividends on certain preferred stock of 20%-or-more-owned public utilities		48	
6	Dividends from less-than-20%-owned foreign corporations and certain FSCs		70	
7	Dividends from 20%-or-more-owned foreign corporations and certain FSCs		80	
8	Dividends from wholly owned foreign subsidiaries		100	
9	**Total.** Add lines 1 through 8. See instructions for limitation			0
10	Dividends from domestic corporations received by a small business investment company operating under the Small Business Investment Act of 1958		100	
11	Dividends from affiliated group members		100	
12	Dividends from certain FSCs		100	
13	Dividends from foreign corporations not included on lines 3, 6, 7, 8, 11, or 12			
14	Income from controlled foreign corporations under subpart F (attach Form(s) 5471)			
15	Foreign dividend gross-up			
16	IC-DISC and former DISC dividends not included on lines 1, 2, or 3			
17	Other dividends			
18	*Deduction for dividends paid on certain preferred stock of public utilities*			
19	**Total dividends.** Add lines 1 through 17. Enter here and on page 1, line 4 ▶	0		
20	**Total special deductions.** Add lines 9, 10, 11, 12, and 18. Enter here and on page 1, line 29b ▶			0

Schedule E Compensation of Officers (see instructions for page 1, line 12)

Note: Complete Schedule E only if total receipts (line 1a plus lines 4 through 10 on page 1) are $500,000 or more.

	(a) Name of officer	(b) Social security number	(c) Percent of time devoted to business	Percent of corporation stock owned (d) Common	(e) Preferred	(f) Amount of compensation
1			%	%	%	
			%	%	%	
			%	%	%	
			%	%	%	
			%	%	%	
2	Total compensation of officers					
3	*Compensation of officers claimed on Schedule A and elsewhere on return*					
4	Subtract line 3 from line 2. Enter the result here and on page 1, line 12					0

Schedule J Tax Computation (see instructions)

1	Check if the corporation is a member of a controlled group (attach Schedule O (Form 1120)) ▶ ☐			
2	Income tax. Check if a qualified personal service corporation (see instructions) ▶ ☐		2	
3	Alternative minimum tax (attach Form 4626)		3	
4	Add lines 2 and 3		4	
5a	Foreign tax credit (attach Form 1118)	5a		
b	Credit from Form 8834, line 29	5b		
c	General business credit (attach Form 3800)	5c		
d	Credit for prior year minimum tax (attach Form 8827)	5d		
e	Bond credits from Form 8912	5e		
6	Total credits. Add lines 5a through 5e		6	
7	Subtract line 6 from line 4		7	
8	Personal holding company tax (attach Schedule PH (Form 1120))		8	
9	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Form 8902 ☐ Other (attach schedule)		9	
10	Total tax. Add lines 7 through 9. Enter here and on page 1, line 31		10	

Schedule K Other Information (see instructions)

		Yes	No
1	Check accounting method: a ☐ Cash b ☒ Accrual c ☐ Other (specify) ▶		
2	See the instructions and enter the:		
a	Business activity code no. ▶ 221210		
b	Business activity ▶ NATURAL GAS DISTRIBUTION		
c	Product or service ▶ NATURAL GAS DISTRIBUTION		
3	Is the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group?	X	
	If "Yes," enter name and EIN of the parent corporation ▶ NiSource Inc 35-2108964		
4	At the end of the tax year:		
a	Did any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, or tax-exempt organization own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of the corporation's stock entitled to vote? If "Yes," complete Part I of Schedule G (Form 1120) (attach Schedule G)	X	
b	Did any individual or estate own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of the corporation's stock entitled to vote? If "Yes", complete Part II of Schedule G (Form 1120) (attach Schedule G)		X
5	At the end of the tax year, did the corporation:	Yes	No
a	Own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of stock entitled to vote of any foreign or domestic corporation not included on Form 851, Affiliations Schedule? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (iv).		X

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage Owned in Voting Stock

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Schedule K Continued

b Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (iv). — X

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Country of Organization	(iv) Maximum Percentage Owned in Profit, Loss, or Capital

6 During this tax year, did the corporation pay dividends (other than stock dividends and distributions in exchange for stock) in excess of the corporation's current and accumulated earnings and profits? (See sections 301 and 316.) X
If "Yes," file **Form 5452,** Corporate Report of Nondividend Distributions.
If this is a consolidated return, answer here for the parent corporation and on Form 851 for each subsidiary.

7 At any time during the tax year, did one foreign person own, directly or indirectly, at least 25% of (a) the total voting power of all classes of the corporation's stock entitled to vote or (b) the total value of all classes of the corporation's stock? X
For rules of attribution, see section 318. If "Yes," enter:
(i) Percentage owned ▶ _____ *and (ii) Owner's country* ▶ _____
(c) The corporation may have to file **Form 5472,** Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business. Enter the number of Forms 5472 attached ▶ _____

8 Check this box if the corporation issued publicly offered debt instruments with original issue discount . . . . . ▶ ☐
If checked, the corporation may have to file **Form 8281,** Information Return for Publicly Offered Original Issue Discount Instruments.

9 Enter the amount of tax-exempt interest received or accrued during the tax year ▶$ NONE

10 Enter the number of shareholders at the end of the tax year (if 100 or fewer) ▶ 1

11 If the corporation has an NOL for the tax year and is electing to forego the carryback period, check here. . . . . ▶ ☐
If the corporation is filing a consolidated return, the statement required by Regulations section 1.1502-21(b)(3) must be attached or the election will not be valid.

12 Enter the available NOL carryover from prior tax years (do not reduce it by any deduction on line 29a.) ▶$ _____

13 *Are the corporation's total receipts (line 1a plus lines 4 through 10 on page 1) for the tax year and its total assets at the end of* the tax year less than $250,000? X
If "Yes," the corporation is not required to complete Schedules L, M-1, and M-2 on page 5. Instead, enter the total amount of cash distributions and the book value of property distributions (other than cash) made during the tax year. ▶$

Schedule L Balance Sheets per Books

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
1 Cash		25,367,865		14,184,587
2a Trade notes and accounts receivable	83,153,867		36,294,691	
b Less allowance for bad debts	(5,497,257)	77,656,610	(3,324,837)	32,969,854
3 Inventories		85,537,825		56,808,546
4 U.S. government obligations				
5 Tax-exempt securities (see instructions)				
6 Other current assets (attach schedule) See Stmt 7		76,469,694		158,258,595
7 Loans to shareholders				
8 Mortgage and real estate loans				
9 Other investments (attach schedule)		0		0
10a Buildings and other depreciable assets	889,483,215		943,841,828	
b Less accumulated depreciation	(260,568,993)	628,914,222	(274,295,972)	669,545,856
11a Depletable assets				
b Less accumulated depletion	( )		( )	
12 Land (net of any amortization)		2,030,678		2,156,415
13a Intangible assets (amortizable only)	5,055,213		5,526,270	
b Less accumulated amortization	(3,327,631)	1,727,582	(2,988,772)	2,537,498
14 Other assets (attach schedule) See Stmt 8		211,522,365		219,684,775
15 Total assets		1,109,226,841		1,156,146,126
Liabilities and Shareholders' Equity				
16 Accounts payable		61,635,256		31,965,401
17 Mortgages, notes, bonds payable in less than 1 year See Stmt 9				
18 Other current liabilities (attach schedule)		196,047,552		129,790,523
19 Loans from shareholders See Stmt 10				
20 Mortgages, notes, bonds payable in 1 yr or more		285,215,000		285,215,000
21 Other liabilities (attach schedule) See Stmt 11		247,437,666		381,628,239
22 Capital stock: a Preferred stock				
b Common stock	45,127,800	45,127,800	45,127,800	45,127,800
23 Additional paid-in capital		7,466,504		7,466,506
24 Retained earnings - Appropriated (attach schedule)		0		0
25 Retained earnings - Unappropriated See Stmt 12		266,297,063		275,006,335
26 Adjustments to shareholders' equity (attach schedule)		0		(53,678)
27 Less cost of treasury stock		( )		( )
28 Total liabilities and shareholders' equity		1,109,226,841		1,156,146,126

Schedule M-1 Reconciliation of Income (Loss) per Books With Income per Return

Note: Schedule M-3 required instead of Schedule M-1 if total assets are $10 million or more - see instructions

1 Net income (loss) per books		7 Income recorded on books this year not included on this return (itemize): Tax-exempt interest $	
2 Federal income tax per books			
3 Excess of capital losses over capital gains			
4 Income subject to tax not recorded on books this year (itemize):		8 Deductions on this return not charged against book income this year (itemize):	
5 Expenses recorded on books this year not deducted on this return (itemize):		a Depreciation $	
a Depreciation $		b Charitable contributions $	
b Charitable contributions $			
c Travel and entertainment $			
		9 Add lines 7 and 8	
6 Add lines 1 through 5		10 Income (page 1, line 28) - line 6 less line 9	

Schedule M-2 Analysis of Unappropriated Retained Earnings per Books (Line 25, Schedule L)

1 Balance at beginning of year	266,297,063	5 Distributions: a Cash	25,000,000
2 Net income (loss) per books	33,709,272	b Stock	
3 Other increases (itemize):		c Property	
		6 Other decreases (itemize):	0
	0	7 Add lines 5 and 6	25,000,000
4 Add lines 1, 2, and 3	300,006,335	8 Balance at end of year (line 4 less line 7)	275,006,335

SCHEDULE G (Form 1120)

Department of the Treasury
Internal Revenue Service

Information on Certain Persons Owning the Corporation's Voting Stock

▶ Attach to Form 1120.

OMB No. 1545-0123

2009

pe

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number (EIN)
25-1100252

Part I **Certain Entities Owning the Corporation's Voting Stock.** (Form 1120, Schedule K, Question 4a). Complete columns (i) through (v) below for any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, or tax-exempt organization that owns directly 20% or more, or owns, directly or indirectly, 50% or more of the total voting power of all classes of the corporation's stock entitled to vote (see instructions).

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Percentage Owned in Voting Stock
Columbia Energy Group	13-1594808	C-Corp	US	100.0000%

Part II **Certain Individuals and Estates Owning the Corporation's Voting Stock.** (Form 1120, Schedule K, Question 4b). Complete columns (i) through (iv) below for any individual or estate that owns directly 20% or more, or owns, directly or indirectly, 50% or more of the total voting power of all classes of the corporation's stock entitled to vote (see instructions).

(i) Name of Individual or Estate	(ii) Identifying Number (if any)	(iii) Country of Citizenship (see instructions)	(iv) Percentage Owned in Voting Stock

SCHEDULE B
(Form 1120)
(Rev. December 2009)
epartment of the Treasury
rnal Revenue Service

Additional Information for Schedule M-3 Filers

▶ Attach to Form 1120.
▶ See instructions.

OMB No. 1545-0123

Name

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number (EIN)

25-1100252

		Yes	No
1	Do the amounts reported on Schedule M-3 (Form 1120), Part II, lines 9 or 10, column (d), reflect allocations to this corporation from a partnership of income, gain, loss, deduction, or credit that are disproportionate to this corporation's capital contribution to the partnership or its ratio for sharing other items of the partnership?		X
2	At any time during the tax year, did the corporation sell, exchange, or transfer any interest in an intangible asset to a related person as defined in section 267(b)?		X
3	At any time during the tax year, did the corporation acquire any interest in an intangible asset from a related person as defined in section 267(b)?		X
4a	During the tax year, did the corporation enter into a cost-sharing arrangement with any related foreign party on whose behalf the corporation did not file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations?		X
b	At any time during the tax year, was the corporation a participant in a cost-sharing arrangement with any related foreign party on whose behalf the corporation did not file Form 5471?		X
5	At any time during the tax year, did the corporation make any change in accounting principle for financial accounting purposes? See instructions for the definition of change in accounting principle		X
6	At any time during the tax year, did the corporation make any change in a method of accounting for U.S. income tax purposes?		X
7	At any time during the tax year, did the corporation own any voluntary employees' beneficiary association (VEBA) trusts that were used to hold funds designated for employee benefits?	X	
8	At any time during the tax year, did the corporation use an allocation method for indirect costs capitalized to self-constructed assets that varied from its financial method of accounting?		X
9	At any time during the tax year, did the corporation treat for tax purposes indirect costs, as defined in Regulations sections 1.263A-1(e)(3)(ii)(F), (G), and (H), as mixed-service costs, as defined in Regulations section 1.263A-1(e)(4)(ii)(C)?		X
10	Did the corporation, under section 118 or 362(c) and the related regulations, take a return filing position characterizing any amount as a contribution to the capital of the corporation during the tax year by any non-shareholders? Amounts so characterized may include, without limitation, incentives, inducements, money, and property		X

Form **4136**
Department of the Treasury
Internal Revenue Service (99)

Credit for Federal Tax Paid on Fuels

▶ See the separate instructions.
▶ Attach this form to your income tax return.

OMB No. 1545-0162
2009
Attachment Sequence No. 23

Name (as shown on your income tax return)
COLUMBIA GAS OF PENNSYLVANIA INC

Taxpayer identification number
25-1100252

Caution. Claimant has the name and address of the person who sold the fuel to the claimant and the dates of purchase. For claims on lines 1c and 2b (type of use 13 and 14), 3d, 4c, and 5, claimant has not waived the right to make the claim. For claims on lines 1c and 2b (type of use 13 and 14), claimant certifies that a certificate has not been provided to the credit card issuer.

1 Nontaxable Use of Gasoline

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Off-highway business use		$ .183			
b Use on a farm for farming purposes		.183			362
c Other nontaxable use (see Caution above line 1)		.183		$	
d Exported		.184			411

2 Nontaxable Use of Aviation Gasoline

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Use in commercial aviation (other than foreign trade)		$ .15/.000*		$	354
b Other nontaxable use (see Caution above line 1)		.193/.043*			324
c Exported		.194/.044*			412
d LUST tax on aviation fuels used in foreign trade		.001			433

*This rate applies after December 31, 2009.

3 Nontaxable Use of Undyed Diesel Fuel

Claimant certifies that the diesel fuel did not contain visible evidence of dye.
Exception. If any of the diesel fuel included in this claim did contain visible evidence of dye, attach an explanation and check here ▶ ☐

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of Credit	(e) CRN
a Nontaxable use	02	$ .243	53,847		
b Use on a farm for farming purposes		.243		$ 13,085	360
c Use in trains		.243			353
d Use in certain intercity and local buses (see Caution above line 1)		.17			350
e Exported		.244			413

4 Nontaxable Use of Undyed Kerosene (Other Than Kerosene Used in Aviation)

Claimant certifies that the kerosene did not contain visible evidence of dye.
Exception. If any of the kerosene included in this claim did contain visible evidence of dye, attach an explanation and check here ▶ ☐

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Nontaxable use taxed at $.244		$ .243			
b Use on a farm for farming purposes		.243		$	346
c Use in certain intercity and local buses (see Caution above line 1)		.17			347
d Exported		.244			414
e Nontaxable use taxed at $.044		.043			377
f Nontaxable use taxed at $.219		.218			369

5 Kerosene Used in Aviation (see Caution above line 1)

		(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Kerosene used in commercial aviation (other than foreign trade) taxed at $.244		$ .200		$	417
b	Kerosene used in commercial aviation (other than foreign trade) taxed at $.219/.044*		.175/.000*			355
c	Nontaxable use (other than use by state or local government) taxed at $.244		.243			346
d	Nontaxable use (other than use by state or local government) taxed at $.219/.044*		.218/.043*			369
e	LUST tax on aviation fuels used in foreign trade		.001			433

*This rate applies after December 31, 2009.

6 Sales by Registered Ultimate Vendors of Undyed Diesel Fuel Registration No. ▶

Claimant certifies that it sold the diesel fuel at a tax-excluded price, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. Claimant certifies that the diesel fuel did not contain visible evidence of dye.

Exception. If any of the diesel fuel included in this claim did contain visible evidence of dye, attach an explanation and check here . . . . ▶ ☐

		(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Use by a state or local government	$ .243		$	360
b	Use in certain intercity and local buses	.17			350

7 Sales by Registered Ultimate Vendors of Undyed Kerosene (Other Than Kerosene For Use in Aviation) Registration No. ▶

Claimant certifies that it sold the kerosene at a tax-excluded price, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. Claimant certifies that the kerosene did not contain visible evidence of dye.

Exception. If any of the kerosene included in this claim did contain visible evidence of dye, attach an explanation and check here . . . . ▶ ☐

		(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Use by a state or local government	$ .243			
b	Sales from a blocked pump	.243		$	346
c	Use in certain intercity and local buses	.17			347

8 Sales by Registered Ultimate Vendors of Kerosene For Use in Aviation Registration No. ▶

Claimant sold the kerosene for use in aviation at a tax-excluded price and has not collected the amount of tax from the buyer, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. See the instructions for additional information to be submitted.

		(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a	Use in commercial aviation (other than foreign trade) taxed at $.219/.044*		$ .175/.000*		$	355
b	Use in commercial aviation (other than foreign trade) taxed at $.244		.200			417
c	Nonexempt use in noncommercial aviation		.025/.200*			418
d	Other nontaxable uses taxed at $.244		.243			346
e	Other nontaxable uses taxed at $.219/.044*		.218/.043*			369
f	LUST tax on aviation fuels used in foreign trade		.001			433

*This rate applies after December 31, 2009.

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

9 Alcohol Fuel Mixture Credit Registration No. ▶

Claimant produced an alcohol fuel mixture by mixing taxable fuel with alcohol. The alcohol fuel mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant.

		(b) Rate	(c) Gallons of alcohol	(d) Amount of credit	(e) C
a	Alcohol fuel mixtures containing ethanol	$ .45		$	393
b	Alcohol fuel mixtures containing alcohol (other than ethanol)	.60			394

10 Biodiesel or Renewable Diesel Mixture Credit Registration No. ▶

Biodiesel mixtures. Claimant produced a mixture by mixing biodiesel with diesel fuel. The biodiesel used to produce the mixture met ASTM D6751 and met EPA's registration requirements for fuels and fuel additives. The mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant. Claimant has attached the Certificate for Biodiesel and, if applicable, the Statement of Biodiesel Reseller. **Renewable diesel mixtures.** Claimant produced a mixture by mixing renewable diesel with liquid fuel (other than renewable diesel). The renewable diesel used to produce the renewable diesel mixture was derived from biomass process, met EPA'S registration requirements for fuels and fuel additives, and met ASTM D975, D396, or other equivalent standard approved by the IRS. The mixture was sold by the claimant to any person for use as a fuel or was used as fuel by the claimant. Claimant has attached the Certificate for Biodiesel and, if applicable, the Statement of Biodiesel Reseller, both of which have been edited as discussed in the Instructions for Form 4136. See the instr for line 10 for information about renewable diesel used in aviation.

		(b) Rate	(c) Gallons of biodiesel or renewable diesel	(d) Amount of credit	(e) CRN
a	Biodiesel (other than agri-biodiesel) mixtures	$ 1.00/.000*		$	388
b	Agri-biodiesel mixtures	$ 1.00/.000*			390
c	Renewable diesel mixtures	$ 1.00/.000*			307

*This rate applies after December 31, 2009.

11 Nontaxable Use of Alternative Fuel

Caution. There is a reduced credit rate for use in certain intercity and local buses (type of use 5). See Instructions for Form 4136 for the credit rate.

		(a) Type of use	(b) Rate	(c) Gallons or gasoline gallon equivalents (GGE)	(d) Amount of credit	(e) C
a	Liquefied petroleum gas (LPG)		$ .183		$	419
b	"P Series" fuels		.183			420
c	Compressed natural gas (CNG) (GGE = 126.67 cu. ft.)		.183			421
d	Liquefied hydrogen		.183			422
e	Any liquid fuel derived from coal (including peat) through the Fischer-Tropsch process		.243			423
f	Liquid fuel derived from biomass		.243			424
g	Liquefied natural gas (LNG)		.243			425
h	Liquefied gas derived from biomass		.183			435

12 Alternative Fuel Credit and Alternative Fuel Mixture Credit Registration No. ▶

		(b) Rate	(c) Gallons or gasoline gallon equivalents (GGE)	(d) Amount of credit	(e) CRN
a	Liquefied petroleum gas (LPG)	$ .50/.000*		$	426
b	"P Series" fuels	.50/.000*			427
c	Compressed natural gas (CNG) (GGE = 121 cu. ft.)	.50/.000*			428
d	Liquefied hydrogen	.50			429
e	Any liquid fuel derived from coal (including peat) through the Fischer-Tropsch process	.50/.000*			430
f	Liquid fuel derived from biomass	.50/.000*			
g	Liquefied natural gas (LNG)	.50/.000*			432
h	Liquefied gas derived from biomass	.50/.000*			436
i	Compressed natural gas derived from biomass (GGE = 121 cu. ft.)	.50/.000*			437

*This rate applies after December 31, 2009.

13 Registered Credit Card Issuers — Registration No. ▶

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
Diesel fuel sold for the exclusive use of a state or local government	$ .243		$	360
Kerosene sold for the exclusive use of a state or local government	.243			346
Kerosene for use in aviation sold for the exclusive use of a state or local government taxed at $.219/.044*	.218/.043*			369

*This rate applies after December 31, 2009.

14 Nontaxable Use of a Diesel-Water Fuel Emulsion

Caution. There is a reduced credit rate for use in certain intercity and local buses (type of use 5). See Instructions for Form 4136 for the credit rate.

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Nontaxable use		$ .197		$	309
b Exported		.198			306

15 Diesel-Water Fuel Emulsion Blending — Registration No. ▶

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
Blender credit	$ .046		$	310

16 Exported Dyed Fuels and Exported Gasoline Blendstocks

	(b) Rate	(c) Gallons	(d) Amount of Credit	(e) CRN
a Exported dyed diesel fuel and exported gasoline blendstocks taxed at $.001	$ .001		$	415
b Exported dyed kerosene	.001			416

17 **Total income tax credit claimed.** Add lines 1 through 16, column (d). Enter here and on Form 1040, line 70 (also check box b on line 70); Form 1120, line 32f(2); Form 1120S, line 23c; Form 1041, line 24g; or the proper line of other returns. ▶	17	$ 13,085	

Form **4626**

Alternative Minimum Tax - Corporations

OMB No. 1545-0175

2009

Department of the Treasury
Internal Revenue Service

▶ See separate instructions.
▶ Attach to the corporation's tax return.

Name

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number

25-1100252

Part I Alternative Minimum Tax Computation

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1	Taxable income or (loss) before net operating loss deduction			1	18,092,241
2	**Adjustments and preferences:**				
a	Depreciation of post-1986 property			2a	2,555,362
b	Amortization of certified pollution control facilities			2b	
c	Amortization of mining exploration and development costs			2c	
d	Amortization of circulation expenditures (personal holding companies only)			2d	
e	Adjusted gain or loss			2e	-912,389
f	Long-term contracts			2f	
g	Merchant marine capital construction funds			2g	
h	Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only)			2h	
i	*Tax shelter farm activities (personal service corporations only)*			2i	
j	Passive activities (closely held corporations and personal service corporations only)			2j	
k	Loss limitations			2k	
l	Depletion			2l	
m	Tax-exempt interest income from specified private activity bonds			2m	
n	Intangible drilling costs			2n	
o	Other adjustments and preferences			2o	
3	Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o			3	19,735,214
4	**Adjusted current earnings (ACE) adjustment:**				
a	ACE from line 10 of the ACE worksheet in the instructions	4a	28,162,772		
b	Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions)	4b	8,427,558		
c	Multiply line 4b by 75% (.75). Enter the result as a positive amount	4c	6,320,669		
d	Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). **Note:** You **must** enter an amount on line 4d (even if line 4b is positive)	4d	40,547,252		
e	ACE adjustment. • If line 4b is zero or more, enter the amount from line 4c • If line 4b is less than zero, enter the **smaller** of line 4c or line 4d as a negative amount			4e	6,320,669
5	Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT			5	26,055,883
6	Alternative tax net operating loss deduction (see instructions)			6	219,976,636
7	**Alternative minimum taxable income.** Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions			7	0
8	**Exemption phase-out** (if line 7 is $310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):				
a	Subtract $150,000 from line 7 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-	8a			
b	Multiply line 8a by 25% (.25)	8b			
c	Exemption. Subtract line 8b from $40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-			8c	
9	Subtract line 8c from line 7. If zero or less, enter -0-			9	
10	If the corporation had qualified timber gain, complete Part II and enter the amount from line 24 here. Otherwise, multiply line 9 by 20% (.20)			10	
11	Alternative minimum tax foreign tax credit (AMTFTC) (see instructions)			11	
12	Tentative minimum tax. Subtract line 11 from line 10			12	
	Regular tax liability before applying all credits except the foreign tax credit			13	
→	**Alternative minimum tax.** Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on Form 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return			14	

Part II **Alternative Tax for Corporations with Qualified Timber Gain.** Complete Part II only if the corporation had qualified timber gain under section 1201(b). See instructions.

15	Enter qualified timber gain from Schedule D (Form 1120), line 15, as refigured for the AMT, if necessary. If you are filing Form 1120-RIC, see instructions for the amount to enter	15	0
16	Enter the amount from Schedule D (Form 1120), line 13, as refigured for the AMT, if necessary	16	0
17	Enter the amount from Part I, line 9	17	0
18	Enter the **smallest** of the amount on line 15, line 16, or line 17	18	0
19	Multiply line 18 by 15% (.15)	19	
20	Subtract line 18 from line 17	20	
21	Multiply line 20 by 20% (.20)	21	
22	Enter the total of line 19 and line 21	22	
23	Multiply line 17 by 20% (.20)	23	
24	Enter the smaller of line 22 or line 23 here and on Part I, line 10	24	

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Adjusted Current Earnings (ACE) Worksheet

▶ See ACE Worksheet Instructions, (which begin on page 8).

1	Pre-adjustment AMTI. Enter the amount from line 3 of Form 4626					1	19,735,214
2	ACE depreciation adjustment:						
a	AMT depreciation			2a	31,986,191		
b	ACE depreciation.						
	(1) Post-1993 property	2b(1)	28,131,948				
	(2) Post-1989, pre-1994 property	2b(2)	2,026,295				
	(3) Pre-1990 MACRS property	2b(3)	1,540,474				
	(4) Pre-1990 original ACRS property	2b(4)	1,536,436				
	(5) Property described in sections 168(f)(1) through (4)	2b(5)					
	(6) Other property	2b(6)	378,211				
	(7) Total ACE depreciation. Add lines 2b(1) through 2b(6)			2b(7)	33,613,364		
c	ACE depreciation adjustment. Subtract line 2b(7) from line 2a					2c	-1,627,173
3	Inclusion in ACE of items included in earnings and profits (E&P):						
a	Tax-exempt interest income			3a			
b	Death benefits from life insurance contracts			3b			
c	All other distributions from life insurance contracts (including surrenders)			3c			
d	Inside buildup of undistributed income in life insurance contracts			3d			
e	Other items (see Regulations sections 1.56(g)-1(c)(6)(iii) through (ix) for a partial list)			3e			
f	*Total increase to ACE from inclusion in ACE of items included in E&P. Add lines 3a through 3e*					3f	0
4	Disallowance of items not deductible from E&P:						
a	Certain dividends received			4a			
b	Dividends paid on certain preferred stock of public utilities that are deductible under section 247			4b			
c	Dividends paid to an ESOP that are deductible under section 404(k)			4c			
d	Nonpatronage dividends that are paid and deductible under section 1382(c)			4d			
e	Other items (see Regulations sections 1.56(g)-1(d)(3)(i) and (ii) for a partial list)			4e			
f	Total increase to ACE because of disallowance of items not deductible from E&P. Add lines 4a through 4e					4f	0
5	Other adjustments based on rules for figuring E&P:						
a	Intangible drilling costs			5a			
b	Circulation expenditures			5b			
c	Organizational expenditures			5c			
d	LIFO inventory adjustments			5d	10,389,274		
e	Installment sales			5e			
f	Total other E&P adjustments. Combine lines 5a through 5e					5f	10,389,274
6	Disallowance of loss on exchange of debt pools					6	
7	Acquisition expenses of life insurance companies for qualified foreign contracts					7	
8	Depletion					8	
9	*Basis adjustments in determining gain or loss from sale or exchange of pre-1994 property*					9	-334,543
10	**Adjusted current earnings.** Combine lines 1, 2c, 3f, 4f, and 5f through 9. Enter the result here and on line 4a of Form 4626					10	28,162,772

For Paperwork Reduction Act Notice, See Instructions.

JXB F 02/10/05

SCHEDULE M-3 (Form 1120)

Department of the Treasury
Internal Revenue Service

Net Income (Loss) Reconciliation for Corporations With Total Assets of $10 Million or More

▶ Attach to Form 1120 or 1120-C.
▶ See separate instructions.

OMB No. 1545-0123

2009

Name of corporation (common parent, if consolidated return)
[redacted]UMBIA GAS OF PENNSYLVANIA INC

Employer identification number
25-1100252

Check applicable box(es): (1) ☐ Non-consolidated return (2) ☐ Consolidated return (Form 1120 only)
(3) ☒ Mixed 1120/L/PC group (4) ☐ Dormant subsidiaries schedule attached

Part I Financial Information and Net Income (Loss) Reconciliation (see instructions)

1 a Did the corporation file SEC Form 10-K for its income statement period ending with or within this tax year?
☐ Yes. Skip lines 1b and 1c and complete lines 2a through 11 with respect to that SEC Form 10-K.
☒ No. Go to line 1b. See instructions if multiple non-tax-basis income statements are prepared.

b Did the corporation prepare a certified audited non-tax-basis income statement for that period?
☐ Yes. Skip line 1c and complete lines 2a through 11 with respect to that income statement.
☒ No. Go to line 1c.

c Did the corporation prepare a non-tax-basis income statement for that period?
☒ Yes. Complete lines 2a through 11 with respect to that income statement.
☐ No. Skip lines 2a through 3c and enter the corporation's net income (loss) per its books and records on line 4a.

2 a Enter the income statement period: Beginning 01/01/2009 Ending 12/31/2009

b Has the corporation's income statement been restated for the income statement period on line 2a?
☐ Yes. (If "Yes," attach an explanation and the amount of each item restated.)
☒ No.

c Has the corporation's income statement been restated for any of the five income statement periods preceding the period on line 2a?
☐ Yes. (If "Yes," attach an explanation and the amount of each item restated.)
☒ No.

3 a Is any of the corporation's voting common stock publicly traded?
☐ Yes.
☒ No. If "No," go to line 4a.

Enter the symbol of the corporation's primary U.S. publicly traded voting common stock

Enter the nine-digit CUSIP number of the corporation's primary publicly traded voting common stock

4 a	Worldwide consolidated net income (loss) from income statement source identified in Part I, line 1	4a	33,709,272
b	Indicate accounting standard used for line 4a (see instructions): (1) ☒ GAAP (2) ☐ IFRS (3) ☐ Statutory (4) ☐ Tax-basis (5) ☐ Other (specify)		
5 a	Net income from nonincludible foreign entities (attach schedule)	5a	( )
b	Net loss from nonincludible foreign entities (attach schedule and enter as a positive amount)	5b	
6 a	Net income from nonincludible U.S. entities (attach schedule)	6a	( )
b	Net loss from nonincludible U.S. entities (attach schedule and enter as a positive amount)	6b	
7 a	Net income (loss) of other includible foreign disregarded entities (attach schedule)	7a	
b	Net income (loss) of other includible U.S. disregarded entities (attach schedule)	7b	
c	Net income (loss) of other includible entities (attach schedule)	7c	
8	Adjustment to eliminations of transactions between includible entities and nonincludible entities (attach schedule)	8	
9	Adjustment to reconcile income statement period to tax year (attach schedule)	9	
10 a	Intercompany dividend adjustments to reconcile to line 11 (attach schedule)	10a	
b	Other statutory accounting adjustments to reconcile to line 11 (attach schedule)	10b	
c	Other adjustments to reconcile to amount on line 11 (attach schedule)	10c	
11	**Net income (loss) per income statement of includible corporations.** Combine lines 4 through 10	11	33,709,272

Note. Part I, line 11, must equal the amount on Part II, line 30, column (a), and Schedule M-2, line 2.

12 Enter the total amount (not just the corporation's share) of the assets and liabilities of all entities included or removed on the following lines.

		Total Assets	Total Liabilities
a	Included on Part I, line 4 ▶	1,156,146,126	828,599,163
b	Removed on Part I, line 5 ▶		
c	Removed on Part I, line 6 ▶		
d	Included on Part I, line 7 ▶		

Schedule M-3 (Form 1120) 2009 — Page 2

Name of corporation (common parent, if consolidated return) — Employer identification number

COLUMBIA GAS OF PENNSYLVANIA INC — 25-1100252

Check applicable box(es): (1) ☐ Consolidated group (2) ☐ Parent corp (3) ☐ Consolidated eliminations (4) ☒ Subsidiary corp (5) ☒ Mixed 1120/L/PC group

Check if a sub-consolidated: (6) ☐ 1120 group (7) ☐ 1120 eliminations

Name of subsidiary (if consolidated return) — Employer identification numbe

Part II Reconciliation of Net Income (Loss) per Income Statement of Includible Corporations With Taxable Income per Return (see instructions)

	Income (Loss) Items (Attach schedules for lines 1 through 11)	(a) Income (Loss) per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Income (Loss) per Tax Return
1	Income (loss) from equity method foreign corporations				
2	Gross foreign dividends not previously taxed				
3	Subpart F, QEF, and similar income inclusions				
4	Section 78 gross-up				
5	Gross foreign distributions previously taxed				
6	Income (loss) from equity method U.S. corporations				
7	U.S. dividends not eliminated in tax consolidation				
8	Minority interest for includible corporations				
9	Income (loss) from U.S. partnerships				
10	Income (loss) from foreign partnerships				
11	Income (loss) from other pass-through entities				
12	Items relating to reportable transactions (attach details)				
13	Interest income (attach Form 8916-A)	2,596,644	3,207,512		5,804,156
14	Total accrual to cash adjustment				
15	Hedging transactions	-26,669,748			-26,669,748
16	Mark-to-market income (loss)				
17	Cost of goods sold (attach Form 8916-A)	(291,197,044)	22,190,422		(269,006,622)
18	Sale versus lease (for sellers and/or lessors)				
19	Section 481(a) adjustments				
	Unearned/deferred revenue	278,445	-278,445		
21	Income recognition from long-term contracts				
22	Original issue discount and other imputed interest				
23 a	Income statement gain/loss on sale, exchange, abandonment, worthlessness, or other disposition of assets other than inventory and pass-through entities	-105,109	105,109		
b	Gross capital gains from Schedule D, excluding amounts from pass-through entities				
c	Gross capital losses from Schedule D, excluding amounts from pass-through entities, abandonment losses, and worthless stock losses				
d	Net gain/loss reported on Form 4797, line 17, excluding amounts from pass-through entities, abandonment losses, and worthless stock losses		2,159,791		2,159,791
e	Abandonment losses		-5,094,249		-5,094,249
f	Worthless stock losses (attach details)				
g	Other gain/loss on disposition of assets other than inventory				
24	Capital loss limitation and carryforward used See Stmt 13				
25	Other income (loss) items with differences (attach schedule)	1,980,936	515,622		2,496,558
26	**Total income (loss) items.** Combine lines 1 through 25	-313,115,876	22,805,762	0	-290,310,114
27	**Total expense/deduction items** (from Part III, line 36)	-112,316,858	-55,820,237	17,397,444	-150,739,651
28	Other items with no differences	459,142,006			459,142,006
29 a	Mixed groups, see instructions. All others, combine lines 26 through 28	33,709,272	-33,014,475	17,397,444	18,092,241
b	PC insurance subgroup reconciliation totals				
c	Life insurance subgroup reconciliation totals				
d	**Reconciliation totals.** Combine lines 29a through 29c	33,709,272	-33,014,475	17,397,444	18,092,241

Note. Line 30, column (a), must equal the amount on Part I, line 11, and column (d) must equal Form 1120, page 1, line 28.

Schedule M-3 (Form 1120) 2009

Name of corporation (common parent, if consolidated return) | Employer identification number

COLUMBIA GAS OF PENNSYLVANIA INC | 25-1100252

Check applicable box(es): (1) ☐ Consolidated group (2) ☐ Parent corp (3) ☐ Consolidated eliminations (4) ☒ Subsidiary corp (5) ☒ Mixed 1120/L/PC group

Check if a sub-consolidated: (6) ☐ 1120 group (7) ☐ 1120 eliminations

Name of subsidiary (if consolidated return) | Employer identification number

Part III Reconciliation of Net Income (Loss) per Income Statement of Includible Corporations With Taxable Income per Return - Expense/Deduction Items (see instructions)

Expense/Deduction Items	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1 U.S. current income tax expense	-31,140,424		31,140,424	
2 U.S. deferred income tax expense	48,347,068		-48,347,068	
3 State and local current income tax expense	2,721,838	335,671		3,057,509
4 State and local deferred income tax expense	-1,728,930	1,728,930		
5 Foreign current income tax expense (other than foreign withholding taxes)				
6 Foreign deferred income tax expense				
7 Foreign withholding taxes				
8 Interest expense (attach Form 8916-A)	22,624,420	-1,374,494		21,249,926
9 Stock option expense				
10 Other equity-based compensation	76,995	58,518	1,445	136,958
11 Meals and entertainment	363,303		-181,651	181,652
12 Fines and penalties	-14,345		14,345	
13 Judgements, damages, awards, and similar costs				
14 Parachute payments				
15 Compensation with section 162(m) limitation				
16 Pension and profit-sharing	2,438,100	6,556,046		8,994,146
17 Other post-retirement benefits	3,525,453	-1,501,226	88,064	2,112,291
18 Deferred compensation	4,178,475	-843,314		3,335,161
19 Charitable contribution of cash and tangible property	447,474	928,202		1,375,676
20 Charitable contribution of intangible property				
21 Charitable contribution limitation/carryforward				
22 Domestic production activities deduction				
23 Current year acquisition or reorganization investment banking fees				
24 Current year acquisition or reorganization legal and accounting fees				
25 Current year acquisition/reorganization other costs				
26 Amortization/impairment of goodwill				
27 Amortization of acquisition, reorganization, and start-up costs				
28 Other amortization or impairment write-offs		126		126
29 Section 198 environmental remediation costs				
30 Depletion				
31 Depreciation	22,932,975	11,608,578		34,541,553
32 Bad debt expense	27,868,647	5,634,461		33,503,108
33 Corporate owned life insurance premiums				
34 Purchase versus lease (for purchasers and/or lessees)				
35 Other expense/deduction items with differences (attach schedule) See Stmt. 14	9,675,809	32,688,739	-113,003	42,251,545
36 Total expense/deduction items. Combine lines 1 through 35. Enter here and on Part II, line 27, reporting positive amounts as negative and negative amounts as positive	112,316,858	55,820,237	-17,397,444	150,739,651

Form **8916-A**
Department of the Treasury
Internal Revenue Service

Supplemental Attachment to Schedule M-3

▶ Attach to Schedule M-3 for Form 1065, 1120, 1120-L, 1120-PC, or 1120S.

OMB No. 1545-2061

2009

Name of common parent

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number

25-1100252

Name of subsidiary

Employer identification number

Part I Cost of Goods Sold

Cost of Goods Sold Items	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1 Amounts attributable to cost flow assumptions		1,647,851		1,647,851
2 Amounts attributable to:				
a Stock option expense				
b Other equity based compensation				
c Meals and entertainment				
d Parachute payments				
e Compensation with section 162(m) limitation				
f Pension and profit sharing				
g Other post-retirement benefits				
h Deferred compensation				
i Section 198 environmental remediation costs				
j Amortization				
k Depletion				
l Depreciation				
m Corporate owned life insurance premiums				
n Other section 263A costs		23,352		23,352
3 Inventory shrinkage accruals				
4 Excess inventory and obsolescence reserves				
5 Lower of cost or market write-downs				
6 Other items with differences (attach schedule). See Stmt 15	23,861,625	-23,861,625		
7 Other items with no differences. See Stmt 16	267,335,419			267,335,419
8 *Total cost of goods sold.* Add lines 1 through 7, in columns a, b, c, and d	291,197,044	-22,190,422		269,006,622

For Paperwork Reduction Act Notice, see Instructions.

Form **8916-A** (2009)

JXB F 01/27/10

Part II Interest Income

	Interest Income Item	(a) Income (Loss) per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Income (Loss) per Tax Return
1	Tax-exempt interest income				
2	Interest income from hybrid securities				
3	Sale/lease interest income				
4 a	Intercompany interest income - From outside tax affiliated group				
4 b	Intercompany interest income - From tax affiliated group	288,186			288,186
5	Other interest income	2,308,458	3,207,512		5,515,970
6	Total Interest Income. Add lines 1 through 5. Enter total on Schedule M-3 (Forms 1120, 1120-PC, and 1120-L), Part II, line 13 or Schedule M-3 (Forms 1065 and 1120-S) Part II, line 11.	2,596,644	3,207,512		5,804,156

Part III Interest Expense

	Interest Expense Item	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1	Interest expense from hybrid securities				
2	Lease/purchase interest expense				
3 a	Intercompany interest expense - Paid to outside tax affiliated group				
3 b	Intercompany interest expense - Paid to tax affiliated group	16,688,157			16,688,157
4	Other interest expense	5,936,263	-1,374,494		4,561,769
5	Total interest expense. Add lines 1 through 4. Enter total on Schedule M-3 (Form 1120) Part III, line 8; Schedule M-3 (Forms 1120-PC and 1120-L), Part III, line 36; Schedule M-3 (Form 1065) Part III, line 27; or Schedule M-3 (Form 1120-S) Part III, line 26.	22,624,420	-1,374,494		21,249,926

Form **4797**

Department of the Treasury
Internal Revenue Service (99)

Sales of Business Property
(Also Involuntary Conversions and Recapture Amounts Under Sections 179 and 280F(b)(2))

▶ Attach to your tax return. ▶ See separate instructions.

OMB No. 1545-0184

2009

Attachment Sequence No. 27

Name(s) shown on return: COLUMBIA GAS OF PENNSYLVANIA INC

Identifying number: 25-1100252

1 Enter the gross proceeds from sales or exchanges reported to you for 2009 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions) . . . 1

Part I Sales or Exchanges of Property Used in a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year (see instructions)

2 (a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)

3	Gain, if any, from Form 4684, line 43	3	
4	Section 1231 gain from installment sales from Form 6252, line 26 or 37	4	
5	Section 1231 gain or (loss) from like-kind exchanges from Form 8824	5	
6	Gain, if any, from line 32, from other than casualty or theft	6	
7	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows: **Partnerships (except electing large partnerships) and S corporations.** Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below. **Individuals, partners, S corporation shareholders, and all others.** If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.	7	0
8	Nonrecaptured net section 1231 losses from prior years (see instructions)	8	
9	Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions)	9	

Part II Ordinary Gains and Losses (see instructions)

10 Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):

Land	Various	Various		-30		(30)
Software Project	Various	Various			105,079	(105,079)
Public Utility	Various	Various	55,115	5,976,477	8,860,941	(2,829,349)

11	Loss, if any, from line 7	11	( )
12	Gain, if any, from line 7 or amount from line 8, if applicable	12	
13	Gain, if any, from line 31	13	
14	Net gain or (loss) from Form 4684, lines 35 and 42a	14	
15	Ordinary gain from installment sales from Form 6252, line 25 or 36	15	
16	Ordinary gain or (loss) from like-kind exchanges from Form 8824	16	
17	Combine lines 10 through 16	17	(2,934,458)
18	For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:		
a	If the loss on line 11 includes a loss from Form 4684, line 39, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions	18a	
b	Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14	18b	

COLUMBIA GAS OF PENNSYLVANIA INC
Form 4797 (2009)

25-1100252
Page 2

Part III Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255
(see instructions)

(a) Description of section 1245, 1250, 1252, 1254, or 1255 property:	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
B		
C		
D		

These columns relate to the properties on lines 19A through 19D. ▶		Property A	Property B	Property C	Property D
20	Gross sales price (Note: See line 1 before completing.)	20			
21	Cost or other basis plus expense of sale	21			
22	Depreciation (or depletion) allowed or allowable	22			
23	Adjusted basis. Subtract line 22 from line 21	23			
24	Total gain. Subtract line 23 from line 20	24			
25	**If section 1245 property:**				
a	Depreciation allowed or allowable from line 22	25a			
b	Enter the smaller of line 24 or 25a	25b			
26	**If section 1250 property:** If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.				
a	Additional depreciation after 1975 (see instructions)	26a			
b	Applicable percentage multiplied by the smaller of line 24 or line 26a (see instructions)	26b			
c	Subtract line 26a from line 24. If residential rental property or line 24 is not more than line 26a, skip lines 26d and 26e	26c			
d	Additional depreciation after 1969 and before 1976	26d			
e	Enter the smaller of line 26c or 26d	26e			
f	Section 291 amount (corporations only)	26f			
g	Add lines 26b, 26e, and 26f	26g			
27	**If section 1252 property:** Skip this section if you did not dispose of farmland or if this form is being completed for a partnership (other than an electing large partnership).				
a	Soil, water, and land clearing expenses	27a			
b	Line 27a multiplied by applicable percentage (see instructions)	27b			
c	Enter the smaller of line 24 or 27b	27c			
28	**If section 1254 property:**				
a	Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion (see instructions)	28a			
b	Enter the smaller of line 24 or 28a	28b			
29	**If section 1255 property:**				
a	Applicable percentage of payments excluded from income under section 126 (see instructions)	29a			
b	Enter the smaller of line 24 or 29a (see instructions)	29b			

Summary of Part III Gains. Complete property columns A through D through line 29b before going to line 30.

30	Total gains for all properties. Add property columns A through D, line 24	30	0
31	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32	Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 37. Enter the portion from other than casualty or theft on Form 4797, line 6	32	0

Part IV Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50% or Less
(see instructions)

		(a) Section 179	(b) Section 280F(b)(2)
33	Section 179 expense deduction or depreciation allowable in prior years	33	
34	Recomputed depreciation (see instructions)	34	
35	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35	0	0

Form **4562**

Department of the Treasury
Internal Revenue Service (99)

Depreciation and Amortization
(Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

OMB No. 1545-0172

2009

Attachment Sequence No. 67

Name(s) shown on return	Business or activity to which this form relates	Identifying number
COLUMBIA GAS OF PENNSYLVANIA INC	NATURAL GAS DISTRIBUTION	25-1100252

Part I Election To Expense Certain Property Under Section 179

Note: If you have any listed property, complete Part V before you complete Part I.

1	Maximum amount. See the instructions for a higher limit for certain businesses	1	$250,000
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	$800,000
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	0
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	250,000

6	(a) Description of property	(b) Cost (business use only)	(c) Elected cost

7	Listed property. Enter the amount from line 29	7		
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7		8	0
9	Tentative deduction. Enter the smaller of line 5 or line 8		9	0
10	Carryover of disallowed deduction from line 13 of your 2008 Form 4562		10	
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions)		11	250,000
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11		12	0
13	Carryover of disallowed deduction to 2010. Add lines 9 and 10, less line 12 ▶	13	0	

Note: Do not use Part II or Part III below for listed property. Instead, use Part V.

Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	18,306,099
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	956,385

Part III MACRS Depreciation (Do not include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2009	17	14,364,304
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B - Assets Placed in Service During 2009 Tax Year Using the General Depreciation System

	(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19 a	3-year property						
b	5-year property						
c	7-year property		-3,462	7.0	HY	200 DB	-495
d	10-year property						
e	15-year property		18,057,299	15.0	HY	150 DB	902,865
f	20-year property						
g	25-year property			25 yrs.		S/L	
h	Residential rental property			27.5 yrs.	MM	S/L	
				27.5 yrs.	MM	S/L	
i	Nonresidential real property		702,709	39 yrs.	MM	S/L	12,395
					MM	S/L	

Section C - Assets Placed in Service During 2009 Tax Year Using the Alternative Depreciation System

20 a	Class life				S/L	
b	12-year			12 yrs.	S/L	
c	40-year			40 yrs.	MM	S/L

Part IV Summary (See instructions.)

21	Listed property. Enter amount from line 28	21	
	Total. Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instr.	22	34,541,53
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	82,373

Part V Listed Property (Include automobiles, certain other vehicles, cellular telephones, certain computers, and property used for entertainment, recreation, or amusement.)

Note: For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete only 24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.

Section A - Depreciation and Other Information (Caution: See the instructions for limits for passenger automobiles.)

24a Do you have evidence to support the business/investment use claimed? [X] Yes [ ] No | 24b If "Yes," is the evidence written? [X] Yes [ ] No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use (see instructions)						25		
26 Property used more than 50% in a qualified business use:								
See Stmt 17		%	65,807					
		%						
		%						
27 Property used 50% or less in a qualified business use:								
		%				S/L-		
		%				S/L-		
		%				S/L-		
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1						28	0	
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1							29	0

Section B - Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other "more than 5% owner," or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
30 Total business/investment miles driven during the year (do not include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
33 Total miles driven during the year. Add lines 30 through 32												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
34 Was the vehicle available for personal use during off-duty hours?												
35 Was the vehicle used primarily by a more than 5% owner or related person?												
36 Is another vehicle available for personal use?												

Section C - Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who are not more than 5% owners or related persons (see instructions).

	Yes	No
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		X
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners	X	
39 Do you treat all use of vehicles by employees as personal use?		X
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?	X	
41 Do you meet the requirements concerning qualified automobile demonstration use? (See instructions.)		X

Note: If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles.

Part VI Amortization

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2009 tax year (see instructions):					
43 Amortization of costs that began before your 2009 tax year				43	126
44 Total. Add amounts in column (f). See the instructions for where to report				44	126

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2009

EIN: 25-1100252

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Form 1120, Page 1, Line 5, Interest income — **Statement: 1**

Description	Amount
INTERCOMPANY INT INCOME FROM TAX AFFILIATED GROUP	288,186
OTHER INTEREST INCOME	5,515,970
Total	5,804,156

Form 1120, Page 1, Line 10, Other income — **Statement: 2**

Description	Amount
CUSTOMER ADVANCES RECEIVED	(356,174)
INCOME ACCRUED ON REGULATORY LIABILITY	3,615,467
CONTRIBUTION IN AID OF CONSTRUCTION	899,530
MISC NON-OPERATING INCOME	1,863,300
Total	6,022,123

Form 1120, Page 1, Line 16, Rent expense — **Statement: 3**

Description	Amount
A&G - RENT EXPENSE	3,010,598
BUILDING LEASE WRITEDOWN/BUYOUTS	(166,709)
RENT EXPENSE: LEASED AUTOMOBILE	(590)
UTILITY RENT EXPENSE	772,412
Total	3,615,711

Form 1120, Page 1, Line 17, Taxes and licenses — **Statement: 4**

Description	Amount
STATE TAXES BASED ON INCOME	3,057,509
NET WORTH OR CAPITAL STOCK TAXES	497,995
REAL ESTATE / PERSONAL PROPERTY TAXES	744,578
GROSS RECEIPTS/STORAGE	13,113
PAYROLL TAXES	1,929,303
LICENSE / FRANCHISE	3,735
SALES/USE	423,990
OTHER TAXES	82,541
Total	6,752,764

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2009

EIN: 25-1100252

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Form 1120, Page 1, Line 18, Interest expense — **Statement: 5**

Description	Amount
INTEREST EXPENSE	4,644,142
INTERCOMPANY INT EXP - PAID TO TAX AFFILIATED GROUP	16,688,157
OTHER INTEREST EXPENSE	(82,373)
Total	21,249,926

Form 1120, Page 1, Line 26, Other deductions — **Statement: 6**

Description	Amount
BOOK HEDGING INCOME/LOSS	26,669,748
MISCELLANEOUS GENERAL EXPENSES	(46)
ENVIRONMENTAL COSTS	451,209
TAX AMORTIZATION: SEC 167	126
EXPENSE ACCRUED ON REGULATORY LIABILITY	2,481,220
PROPERTY COST OF REMOVAL	449,290
UNDERGROUND STORAGE OPERATING EXPENSES	158,612
GAS DISTRIBUTION OPERATING EXP	20,812,884
CUSTOMER ACCOUNTS EXPENSE	6,531,071
CUSTOMER SERVICE AND INFORMATIONAL EXPENSE	4,677,934
SALES EXPENSE	495,462
OFFICE SUPPLIES & EXP- NET OF ADMIN EXP TRNF	1,389,481
BUSINESS MEALS & ENTERTAINMENT	181,652
OUTSIDE SERVICES EMPLOYED	7,554,097
PROPERTY INSURANCE	669,612
INJURIES & DAMAGES	6,045,999
REGULATORY COMMISSION EXPENSE	1,720,599
MISCELLANEOUS GENERAL EXPENSES	214,669
Total	80,503,619

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2009

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Form 1120, Page 5, Schedule L, Line 6, Other current assets — **Statement: 7**

Description	Beginning Amount	Ending Amount
UNRECOVERED PURCHASED GAS	0	32,398,373
REGULATORY ASSETS	0	20,653,125
ACCTS REC - ASSOCIATES	1,054,284	48,943,907
PREPAYMENTS	2,402,838	2,895,741
INTEREST & DIVIDENDS REC	0	115,227
ACCRUED UTILITY REVENUES	71,636,552	52,978,404
MISC CURR & ACCR ASSETS	1,376,020	273,818
Total	76,469,694	158,258,595

Form 1120, Page 5, Schedule L, Line 14, Other assets — **Statement: 8**

Description	Beginning Amount	Ending Amount
CONSTRUCTION WORK IN PROGRESS	14,824,174	1,234,886
CUSTOMER ACCTS REC-UTILITY	0	4,696,666
CUSHION GAS	895,339	895,339
REGULATORY ASSETS	133,181,030	207,167,420
PRELIM GAS SURVEY & INVES	(202,717)	401,608
MISCELLANEOUS DFD DEBITS	5,566,314	5,288,856
UNRECOVERED PURCHSED GAS	57,258,225	0
Total	211,522,365	219,684,775

Form 1120, Page 5, Schedule L, Line 18, Other current liabilities — **Statement: 9**

Description	Beginning Amount	Ending Amount
DEFERRED REVENUE	0	658,863
ACCT PAYABLE-ASSOCIATES	89,659,515	13,377,965
ACCRUED TAXES	3,772,880	(886,829)
ACCRUED INTEREST	179,997	235,300
TAX COLLECTIONS PAYABLE	1,420,369	596,063
ACCRUED VACATIONS	3,480,309	3,601,908
CMEP-MAP MEDICAL RESERVE	123,750	96,797
OPEB LIABILITY-CUR	132,128	140,132
OTHER ACCRUED LIABILITIES	96,882,778	98,769,868
ACCRUED RATE REFUNDS	395,826	216,068
ACCUMULATED DFD TAXES	0	12,984,388
Total	196,047,552	129,790,523

COLUMBIA GAS OF PENNSYLVANIA INC

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Form 1120, Page 5, Schedule L, Line 20, Mortgages, notes, bonds payable in 1 year or more — **Statement: 10**

Description	Beginning Amount	Ending Amount
NOTES PAYABLE	285,215,000	285,215,000
Total	285,215,000	285,215,000

Form 1120, Page 5, Schedule L, Line 21, Other liabilities — **Statement: 11**

Description	Beginning Amount	Ending Amount
OTHER LIABILITIES	0	2,288,370
ASSET RETIREMENT OBLIGATIONS	8,658,204	9,726,290
OTHER DEFERRED CREDITS	39,084,409	64,499,918
DEFERRED REVENUE	0	1,364,311
OPEB LIABILITY-DEFERRED	14,653,705	10,818,401
OUTSTANDING LOSS RESERVES	2,785,040	212,051
POST EMPL. BENEFTI OBLIG	528,336	792,642
REGULATORY LIABILITIES NONCURRENT	6,263,898	76,054,570
ACCUM DFD INCOME TAXES	175,464,074	215,871,686
Total	247,437,666	381,628,239

Form 1120, Page 5, Schedule L, Line 26, Adjustments to shareholders' equity — **Statement: 12**

Description	Beginning Amount	Ending Amount
OTHER COMPREHENSIVE INCOME	0	(53,678)
Total	0	(53,678)

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2009

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Form 1120, Schedule M-3, Page 2, Part II, Line 25, Other income (loss) items with differences — **Statement: 13**

Description	Income (Loss) per Income Statement	Temporary Difference	Permanent Difference	Income (Loss) per Tax Return
MISC NON-OPERATING INCOME	1,988,418	(125,118)	0	1,863,300
CONTRIBUTION IN AID OF CONSTRUCTION	0	899,530	0	899,530
INCOME ACCRUED ON REGULATORY ASSET	(250,000)	250,000	0	0
CUSTOMER ADVANCES RECEIVED	0	(356,174)	0	(356,174)
RATE REFUND	242,518	(152,616)	0	89,902
Total	1,980,936	515,622	0	2,496,558

Form 1120, Schedule M-3, Page 3, Part III, Line 35, Other expense/deduction items with differences — **Statement: 14**

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
INJURIES & DAMAGES	3,473,010	2,572,989	0	6,045,999
PROPERTY INSURANCE	176,709	492,903	0	669,612
PROPERTY COST OF REMOVAL	0	449,290	0	449,290
LOBBYING EXPENSES	112,413	0	(112,413)	0
EXPENSE ACCRUED ON REGULATORY ASSET	1,912,941	(1,912,941)	0	0
ENVIRONMENTAL COSTS	0	451,209	0	451,209
EMPLOYEE INSURANCE PLANS	972,640	(20,174)	0	952,466
OTHER TAXES	7,011	75,530	0	82,541
SALES/USE	610,536	(186,546)	0	423,990
PAYROLL TAXES	1,913,709	15,594	0	1,929,303
REAL ESTATE / PERSONAL PROPERTY TAXES	496,840	247,738	0	744,578
RENT EXPENSE: LEASED AUTOMOBILE	0	0	(590)	(590)
BUILDING LEASE WRITEDOWN/BUYOUTS	0	(166,709)	0	(166,709)
REPAIRS OF GAS PIPELINE	0	30,669,856	0	30,669,856
Total	9,675,809	32,688,739	(113,003)	42,251,545

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2009

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Form 8916-A, Line 6, Other items with differences — **Statement: 15**

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
SYSTEM GAS LOSSES	4,398	(4,398)	0	0
PURCHSE GAS ADJUSTMENT	23,602,472	(23,602,472)	0	0
EXCESS BANK PURCHASES	254,755	(254,755)	0	0
Total	23,861,625	(23,861,625)	0	0

Form 8916-A, Line 7, Other items with no differences — **Statement: 16**

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
OTHER GAS SUPPLY EXPENSES	30,174,521	0	0	30,174,521
EXCHANGE GAS EXPENSE	(10,533,510)	0	0	(10,533,510)
NATURAL GAS PURCHASES	247,694,408	0	0	247,694,408
Total	267,335,419	0	0	267,335,419

COLUMBIA GAS OF PENNSYLVANIA INC

Tax Year 2009

EIN 25-1100252
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Statement: 17

Form 4562, Page 2, Part V, Section A, Line 26, Listed property used more than 50%

Row ID	Type of Property	Date Placed in Service	Business Use Percentage	Cost	Basis for Depreciation	Recovery Period	Method (200 DB) (150 DB) (DB) (S/L) Convention (HY) (MM) (MQ) (S/L) (PRE)	Depreciation Deduction	Elected Sec 179 Cost
1	Leased Vehicles	07/01/2004	100.000000%	102					
2	Leased Vehicles	07/01/2005	100.000000%	9,295					
3	Leased Vehicles	07/01/2006	100.000000%	12,356					
4	Leased Vehicles	07/01/2007	100.000000%	14,347					
5	Leased Vehicles	07/01/2008	100.000000%	13,688					
6	Leased Vehicles	07/01/2009	100.000000%	16,019					
Total				65,807					

Form **1120**

Department of the Treasury
Internal Revenue Service

U.S. Corporation Income Tax Return

For calendar year 2010 or tax year beginning _____ ending _____

▶ See separate instructions.

OMB No. 1545-0123

2010

A Check if:
1a Consolidated return (attach Form 851) ☐
b Life/nonlife consolidated return ☐
2 Personal holding co. (attach Sch. PH) ☐
3 Personal service corp. (see instr) ☐
4 Schedule M-3 attached ☒

Print or type

Name: COLUMBIA GAS OF PENNSYLVANIA INC

Number, street, and room or suite no. If a P.O. box, see instructions.: 200 CIVIC CENTER DRIVE

City or town, state, and ZIP code: COLUMBUS OH 43215

B Employer identification number: 25-1100252

C Date incorporated: 06/23/1960

D Total assets (see instructions): $ 1,198,806,775

E Check if: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change

Income	1a Gross receipts or sales 559,676,056 b Less returns and allowances _____ c Bal ▶	1c	559,676,056
	2 Cost of goods sold (Schedule A, line 8)	2	315,316,985
	3 Gross profit. Subtract line 2 from line 1c	3	244,359,071
	4 Dividends (Schedule C, line 19)	4	0
	5 Interest See Stmt 1	5	-796,425
	6 Gross rents	6	113,430
	7 Gross royalties	7	
	8 Capital gain net income (attach Schedule D (Form 1120))	8	0
	9 Net gain or (loss) from Form 4797, Part II, line 17 (attach Form 4797)	9	-3,496,916
	10 Other income (see instructions - attach schedule) See Stmt 2	10	1,585,113
	11 Total income. Add lines 3 through 10 ▶	11	241,764,273
Deductions (See instructions for limitations on deductions.)	12 Compensation of officers (Schedule E, line 4) ▶	12	0
	13 Salaries and wages (less employment credits)	13	25,033,765
	14 Repairs and maintenance	14	50,297,721
	15 Bad debts	15	20,878,715
	16 Rents See Stmt 3	16	3,301,338
	17 Taxes and licenses See Stmt 4	17	3,945,867
	18 Interest See Stmt 5	18	14,747,845
	19 Charitable contributions	19	475,986
	20 Depreciation from Form 4562 not claimed on Schedule A or elsewhere on return (attach Form 4562)	20	43,083,366
	21 Depletion	21	
	22 Advertising	22	291,541
	23 Pension, profit-sharing, etc., plans	23	10,039,545
	24 Employee benefit programs	24	6,219,326
	25 Domestic production activities deduction (attach Form 8903)	25	
	26 Other deductions (attach schedule) See Stmt 6	26	75,272,649
	27 Total deductions. Add lines 12 through 26 ▶	27	253,587,664
	28 Taxable income before net operating loss deduction and special deductions. Subtract line 27 from line 11	28	-11,823,391
	29 Less: a Net operating loss deduction (see instructions) 29a _____		
	b Special deductions (Schedule C, line 20) 29b 0	29c	0
	30 Taxable income. Subtract line 29c from line 28 (see instructions)	30	-11,823,391
Tax, Refundable Credits, and Payments	31 Total tax (Schedule J, line 10)	31	
	32a 2009 overpayment credited to 2010 32a _____		
	b 2010 estimated tax payments 32b _____		
	c 2010 refund applied for on Form 4466 32c ( ) d Bal ▶ 32d _____		
	e Tax deposited with Form 7004 32e _____		
	f Credits: (1) Form 2439 _____ (2) Form 4136 _____ 32f _____		
	g Refundable credits from Form 3800, line 19c, and Form 8827, line 8c 32g _____	32h	
	33 Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐	33	
	34 Amount owed. If line 32h is smaller than the total of lines 31 and 33, enter amount owed	34	
	35 Overpayment. If line 32h is larger than the total of lines 31 and 33, enter amount overpaid	35	
	36 Enter amount from line 35 you want: Credited to 2011 estimated tax ▶ Refunded ▶	36	

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign Here

Signature of officer _____ Date _____ Title _____

May the IRS discuss this return with the preparer shown below (see instr)? ☐ Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN

Firm's name ▶ _____ Firm's EIN ▶ _____

Firm's address ▶ _____ Phone no. _____

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Schedule A Cost of Goods Sold (see instructions)

1	Inventory at beginning of year	1	66,728,792
2	Purchases	2	306,035,133
3	Cost of labor	3	
4	Additional section 263A costs (attach schedule)	4	0
5	Other costs (attach schedule)	5	0
6	Total. Add lines 1 through 5	6	372,763,925
7	Inventory at end of year	7	57,446,940
8	Cost of goods sold. Subtract line 7 from line 6. Enter here and on page 1, line 2	8	315,316,985

9 a Check all methods used for valuing closing inventory:
- (i) ☒ Cost
- (ii) ☐ Lower of cost or market
- (iii) ☐ Other (Specify method used and attach explanation.) ▶

b Check if there was a writedown of subnormal goods ▶ ☐

c Check if the LIFO inventory method was adopted this tax year for any goods (if checked, attach Form 970) ▶ ☐

d If the LIFO inventory method was used for this tax year, enter percentage (or amounts) of closing inventory computed under LIFO 9d

e If property is produced or acquired for resale, do the rules of section 263A apply to the corporation? ☒ Yes ☐ No

f Was there any change in determining quantities, cost, or valuations between opening and closing inventory? If "Yes," attach explanation ☐ Yes ☒ No

Schedule C Dividends and Special Deductions (see instructions)

		(a) Dividends received	(b)	(c) Special deductions (a) x (b)
1	Dividends from less-than-20 -owned domestic corporations (other than debt-financed stock)		70	
2	Dividends from 20 -or-more-owned domestic corporations (other than debt-financed stock)		80	
3	Dividends on debt-financed stock of domestic and foreign corporations		see instructions	
4	Dividends on certain preferred stock of less-than-20 -owned public utilities		42	
5	Dividends on certain preferred stock of 20 -or-more-owned public utilities		48	
6	Dividends from less-than-20 -owned foreign corporations and certain FSCs		70	
7	Dividends from 20 -or-more-owned foreign corporations and certain FSCs		80	
8	Dividends from wholly owned foreign subsidiaries		100	
9	*Total. Add lines 1 through 8. See instructions for limitation*			0
10	Dividends from domestic corporations received by a small business investment company operating under the Small Business Investment Act of 1958		100	
11	Dividends from affiliated group members		100	
12	Dividends from certain FSCs		100	
13	Dividends from foreign corporations not included on lines 3, 6, 7, 8, 11, or 12			
14	Income from controlled foreign corporations under subpart F (attach Form(s) 5471)			
15	Foreign dividend gross-up			
16	IC-DISC and former DISC dividends not included on lines 1, 2, or 3			
17	Other dividends			
18	Deduction for dividends paid on certain preferred stock of public utilities			
19	Total dividends. Add lines 1 through 17. Enter here and on page 1, line 4 ▶	0		
20	Total special deductions. Add lines 9, 10, 11, 12, and 18. Enter here and on page 1, line 29b ▶			0

Schedule E Compensation of Officers (see instructions for page 1, line 12)

Note: Complete Schedule E only if total receipts (line 1a plus lines 4 through 10 on page 1) are $500,000 or more.

	(a) Name of officer	(b) Social security number	(c) Percent of time devoted to business	Percent of corporation stock owned (d) Common	Percent of corporation stock owned (e) Preferred	(f) Amount of compensation
1						
2	Total compensation of officers					0
3	Compensation of officers claimed on Schedule A and elsewhere on return					
4	Subtract line 3 from line 2. Enter the result here and on page 1, line 12					0

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Schedule J Tax Computation (see instructions)

1	Check if the corporation is a member of a controlled group (attach Schedule O (Form 1120)) ▶ ☐			
2	Income tax. Check if a qualified personal service corporation (see instructions) ▶ ☐		2	
3	Alternative minimum tax (attach Form 4626)		3	
4	Add lines 2 and 3		4	
5a	Foreign tax credit (attach Form 1118)	5a		
b	Credit from Form 8834, line 29	5b		
c	General business credit (attach Form 3800)	5c		
d	Credit for prior year minimum tax (attach Form 8827)	5d		
e	Bond credits from Form 8912	5e		
6	Total credits. Add lines 5a through 5e		6	
7	Subtract line 6 from line 4		7	
8	Personal holding company tax (attach Schedule PH (Form 1120))		8	
9	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Form 8902 ☐ Other (attach schedule)		9	
10	Total tax. Add lines 7 through 9. Enter here and on page 1, line 31		10	

Schedule K Other Information (see instructions)

		Yes	No
1	Check accounting method: a ☐ Cash b ☒ Accrual c ☐ Other (specify) ▶		
2	See the instructions and enter the:		
a	Business activity code no. ▶ 221210		
b	Business activity ▶ NATURAL GAS DISTRIBUTION		
c	Product or service ▶ NATURAL GAS DISTRIBUTION		
3	Is the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group?	X	
	If "Yes," enter name and EIN of the parent corporation ▶ NiSource Inc 35-2108964		
4	At the end of the tax year:		
a	Did any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, or tax-exempt organization own directly 20 or more, or own, directly or indirectly, 50 or more of the total voting power of all classes of the corporation's stock entitled to vote? If "Yes," complete Part I of Schedule G (Form 1120) (attach Schedule G)	X	
b	Did any individual or estate own directly 20 or more, or own, directly or indirectly, 50 or more of the total voting power of all classes of the corporation's stock entitled to vote? If "Yes", complete Part II of Schedule G (Form 1120) (attach Schedule G)		X
5	At the end of the tax year, did the corporation:		
a	Own directly 20 or more, or own, directly or indirectly, 50 or more of the total voting power of all classes of stock entitled to vote of any foreign or domestic corporation not included on Form 851, Affiliations Schedule? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (iv).		X

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage Owned in Voting Stock

OLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Schedule K Continued

		Yes	No
b	Own directly an interest of 20 or more, or own, directly or indirectly, an interest of 50 or more in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (iv).		X

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Country of Organization	(iv) Maximum Percentage Owned in Profit, Loss, or Capital

6	During this tax year, did the corporation pay dividends (other than stock dividends and distributions in exchange for stock) in excess of the corporation's current and accumulated earnings and profits? (See sections 301 and 316.) . . . . . If "Yes," file Form 5452, Corporate Report of Nondividend Distributions. If this is a consolidated return, answer here for the parent corporation and on Form 851 for each subsidiary.		X
7	At any time during the tax year, did one foreign person own, directly or indirectly, at least 25 of (a) the total voting power of all classes of the corporation's stock entitled to vote or (b) the total value of all classes of the corporation's stock? . . . . . For rules of attribution, see section 318. If "Yes," enter: (i) Percentage owned ▶ _____ and (ii) Owner's country ▶ _____		X
	(c) The corporation may have to file Form 5472, Information Return of a 25 Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business. Enter the number of Forms 5472 attached ▶ _____		
	Check this box if the corporation issued publicly offered debt instruments with original issue discount . . . . . ▶ ☐ If checked, the corporation may have to file Form 8281, Information Return for Publicly Offered Original Issue Discount Instruments.		
9	Enter the amount of tax-exempt interest received or accrued during the tax year ▶$ NONE		
10	Enter the number of shareholders at the end of the tax year (if 100 or fewer) ▶ 1		
11	If the corporation has an NOL for the tax year and is electing to forego the carryback period, check here. . . . . ▶ ☐ If the corporation is filing a consolidated return, the statement required by Regulations section 1.1502-21(b)(3) must be attached or the election will not be valid.		
12	Enter the available NOL carryover from prior tax years (do not reduce it by any deduction on line 29a.) ▶$ _____		
13	Are the corporation's total receipts (line 1a plus lines 4 through 10 on page 1) for the tax year and its total assets at the end of the tax year less than $250,000? . . . . . If "Yes," the corporation is not required to complete Schedules L, M-1, and M-2 on page 5. Instead, enter the total amount of cash distributions and the book value of property distributions (other than cash) made during the tax year. ▶$ _____		X
14	Is the corporation required to file Schedule UTP (Form 1120), Uncertain Tax Position Statement (see instructions)? . . . . . If "Yes," complete and attach Schedule UTP.		

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Form 1120 (2010) Page 5

Schedule L Balance Sheets per Books

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
Cash		14,184,587		12,629,142
Trade notes and accounts receivable	36,294,691		50,650,880	
Less allowance for bad debts	(3,324,837)	32,969,854	(21)	50,650,859
3 Inventories		56,808,546		47,563,441
4 U.S. government obligations				
5 Tax-exempt securities (see instructions)				
6 Other current assets (attach schedule) See Stmt 7		158,258,595		117,411,504
7 Loans to shareholders				
8 Mortgage and real estate loans				
9 Other investments (attach schedule) See Stmt 8		0		15,995,659
10 a Buildings and other depreciable assets	943,841,828		1,004,361,797	
b Less accumulated depreciation	(274,295,972)	669,545,856	(283,974,703)	720,387,094
11 a Depletable assets				
b Less accumulated depletion	( )		( )	
12 Land (net of any amortization)		2,156,415		2,325,305
13 a Intangible assets (amortizable only)	5,526,270		6,995,988	
b Less accumulated amortization	(2,988,772)	2,537,498	(3,456,987)	3,539,001
14 Other assets (attach schedule) See Stmt 9		219,684,775		228,304,770
15 Total assets		1,156,146,126		1,198,806,775
Liabilities and Shareholders' Equity				
16 Accounts payable		31,965,401		43,808,681
17 Mortgages, notes, bonds payable in less than 1 year				
18 Other current liabilities (attach schedule) See Stmt 10		129,790,523		96,533,680
19 Loans from shareholders				
20 Mortgages, notes, bonds payable in 1 yr or more See Stmt 11		285,215,000		313,215,000
21 Other liabilities (attach schedule) See Stmt 12		381,628,239		398,905,266
22 Capital stock: a Preferred stock				
b Common stock	45,127,800	45,127,800	45,127,800	45,127,800
23 Additional paid-in capital		7,466,506		7,577,387
24 Retained earnings - Appropriated (attach schedule)		0		0
25 Retained earnings - Unappropriated See Stmt 13		275,006,335		293,693,404
26 Adjustments to shareholders' equity (attach schedule)		(53,678)		(54,443)
27 Less cost of treasury stock		( )		( )
28 Total liabilities and shareholders' equity		1,156,146,126		1,198,806,775

Schedule M-1 Reconciliation of Income (Loss) per Books With Income per Return

Note: Schedule M-3 required instead of Schedule M-1 if total assets are $10 million or more - see instructions

1 Net income (loss) per books		7 Income recorded on books this year not included on this return (itemize): Tax-exempt interest $	
2 Federal income tax per books			
3 Excess of capital losses over capital gains			
4 Income subject to tax not recorded on books this year (itemize):		8 Deductions on this return not charged against book income this year (itemize):	
5 Expenses recorded on books this year not deducted on this return (itemize):		a Depreciation $	
a Depreciation $		b Charitable contributions $	
b Charitable contributions $			
c Travel and entertainment $			
6 Add lines 1 through 5		9 Add lines 7 and 8	
		10 Income (page 1, line 28) - line 6 less line 9	

Schedule M-2 Analysis of Unappropriated Retained Earnings per Books (Line 25, Schedule L)

1 Balance at beginning of year	275,006,335	5 Distributions: a Cash	31,500,000
2 Net income (loss) per books	50,187,069	b Stock	
3 Other increases (itemize):		c Property	
		6 Other decreases (itemize):	0
	0	7 Add lines 5 and 6	31,500,000
4 Add lines 1, 2, and 3	325,193,404	8 Balance at end of year (line 4 less line 7)	293,693,404

Form **4626**

ment of the Treasury
...al Revenue Service

Alternative Minimum Tax - Corporations

▶ See separate instructions.
▶ Attach to the corporation's tax return.

OMB No. 1545-0175

2010

Name

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number

25-1100252

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1	Taxable income or (loss) before net operating loss deduction			1	-11,823,391
2	**Adjustments and preferences:**				
a	Depreciation of post-1986 property			2a	463,664
b	Amortization of certified pollution control facilities			2b	
c	Amortization of mining exploration and development costs			2c	
d	Amortization of circulation expenditures (personal holding companies only)			2d	
e	Adjusted gain or loss			2e	-767,620
f	Long-term contracts			2f	
g	Merchant marine capital construction funds			2g	
h	Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only)			2h	
i	Tax shelter farm activities (personal service corporations only)			2i	
j	Passive activities (closely held corporations and personal service corporations only)			2j	
k	Loss limitations			2k	
l	Depletion			2l	
m	Tax-exempt interest income from specified private activity bonds			2m	
n	Intangible drilling costs			2n	
o	Other adjustments and preferences			2o	
3	Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o			3	-12,127,347
4	**Adjusted current earnings (ACE) adjustment:**				
a	ACE from line 10 of the ACE worksheet in the instructions	4a	-15,920,695		
	Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions)	4b	-3,793,348		
c	Multiply line 4b by 75 (.75). Enter the result as a positive amount	4c	2,845,011		
d	Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). Note: You **must** enter an amount on line 4d (even if line 4b is positive)	4d	46,867,921		
e	ACE adjustment. • If line 4b is zero or more, enter the amount from line 4c • If line 4b is less than zero, enter the smaller of line 4c or line 4d as a negative amount			4e	-2,845,011
5	Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT			5	-14,972,358
6	Alternative tax net operating loss deduction (see instructions)			6	
7	**Alternative minimum taxable income.** Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions			7	
8	**Exemption phase-out** (if line 7 is $310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):				
a	Subtract $150,000 from line 7 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-	8a			
b	Multiply line 8a by 25 (.25)	8b			
c	Exemption. Subtract line 8b from $40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-			8c	
9	Subtract line 8c from line 7. If zero or less, enter -0-			9	
10	Multiply line 9 by 20 (.20)			10	
11	Alternative minimum tax foreign tax credit (AMTFTC) (see instructions)			11	
12	Tentative minimum tax. Subtract line 11 from line 10			12	
13	Regular tax liability before applying all credits except the foreign tax credit			13	
	Alternative minimum tax. Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on Form 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return.			14	

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Adjusted Current Earnings (ACE) Worksheet

▶ See ACE Worksheet Instructions. (which begin on page 8).

1	Pre-adjustment AMTI. Enter the amount from line 3 of Form 4626					1	-12,127,347
	ACE depreciation adjustment:						
a	AMT depreciation			2a	42,619,702		
b	ACE depreciation.						
	(1) Post-1993 property	2b(1)	39,371,341				
	(2) Post-1989, pre-1994 property	2b(2)	1,810,997				
	(3) Pre-1990 MACRS property	2b(3)	1,511,355				
	(4) Pre-1990 original ACRS property	2b(4)	1,514,919				
	(5) Property described in sections 168(f)(1) through (4)	2b(5)					
	(6) Other property	2b(6)	772,546				
	(7) Total ACE depreciation. Add lines 2b(1) through 2b(6)			2b(7)	44,981,158		
c	ACE depreciation adjustment. Subtract line 2b(7) from line 2a					2c	-2,361,456
3	Inclusion in ACE of items included in earnings and profits (E&P):						
a	Tax-exempt interest income			3a			
b	Death benefits from life insurance contracts			3b			
c	All other distributions from life insurance contracts (including surrenders)			3c			
d	Inside buildup of undistributed income in life insurance contracts			3d			
e	Other items (see Regulations sections 1.56(g)-1(c)(6)(iii) through (ix) for a partial list)			3e			
f	Total increase to ACE from inclusion in ACE of items included in E&P. Add lines 3a through 3e					3f	0
4	Disallowance of items not deductible from E&P:						
a	Certain dividends received			4a			
b	Dividends paid on certain preferred stock of public utilities that are deductible under section 247			4b			
c	Dividends paid to an ESOP that are deductible under section 404(k)			4c			
d	Nonpatronage dividends that are paid and deductible under section 1382(c)			4d			
e	Other items (see Regulations sections 1.56(g)-1(d)(3)(i) and (ii) for a partial list)			4e			
f	Total increase to ACE because of disallowance of items not deductible from E&P. Add lines 4a through 4e					4f	0
5	Other adjustments based on rules for figuring E&P:						
a	Intangible drilling costs			5a			
b	Circulation expenditures			6b			
c	Organizational expenditures			5c			
d	LIFO inventory adjustments			5d	-1,192,107		
e	Installment sales			5e			
f	Total other E&P adjustments. Combine lines 5a through 5e					6f	-1,192,107
6	Disallowance of loss on exchange of debt pools					6	
7	Acquisition expenses of life insurance companies for qualified foreign contracts					7	
8	Depletion					8	
9	Basis adjustments in determining gain or loss from sale or exchange of pre-1994 property					9	-239,785
10	Adjusted current earnings. Combine lines 1, 2c, 3f, 4f, and 5f through 9. Enter the result here and on line 4a of Form 4626					10	-15,920,695

For Paperwork Reduction Act Notice, See Instructions.

JXB F 02/10/05

Form **4136**
Department of the Treasury
Internal Revenue Service (99)

Credit for Federal Tax Paid on Fuels

▶ See the separate instructions.
▶ Attach this form to your income tax return.

OMB No. 1545-0162
2010
Attachment Sequence No. 23

Name (as shown on your income tax return): COLUMBIA GAS OF PENNSYLVANIA INC
Taxpayer identification number: 25-1100252

Caution. Claimant has the name and address of the person who sold the fuel to the claimant and the dates of purchase. For claims on lines 1c and 2b (type of use 13 and 14), 3d, 4c, and 5, claimant has not waived the right to make the claim. For claims on lines 1c and 2b (type of use 13 and 14), claimant certifies that a certificate has not been provided to the credit card issuer.

1 Nontaxable Use of Gasoline

Note. CRN is credit reference number.

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Off-highway business use		$ .183			
b Use on a farm for farming purposes		.183			362
c Other nontaxable use (see Caution above line 1)		.183		$	
d Exported		.184			411

2 Nontaxable Use of Aviation Gasoline

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Use in commercial aviation (other than foreign trade)		$ .15*		$	354
b Other nontaxable use (see Caution above line 1)		.193*			324
c Exported		.194*			412
d LUST tax on aviation fuels used in foreign trade		.001			433

*See instructions for possible rate changes.

Nontaxable Use of Undyed Diesel Fuel

Claimant certifies that the diesel fuel did not contain visible evidence of dye.
Exception. If any of the diesel fuel included in this claim did contain visible evidence of dye, attach an explanation and check here ▶ ☐

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Nontaxable use	02	$ .243	49,346		
b Use on a farm for farming purposes		.243		$ 11,991	360
c Use in trains		.243			353
d Use in certain intercity and local buses (see Caution above line 1)		.17			350
e Exported		.244			413

4 Nontaxable Use of Undyed Kerosene (Other Than Kerosene Used In Aviation)

Claimant certifies that the kerosene did not contain visible evidence of dye.
Exception. If any of the kerosene included in this claim did contain visible evidence of dye, attach an explanation and check here ▶ ☐

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Nontaxable use taxed at $.244		$ .243			
b Use on a farm for farming purposes		.243		$	346
c Use in certain intercity and local buses (see Caution above line 1)		.17			347
d Exported		.244			414
e Nontaxable use taxed at $.044		.043			377
f Nontaxable use taxed at $.219		.218			369

5 Kerosene Used in Aviation (see Caution above line 1)

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Kerosene used in commercial aviation (other than foreign trade) taxed at $.244		$ .200		$	417
b Kerosene used in commercial aviation (other than foreign trade) taxed at $.219*		.175*			355
c Nontaxable use (other than use by state or local government) taxed at $.244		.243			346
d Nontaxable use (other than use by state or local government) taxed at $.219*		.218*			369
e LUST tax on aviation fuels used in foreign trade		.001			433

*See instructions for possible rate changes.

6 Sales by Registered Ultimate Vendors of Undyed Diesel Fuel Registration No. ▶

Claimant certifies that it sold the diesel fuel at a tax-excluded price, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. Claimant certifies that the diesel fuel did not contain visible evidence of dye.

Exception. If any of the diesel fuel included in this claim did contain visible evidence of dye, attach an explanation and check here . . . . ▶ ☐

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Use by a state or local government	$ .243		$	360
b Use in certain intercity and local buses	.17			350

7 Sales by Registered Ultimate Vendors of Undyed Kerosene (Other Than Kerosene For Use in Aviation) Registration No. ▶

Claimant certifies that it sold the kerosene at a tax-excluded price, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. Claimant certifies that the kerosene did not contain visible evidence of dye.

Exception. If any of the kerosene included in this claim did contain visible evidence of dye, attach an explanation and check here . . . . ▶ ☐

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Use by a state or local government	$ .243			
b Sales from a blocked pump	.243		$	346
c Use in certain intercity and local buses	.17			347

8 Sales by Registered Ultimate Vendors of Kerosene For Use In Aviation Registration No. ▶

Claimant sold the kerosene for use in aviation at a tax-excluded price and has not collected the amount of tax from the buyer, repaid the amount of tax to the buyer, or has obtained the written consent of the buyer to make the claim. See the instructions for additional information to be submitted.

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Use in commercial aviation (other than foreign trade) taxed at $.219*		$ .175*		$	355
b Use in commercial aviation (other than foreign trade) taxed at $.244		.200			417
c Nonexempt use in noncommercial aviation		.025*			418
d Other nontaxable uses taxed at $.244		.243			346
e Other nontaxable uses taxed at $.219*		.218*			369
f LUST tax on aviation fuels used in foreign trade		.001			433

* See instructions for possible rate changes.

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Form 4136 (2010)

9 Alcohol Fuel Mixture Credit Registration No. ▶

Claimant produced an alcohol fuel mixture by mixing taxable fuel with alcohol. The alcohol fuel mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant.

		(b) Rate	(c) Gallons of alcohol	(d) Amount of credit	(e) CRN
a	Alcohol fuel mixtures containing ethanol	$ .45		$	393
b	Alcohol fuel mixtures containing alcohol (other than ethanol)	.60			394

10 Biodiesel or Renewable Diesel Mixture Credit Registration No. ▶

Biodiesel mixtures. Claimant produced a mixture by mixing biodiesel with diesel fuel. The biodiesel used to produce the mixture met ASTM D6751 and met EPA's registration requirements for fuels and fuel additives. The mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant. Claimant has attached the Certificate for Biodiesel and, if applicable, the Statement of Biodiesel Reseller. **Renewable diesel mixtures.** Claimant produced a mixture by mixing renewable diesel with liquid fuel (other than renewable diesel). The renewable diesel used to produce the renewable diesel mixture was derived from biomass process, met EPA's registration requirements for fuels and fuel additives, and met ASTM D975, D396, or other equivalent standard approved by the IRS. The mixture was sold by the claimant to any person for use as a fuel or was used as a fuel by the claimant. Claimant has attached the Certificate for Biodiesel and, if applicable, the Statement of Biodiesel Reseller, both of which have been edited as discussed in the Instructions for Form 4136. See the Instr for line 10 for information about renewable diesel used in aviation.

		(b) Rate	(c) Gallons of biodiesel or renewable diesel	(d) Amount of credit	(e) CRN
a	Biodiesel (other than agri-biodiesel) mixtures	$ 1.00		$	388
b	Agri-biodiesel mixtures	$ 1.00			390
c	Renewable diesel mixtures	$ 1.00			307

11 Nontaxable Use of Alternative Fuel

Caution. There is a reduced credit rate for use in certain intercity and local buses (type of use 5) (see instructions).

		(a) Type of use	(b) Rate	(c) Gallons or gasoline gallon equivalents (GGE)	(d) Amount of credit	(e) CRN
a	Liquefied petroleum gas (LPG)		$ .183		$	419
b	"P Series" fuels		.183			420
c	Compressed natural gas (CNG) (GGE = 126.67 cu. ft.)		.183			421
d	Liquefied hydrogen		.183			422
e	Any liquid fuel derived from coal (including peat) through the Fischer-Tropsch process		.243			423
f	Liquid fuel derived from biomass		.243			424
g	Liquefied natural gas (LNG)		.243			425
h	Liquefied gas derived from biomass		.183			435

12 Alternative Fuel Credit and Alternative Fuel Mixture Credit Registration No. ▶

		(b) Rate	(c) Gallons or gasoline gallon equivalents (GGE)	(d) Amount of credit	(e) CRN
a	Liquefied petroleum gas (LPG)	$ .50		$	426
b	"P Series" fuels	.50			427
c	Compressed natural gas (CNG) (GGE = 121 cu. ft.)	.50			428
d	Liquefied hydrogen	.50			429
e	Any liquid fuel derived from coal (including peat) through the Fischer-Tropsch process	.50			430
f	Liquid fuel derived from biomass	.50			431
g	Liquefied natural gas (LNG)	.50			432
h	Liquefied gas derived from biomass	.50			436
i	Compressed gas derived from biomass (GGE = 121 cu. ft.)	.50			437

13 Registered Credit Card Issuers — Registration No. ▶

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
Diesel fuel sold for the exclusive use of a state or local government	$ .243		$	360
Kerosene sold for the exclusive use of a state or local government	.243			346
c Kerosene for use in aviation sold for the exclusive use of a state or local government taxed at $.219*	.218*			369

*See instructions for possible rate changes.

14 Nontaxable Use of a Diesel-Water Fuel Emulsion

Caution. There is a reduced credit rate for use in certain intercity and local buses (type of use 5) (see instructions).

	(a) Type of use	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Nontaxable use		$ .197		$	309
b Exported		.198			306

15 Diesel-Water Fuel Emulsion Blending — Registration No. ▶

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
Blender credit	$ .046		$	310

16 Exported Dyed Fuels and Exported Gasoline Blendstocks

	(b) Rate	(c) Gallons	(d) Amount of credit	(e) CRN
a Exported dyed diesel fuel and exported gasoline blendstocks taxed at $.001	$ .001		$	415
b Exported dyed kerosene	.001			416

17 **Total income tax credit claimed.** Add lines 1 through 16, column (d). Enter here and on Form 1040, line 70; Form 1120, line 32f(2); Form 1120S, line 23c; Form 1041, line 24g; or the proper line of other returns. ▶	17	$ 11,991	

SCHEDULE B
(Form 1120)
(Rev. December 2009)
Department of the Treasury
Internal Revenue Service

Additional Information for Schedule M-3 Filers

▶ Attach to Form 1120.
▶ See Instructions.

OMB No. 1545-0123

Name: COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number (EIN): 25-1100252

		Yes	No
1	Do the amounts reported on Schedule M-3 (Form 1120), Part II, lines 9 or 10, column (d), reflect allocations to this corporation from a partnership of income, gain, loss, deduction, or credit that are disproportionate to this corporation's capital contribution to the partnership or its ratio for sharing other items of the partnership?		X
2	At any time during the tax year, did the corporation sell, exchange, or transfer any interest in an intangible asset to a related person as defined in section 267(b)?		X
3	At any time during the tax year, did the corporation acquire any interest in an intangible asset from a related person as defined in section 267(b)?		X
4a	During the tax year, did the corporation enter into a cost-sharing arrangement with any related foreign party *on whose behalf the corporation did not file Form 5471, Information Return of U.S. Persons With Respect To* Certain Foreign Corporations?		X
b	At any time during the tax year, was the corporation a participant in a cost-sharing arrangement with any related foreign party on whose behalf the corporation did not file Form 5471?		X
5	At any time during the tax year, did the corporation make any change in accounting principle for financial accounting purposes? See Instructions for the definition of change in accounting principle		X
6	At any time during the tax year, did the corporation make any change in a method of accounting for U.S. income tax purposes?		X
7	At any time during the tax year, did the corporation own any voluntary employees' beneficiary association (VEBA) trusts that were used to hold funds designated for employee benefits?	X	
8	At any time during the tax year, did the corporation use an allocation method for indirect costs capitalized to self-constructed assets that varied from its financial method of accounting?	X	X
9	At any time during the tax year, did the corporation treat for tax purposes indirect costs, as defined in Regulations sections 1.263A-1(e)(3)(ii)(F), (G), and (H), as mixed-service costs, as defined in Regulations section 1.263A-1(e)(4)(ii)(C)?		X
10	Did the corporation, under section 118 or 362(c) and the related regulations, take a return filing position *characterizing any amount as a contribution to the capital of the corporation during the tax year by any* non-shareholders? Amounts so characterized may include, without limitation, incentives, inducements, money, and property	X	X

SCHEDULE G
(Form 1120)
Department of the Treasury
Internal Revenue Service

Information on Certain Persons Owning the Corporation's Voting Stock

▶ Attach to Form 1120.
▶ See Instructions.

OMB No. 1545-0123

2010

[redacted]BIA GAS OF PENNSYLVANIA INC

Employer identification number (EIN)
25-1100252

Part I Certain Entities Owning the Corporation's Voting Stock. (Form 1120, Schedule K, Question 4a). Complete columns (i) through (v) below for any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, or tax-exempt organization that owns directly 20 or more, or owns, directly or indirectly, 50 or more of the total voting power of all classes of the corporation's stock entitled to vote (see instructions).

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Percentage Owned in Voting Stock
Columbia Energy Group	13-1594808	C-Corp	US	100.0000%

Part II Certain Individuals and Estates Owning the Corporation's Voting Stock. (Form 1120, Schedule K, Question 4b). Complete columns (i) through (iv) below for any individual or estate that owns directly 20 or more, or owns, directly or indirectly, 50 or more of the total voting power of all classes of the corporation's stock entitled to vote (see instructions).

(i) Name of Individual or Estate	(ii) Identifying Number (if any)	(iii) Country of Citizenship (see instructions)	(iv) Percentage Owned in Voting Stock

SCHEDULE M-3 (Form 1120)

Department of the Treasury
Internal Revenue Service

Net Income (Loss) Reconciliation for Corporations With Total Assets of $10 Million or More

▶ Attach to Form 1120 or 1120-C.
▶ See separate instructions.

OMB No. 1545-0123

2010

Name of corporation (common parent, if consolidated return)

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number

25-1100252

Check applicable box(es): (1) ☐ Non-consolidated return (2) ☐ Consolidated return (Form 1120 only)
(3) ☐ Mixed 1120/L/PC group (4) ☐ Dormant subsidiaries schedule attached

Part I Financial Information and Net Income (Loss) Reconciliation (see instructions)

1 a Did the corporation file SEC Form 10-K for its income statement period ending with or within this tax year?
☐ Yes. Skip lines 1b and 1c and complete lines 2a through 11 with respect to that SEC Form 10-K.
☒ No. Go to line 1b. See instructions if multiple non-tax-basis income statements are prepared.

b Did the corporation prepare a certified audited non-tax-basis income statement for that period?
☐ Yes. Skip line 1c and complete lines 2a through 11 with respect to that income statement.
☒ No. Go to line 1c.

c Did the corporation prepare a non-tax-basis income statement for that period?
☒ Yes. Complete lines 2a through 11 with respect to that income statement.
☐ No. Skip lines 2a through 3c and enter the corporation's net income (loss) per its books and records on line 4a.

2 a Enter the income statement period: Beginning 01/01/2010 Ending 12/31/2010

b Has the corporation's income statement been restated for the income statement period on line 2a?
☐ Yes. (If "Yes," attach an explanation and the amount of each item restated.)
☒ No.

c Has the corporation's income statement been restated for any of the five income statement periods preceding the period on line 2a?
☐ Yes. (If "Yes," attach an explanation and the amount of each item restated.)
☒ No.

3 a Is any of the corporation's voting common stock publicly traded?
☐ Yes.
☒ No. If "No," go to line 4a.

Enter the symbol of the corporation's primary U.S. publicly traded voting common stock

c Enter the *nine-digit* CUSIP number of the corporation's primary publicly traded voting common stock

4 a	Worldwide consolidated net income (loss) from income statement source identified in Part I, line 1	4a	50,187,069
b	Indicate accounting standard used for line 4a (see instructions): (1) ☒ GAAP (2) ☐ IFRS (3) ☐ Statutory (4) ☐ Tax-basis (5) ☐ Other (specify)		
5 a	Net income from nonincludible foreign entities (attach schedule)	5a	( )
b	Net loss from nonincludible foreign entities (attach schedule and enter as a positive amount)	5b	
6 a	Net income from nonincludible U.S. entities (attach schedule)	6a	( )
b	Net loss from nonincludible U.S. entities (attach schedule and enter as a positive amount)	6b	
7 a	Net income (loss) of other includible foreign disregarded entities (attach schedule)	7a	
b	Net income (loss) of other includible U.S. disregarded entities (attach schedule)	7b	
c	Net income (loss) of other includible entities (attach schedule)	7c	
8	Adjustment to eliminations of transactions between includible entities and nonincludible entities (attach schedule)	8	
9	Adjustment to reconcile income statement period to tax year (attach schedule)	9	
10 a	Intercompany dividend adjustments to reconcile to line 11 (attach schedule)	10a	
b	Other statutory accounting adjustments to reconcile to line 11 (attach schedule)	10b	
c	Other adjustments to reconcile to amount on line 11 (attach schedule)	10c	
11	**Net income (loss) per income statement of includible corporations.** Combine lines 4 through 10	11	50,187,069

Note. Part I, line 11, must equal the amount on Part II, line 30, column (a), and Schedule M-2, line 2.

12 Enter the total amount (not just the corporation's share) of the assets and liabilities of all entities included or removed on the following lines.

		Total Assets	Total Liabilities
a	Included on Part I, line 4 ▶	1,198,806,775	852,462,627
b	Removed on Part I, line 5 ▶		
c	Removed on Part I, line 6 ▶		
d	Included on Part I, line 7 ▶		

Schedule M-3 (Form 1120) 2010 — Page 2

Name of corporation (common parent, if consolidated return): COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number: 25-1100252

Check applicable box(es): (1) ☐ Consolidated group (2) ☐ Parent corp (3) ☐ Consolidated eliminations (4) ☒ Subsidiary corp (5) ☐ Mixed 1120/L/PC group

If a sub-consolidated: (6) ☐ 1120 group (7) ☐ 1120 eliminations

Name of subsidiary (if consolidated return):

Employer identification number:

Part II Reconciliation of Net Income (Loss) per Income Statement of Includible Corporations With Taxable Income per Return (see instructions)

Income (Loss) Items (Attach schedules for lines 1 through 11)	(a) Income (Loss) per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Income (Loss) per Tax Return
1 Income (loss) from equity method foreign corporations				
2 Gross foreign dividends not previously taxed				
3 Subpart F, QEF, and similar income inclusions				
4 Section 78 gross-up				
5 Gross foreign distributions previously taxed				
6 Income (loss) from equity method U.S. corporations	995,559	-995,559		
7 U.S. dividends not eliminated in tax consolidation				
8 Minority interest for includible corporations				
9 Income (loss) from U.S. partnerships				
10 Income (loss) from foreign partnerships				
11 Income (loss) from other pass-through entities				
12 Items relating to reportable transactions (attach details)				
13 Interest income (attach Form 8916-A)	2,483,104	-3,279,529		-796,425
14 Total accrual to cash adjustment				
15 Hedging transactions	-22,176,365			-22,176,365
16 Mark-to-market income (loss)				
17 Cost of goods sold (attach Form 8916-A)	(317,203,563)	1,886,578		(315,316,985)
18 Sale versus lease (for sellers and/or lessors)				
19 Section 481(a) adjustments				
20 Unearned/deferred revenue	281,947	-281,947		
21 Income recognition from long-term contracts				
22 Original issue discount and other imputed interest				
23 a Income statement gain/loss on sale, exchange, abandonment, worthlessness, or other disposition of assets other than inventory and pass-through entities	10,844	-10,844		
b Gross capital gains from Schedule D, excluding amounts from pass-through entities				
c Gross capital losses from Schedule D, excluding amounts from pass-through entities, abandonment losses, and worthless stock losses				
d Net gain/loss reported on Form 4797, line 17, excluding amounts from pass-through entities, abandonment losses, and worthless stock losses		10,844		10,844
e Abandonment losses		-3,507,760		-3,507,760
f Worthless stock losses (attach details)				
g Other gain/loss on disposition of assets other than inventory				
24 Capital loss limitation and carryforward used See Stmt 14				
25 Other income (loss) items with differences (attach schedule)	-892,308	376,868		-515,440
26 Total income (loss) items. Combine lines 1 through 25	-336,500,782	-5,801,349	0	-342,302,131
27 Total expense/deduction items (from Part III, line 38)	-88,963,552	-48,829,641	-7,379,470	-145,172,663
28 Other items with no differences See Stmt 15	475,651,403			475,651,403
29 a Mixed groups, see instructions. All others, combine lines 26 through 28	50,187,069	-54,630,990	-7,379,470	-11,823,391
b PC insurance subgroup reconciliation totals				
c Life insurance subgroup reconciliation totals				
d Reconciliation totals. Combine lines 29a through 29c	50,187,069	-54,630,990	-7,379,470	-11,823,391

Note. Line 30, column (a), must equal the amount on Part I, line 11, and column (d) must equal Form 1120, page 1, line 28.

Name of corporation (common parent, if consolidated return) | Employer identification number

COLUMBIA GAS OF PENNSYLVANIA INC | 25-1100252

Check applicable box(es): (1) ☐ Consolidated group (2) ☐ Parent corp (3) ☐ Consolidated eliminations (4) ☒ Subsidiary corp (5) ☐ Mixed 1120/L/PC group

(6) ☐ 1120 group (7) ☐ 1120 eliminations

Name of subsidiary (if consolidated return) | Employer identification number

Part II Reconciliation of Net Income (Loss) per Income Statement of Includible Corporations With Taxable Income per Return - Expense/Deduction Items (see instructions)

Expense/Deduction Items	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1 U.S. current income tax expense	-330,674		330,674	
2 U.S. deferred income tax expense	-7,211,525		7,211,525	
3 State and local current income tax expense	1,455,428	-1,487,019		-31,591
4 State and local deferred income tax expense	48,440	-48,440		
5 Foreign current income tax expense (other than foreign withholding taxes)				
6 Foreign deferred income tax expense				
7 Foreign withholding taxes				
8 Interest expense (attach Form 8916-A)	16,384,807	-1,636,962		14,747,845
9 Stock option expense				
10 Other equity-based compensation	140,309	18,506	-320	158,495
11 Meals and entertainment	325,340		-162,670	162,670
12 Fines and penalties	-4,811		4,811	
13 Judgments, damages, awards, and similar costs				
14 Parachute payments				
15 Compensation with section 162(m) limitation				
16 Pension and profit-sharing	10,082,893	-43,348		10,039,545
17 Other post-retirement benefits	3,346,285	599,240	97,234	4,042,759
18 Deferred compensation	3,128,827	1,277,665		4,406,492
Charitable contribution of cash and tangible property	475,986			475,986
20 Charitable contribution of intangible property				
21 Charitable contribution limitation/carryforward				
22 Domestic production activities deduction				
23 Current year acquisition or reorganization investment banking fees				
24 Current year acquisition or reorganization legal and accounting fees				
25 Current year acquisition/reorganization other costs				
26 Amortization/impairment of goodwill				
27 Amortization of acquisition, reorganization, and start-up costs				
28 Other amortization or impairment write-offs		55		55
29 Section 198 environmental remediation costs				
30 Depletion				
31 Depreciation	24,266,759	18,816,607		43,083,366
32 Bad debt expense	22,954,391	-2,075,676		20,878,715
33 Corporate owned life insurance premiums				
34 Purchase versus lease (for purchasers and/or lessees)				
35 Research and development costs (attach schedule) See Stmt 16	1,272,743			1,272,743
36 Section 118 exclusion (attach schedule)				
37 Other expense/deduction items with differences (attach schedule) See Stmt 17	12,628,354	33,409,013	-101,784	45,935,583
38 Total expense/deduction items. Combine lines 1 through 37. Enter here and on Part II, line 27, reporting positive amounts as negative and negative amounts as positive	88,963,552	48,829,641	7,379,470	145,172,663

Form **8916-A**

Department of the Treasury
Internal Revenue Service

Supplemental Attachment to Schedule M-3

▶ Attach to Schedule M-3 for Form 1065, 1120, 1120-L, 1120-PC, or 1120S.

OMB No. 1545-2061

2010

[redacted] common parent

COLUMBIA GAS OF PENNSYLVANIA INC

Employer identification number: 25-1100252

Name of subsidiary

Employer identification number

Part I Cost of Goods Sold

Cost of Goods Sold Items	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1 Amounts attributable to cost flow assumptions		-23,795		-23,795
2 Amounts attributable to:				
a Stock option expense				
b Other equity based compensation				
c Meals and entertainment				
d Parachute payments				
e Compensation with section 162(m) limitation				
f Pension and profit sharing				
[redacted]ther post-retirement benefits				
h Deferred compensation				
i Section 198 environmental remediation costs				
j Amortization				
k Depletion				
l Depreciation				
m Corporate owned life insurance premiums				
n Other section 263A costs		14,397		14,397
3 Inventory shrinkage accruals				
4 Excess inventory and obsolescence reserves				
5 Lower of cost or market write-downs				
6 Other items with differences (attach schedule). See Stmt 18	1,877,180	-1,877,180		
Other items with no differences. See Stmt 19	315,326,383			315,326,383
7 Total cost of goods sold. Add lines 1 through 7, in columns a, b, c, and d	317,203,563	-1,886,578		315,316,985

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Form 8916-A (2010) Page 2

Part II Interest Income

	Interest Income Item	(a) Income (Loss) per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Income (Loss) per Tax Return
1	Tax-exempt interest income				
2	Interest income from hybrid securities				
3	Sale/lease interest income				
4 a	Intercompany interest income - From outside tax affiliated group				
4 b	Intercompany interest income - From tax affiliated group	432,812			432,812
5	Other interest income	2,050,292	-3,279,529		-1,229,237
6	Total interest income. Add lines 1 through 5. Enter total on Schedule M-3 (Forms 1120, 1120-PC, and 1120-L), Part II, line 13 or Schedule M-3 (Forms 1065 and 1120-S) Part II, line 11.	2,483,104	-3,279,529		-796,425

Part III Interest Expense

	Interest Expense Item	(a) Expense per Income Statement	(b) Temporary Difference	(c) Permanent Difference	(d) Deduction per Tax Return
1	Interest expense from hybrid securities				
2	Lease/purchase interest expense				
3 a	Intercompany interest expense - Paid to outside tax affiliated group				
3 b	Intercompany interest expense - Paid to tax affiliated group	16,114,098			16,114,098
4	Other interest expense	270,709	-1,636,962		-1,366,253
5	Total interest expense. Add lines 1 through 4. Enter total on Schedule M-3 (Form 1120) Part III, line 8; Schedule M-3 (Forms 1120-PC and 1120-L), Part III, line 36; Schedule M-3 (Form 1065) Part III, line 27; or Schedule M-3 (Form 1120S) Part III, line 26.	16,384,807	-1,636,962		14,747,845

Form **4562**

Department of the Treasury
Internal Revenue Service (99)

Depreciation and Amortization
(Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

OMB No. 1545-0172

2010

Attachment Sequence No. 67

(s) shown on return	Business or activity to which this form relates	Identifying number
[redacted]BIA GAS OF PENNSYLVANIA INC	NATURAL GAS DISTRIBUTION	25-1100252

Part I Election To Expense Certain Property Under Section 179

Note: If you have any listed property, complete Part V before you complete Part I.

1	Maximum amount (see instructions)	1	500,000
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	2,000,000
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	0
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	500,000

6	(a) Description of property	(b) Cost (business use only)	(c) Elected cost

7	Listed property. Enter the amount from line 29	7		
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	8		0
9	Tentative deduction. Enter the smaller of line 5 or line 8	9		0
10	Carryover of disallowed deduction from line 13 of your 2009 Form 4562	10		
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions)	11		0
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11	12		0
13	Carryover of disallowed deduction to 2011. Add lines 9 and 10, less line 12 ▶	13	0	

Note: Do not use Part II or Part III below for listed property. Instead, use Part V.

Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	26,568,454
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	1,349,651

Part III MACRS Depreciation (Do not include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2010	17	14,728,986
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B - Assets Placed in Service During 2010 Tax Year Using the General Depreciation System

	(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19 a	3-year property						
b	5-year property						
c	7-year property		168,831	7.0	HY	200 DB	24,119
d	10-year property						
e	15-year property		8,496,809	15.0	HY	150 DB	424,840
f	20-year property						
g	25-year property			25 yrs.		S/L	
h	Residential rental property			27.5 yrs.	MM	S/L	
				27.5 yrs.	MM	S/L	
i	Nonresidential real property		-569,260	39 yrs.	MM	S/L	-12,684
					MM	S/L	

Section C - Assets Placed in Service During 2010 Tax Year Using the Alternative Depreciation System

20 a	Class life					S/L	
b	12-year			12 yrs.		S/L	
c	40-year			40 yrs.	MM	S/L	

Part IV Summary (See instructions.)

21	Listed property. Enter amount from line 28	21	
22	Total. Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instr.	22	43,083,366
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	184,893

COLUMBIA GAS OF PENNSYLVANIA INC 25-1100252

Part V Listed Property (Include automobiles, certain other vehicles, certain computers, and property used for entertainment, recreation, or amusement.)

Note: For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete only 24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.

Section A - Depreciation and Other Information (Caution: See the instructions for limits for passenger automobiles.)

24a Do you have evidence to support the business/investment use claimed? ☒ Yes ☐ No 24b If "Yes," is the evidence written? ☒ Yes ☐ No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50 in a qualified business use (see instructions)						25		
26 Property used more than 50 in a qualified business use:								
See Stmt 20			49,287					
27 Property used 50 or less in a qualified business use:								
						S/L-		
						S/L-		
						S/L-		
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1						28	0	
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1							29	0

Section B - Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other "more than 5 owner," or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
30 Total business/investment miles driven during the year (do not include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
33 Total miles driven during the year. Add lines 30 through 32												
34 Was the vehicle available for personal use during off-duty hours?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
35 Was the vehicle used primarily by a more than 5 owner or related person?												
36 Is another vehicle available for personal use?												

Section C - Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who are not more than 5 owners or related persons (see instructions).

	Yes	No
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		X
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1 or more owners	X	
39 Do you treat all use of vehicles by employees as personal use?		X
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?	X	
41 Do you meet the requirements concerning qualified automobile demonstration use? (See instructions.)		X

Note: If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles.

Part VI Amortization

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2010 tax year (see instructions):					
43 Amortization of costs that began before your 2010 tax year				43	55
44 Total. Add amounts in column (f). See the instructions for where to report				44	55

Form **4797**

Department of the Treasury
Internal Revenue Service (99)

Sales of Business Property
(Also Involuntary Conversions and Recapture Amounts Under Sections 179 and 280F(b)(2))

▶ Attach to your tax return. ▶ See separate instructions.

OMB No. 1545-0184

2010

Attachment Sequence No. 27

Name(s) shown on return: COLUMBIA GAS OF PENNSYLVANIA INC

Identifying number: 25-1100252

1 Enter the gross proceeds from sales or exchanges reported to you for 2010 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions) . . . 1

Part I Sales or Exchanges of Property Used in a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year (see instructions)

2 (a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)

3	Gain, if any, from Form 4684, line 42	3	
4	Section 1231 gain from installment sales from Form 6252, line 26 or 37	4	
5	Section 1231 gain or (loss) from like-kind exchanges from Form 8824	5	
6	Gain, if any, from line 32, from other than casualty or theft	6	
7	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows: **Partnerships (except electing large partnerships) and S corporations.** Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below. **Individuals, partners, S corporation shareholders, and all others.** If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.	7	0
8	Nonrecaptured net section 1231 losses from prior years (see instructions)	8	
9	Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions)	9	

Part II Ordinary Gains and Losses (see instructions)

10 Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):

Land	Various	Various	10,844			10,844
Public Utility	Various	Various	45,427	4,643,355	8,196,542	(3,507,760)

11	Loss, if any, from line 7	11	( )
12	Gain, if any, from line 7 or amount from line 8, if applicable	12	
13	Gain, if any, from line 31	13	
14	Net gain or (loss) from Form 4684, lines 34 and 41a	14	
15	Ordinary gain from installment sales from Form 6252, line 25 or 36	15	
16	Ordinary gain or (loss) from like-kind exchanges from Form 8824	16	
17	Combine lines 10 through 16	17	(3,496,916)
18	For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:		
a	If the loss on line 11 includes a loss from Form 4684, line 38, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions	18a	
b	Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14	18b	

Part III Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255
(see instructions)

	(a) Description of section 1245, 1250, 1252, 1254, or 1255 property:	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
A			
B			
C			
D			

These columns relate to the properties on lines 19A through 19D. ▶		Property A	Property B	Property C	Property D
20	Gross sales price (Note: See line 1 before completing.)	20			
21	Cost or other basis plus expense of sale	21			
22	Depreciation (or depletion) allowed or allowable	22			
23	Adjusted basis. Subtract line 22 from line 21	23			
24	Total gain. Subtract line 23 from line 20	24			
25	**If section 1245 property:**				
a	Depreciation allowed or allowable from line 22	25a			
b	Enter the smaller of line 24 or 25a	25b			
26	**If section 1250 property:** If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.				
a	Additional depreciation after 1975 (see instructions)	26a			
b	Applicable percentage multiplied by the smaller of line 24 or line 26a (see instructions)	26b			
c	Subtract line 26a from line 24. If residential rental property or line 24 is not more than line 26a, skip lines 26d and 26e	26c			
d	Additional depreciation after 1969 and before 1976	26d			
e	Enter the smaller of line 26c or 26d	26e			
f	Section 291 amount (corporations only)	26f			
g	Add lines 26b, 26e, and 26f	26g			
27	**If section 1252 property:** Skip this section if you did not dispose of farmland or if this form is being completed for a partnership (other than an electing large partnership).				
a	Soil, water, and land clearing expenses	27a			
b	Line 27a multiplied by applicable percentage (see instructions)	27b			
c	Enter the smaller of line 24 or 27b	27c			
28	**If section 1254 property:**				
a	Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion (see instructions)	28a			
b	Enter the smaller of line 24 or 28a	28b			
29	**If section 1255 property:**				
a	Applicable percentage of payments excluded from income under section 126 (see instructions)	29a			
b	Enter the smaller of line 24 or 29a (see instructions)	29b			

Summary of Part III Gains. Complete property columns A through D through line 29b before going to line 30.

30	Total gains for all properties. Add property columns A through D, line 24	30	0
31	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32	Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 36. Enter the portion from other than casualty or theft on Form 4797, line 6	32	0

Part IV Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50 or Less
(see instructions)

			(a) Section 179	(b) Section 280F(b)(2)
33	Section 179 expense deduction or depreciation allowable in prior years	33		
34	Recomputed depreciation (see instructions)	34		
35	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35	0	0

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Form 1120, Page 1, Line 5, Interest income — Statement: 1

Description	Amount
INTERCOMPANY INT INCOME FROM TAX AFFILIATED GROUP	432,812
OTHER INTEREST INCOME	(1,229,237)
Total	(796,425)

Form 1120, Page 1, Line 10, Other income — Statement: 2

Description	Amount
CUSTOMER ADVANCES RECEIVED	(531,618)
INCOME ACCRUED ON REGULATORY LIABILITY	2,235,251
CONTRIBUTION IN AID OF CONSTRUCTION	837,439
MISC NON-OPERATING INCOME	(955,959)
Total	1,585,113

Form 1120, Page 1, Line 16, Rent expense — Statement: 3

Description	Amount
A&G - RENT EXPENSE	2,780,224
BUILDING LEASE WRITEDOWN/BUYOUTS	(166,709)
RENT EXPENSE: LEASED AUTOMOBILE	(854)
UTILITY RENT EXPENSE	688,677
Total	3,301,338

Form 1120, Page 1, Line 17, Taxes and licenses — Statement: 4

Description	Amount
STATE TAXES BASED ON INCOME	(31,591)
NET WORTH OR CAPITAL STOCK TAXES	813,713
REAL ESTATE / PERSONAL PROPERTY TAXES	512,109
GROSS RECEIPTS/STORAGE	2,092
PAYROLL TAXES	1,866,955
LICENSE / FRANCHISE	3,245
SALES/USE	751,750
OTHER TAXES	27,594
Total	3,945,867

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Form 1120, Page 1, Line 18, Interest expense — **Statement: 5**

Description	Amount
INTEREST EXPENSE	(1,181,360)
INTERCOMPANY INT EXP - PAID TO TAX AFFILIATED GROUP	16,114,098
OTHER INTEREST EXPENSE	(184,893)
Total	14,747,845

Form 1120, Page 1, Line 26, Other deductions — **Statement: 6**

Description	Amount
RESEARCH AND DEVELOPMENT COSTS	1,272,743
BOOK HEDGING INCOME/LOSS	22,176,365
ENVIRONMENTAL COSTS	474,719
TAX AMORTIZATION: SEC 167	55
EXPENSE ACCRUED ON REGULATORY LIABILITY	1,404,018
PROPERTY COST OF REMOVAL	703,492
UNDERGROUND STORAGE OPERATING EXPENSES	196,183
GAS DISTRIBUTION OPERATING EXP	23,144,563
CUSTOMER ACCOUNTS EXPENSE	6,410,234
CUSTOMER SERVICE AND INFORMATIONAL EXPENSE	6,966,566
SALES EXPENSE	500,876
OFFICE SUPPLIES & EXP- NET OF ADMIN EXP TRNF	(473,332)
BUSINESS MEALS & ENTERTAINMENT	162,670
OUTSIDE SERVICES EMPLOYED	7,221,188
PROPERTY INSURANCE	(335,365)
INJURIES & DAMAGES	3,493,500
REGULATORY COMMISSION EXPENSE	1,539,278
MISCELLANEOUS GENERAL EXPENSES	414,896
Total	75,272,649

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Form 1120, Page 5, Schedule L, Line 6, Other current assets — Statement: 7

Description	Beginning Amount	Ending Amount
CUSTOMER ACCTS REC- UTILITY	0	3,332,352
UNRECOVERED PURCHASED GAS	32,398,373	29,094,815
REGULATORY ASSETS	20,653,125	18,003,285
ACCTS REC - ASSOCIATES	48,943,907	64,351,097
PREPAYMENTS	2,895,741	2,381,023
INTEREST & DIVIDENDS REC	115,227	(4,751)
RENTS RECEIVABLE	0	(4)
ACCRUED UTILITY REVENUES	52,978,404	26
MISC CURR & ACCR ASSETS	273,818	253,661
Total	158,258,595	117,411,504

Form 1120, Page 5, Schedule L, Line 9, Other investments — Statement: 8

Description	Beginning Amount	Ending Amount
INVESTMENT IN SUBSIDIARY	0	15,995,659
Total	0	15,995,659

Form 1120, Page 5, Schedule L, Line 14, Other assets — Statement: 9

Description	Beginning Amount	Ending Amount
CONSTRUCTION WORK IN PROGRESS	1,234,886	9,375,062
INTEREST RECEIVABLE	0	4,828
CUSTOMER ACCTS REC-UTILITY	4,696,666	454,770
CUSHION GAS	895,339	895,339
REGULATORY ASSETS	207,167,420	212,448,446
PRELIM GAS SURVEY & INVES	401,608	375,256
MISCELLANEOUS DFD DEBITS	5,288,856	4,751,069
Total	219,684,775	228,304,770

Form 1120, Page 5, Schedule L, Line 18, Other current liabilities — Statement: 10

Description	Beginning Amount	Ending Amount
OPEB LIABILITY DEFERRED	0	297,234
DEFERRED REVENUE	658,863	961,567
REGULATORY LIABILITIES CURRENT	0	6,553,203

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ACCT PAYABLE-ASSOCIATES	13,377,965	14,179,980
ACCRUED TAXES	(886,829)	3,262,226
ACCRUED INTEREST	235,300	253,142
TAX COLLECTIONS PAYABLE	596,063	654,698
ACCRUED VACATIONS	3,601,908	3,082,367
CMEP-MAP MEDICAL RESERVE	96,797	118,412
OPEB LIABILITY-CUR	140,132	226,147
OTHER ACCRUED LIABILITIES	98,769,868	77,821,253
ACCRUED RATE REFUNDS	216,068	47,285
ACCUMULATED DFD TAXES	12,984,388	(10,923,834)
Total	129,790,523	96,533,680

Form 1120, Page 5, Schedule L, Line 20, Mortgages, notes, bonds payable in 1 year or more Statement: 11

Description	Beginning Amount	Ending Amount
NOTES PAYABLE	285,215,000	313,215,000
Total	285,215,000	313,215,000

Form 1120, Page 5, Schedule L, Line 21, Other liabilities Statement: 12

Description	Beginning Amount	Ending Amount
ACCRUED INTEREST - NON CURRENT	0	81
OTHER LIABILITIES	2,288,370	2,623,630
ASSET RETIREMENT OBLIGATIONS	9,726,290	10,566,493
OTHER DEFERRED CREDITS	64,499,918	37,449,434
DEFERRED REVENUE	1,364,311	454,770
OPEB LIABILITY-DEFERRED	10,818,401	5,826,305
OUTSTANDING LOSS RESERVES	212,051	324,675
POST EMPL. BENEFTI OBLIG	792,642	68,961
REGULATORY LIABILITIES NONCURRENT	76,054,570	67,664,439
ACCUM DFD INCOME TAXES	215,871,686	273,926,478
Total	381,628,239	398,905,266

Form 1120, Page 5, Schedule L, Line 26, Adjustments to shareholders' equity Statement: 13

Description	Beginning Amount	Ending Amount
OTHER COMPREHENSIVE INCOME	(53,678)	(54,443)
Total	(53,678)	(54,443)

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Form 1120, Schedule M-3, Page 2, Part II, Line 25, Other income (loss) items with differences

Statement: 14

Description	Income (Loss) per Income Statement	Temporary Difference	Permanent Difference	Income (Loss) per Tax Return
MISC NON-OPERATING INCOME	(884,997)	(70,962)	0	(955,959)
CONTRIBUTION IN AID OF CONSTRUCTION	0	837,439	0	837,439
INCOME ACCRUED ON REGULATORY ASSET	(189,995)	189,995	0	0
CUSTOMER ADVANCES RECEIVED	0	(531,618)	0	(531,618)
RATE REFUND	182,684	(47,986)	0	134,698
Total	(892,308)	376,868	0	(515,440)

items with no differences, Other income (loss) and exp/ded items with no differences

Statement: 15

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
MISCELLANEOUS GENERAL EXPENSES	(414,896)	0	0	(414,896)
REGULATORY COMMISSION EXPENSE	(1,539,278)	0	0	(1,539,278)
OUTSIDE SERVICES EMPLOYED	(7,221,188)	0	0	(7,221,188)
OFFICE SUPPLIES & EXP- NET OF ADMIN EXP TRNF	473,332	0	0	473,332
SALES EXPENSE	(500,876)	0	0	(500,876)
CUSTOMER SERVICE AND INFORMATIONAL EXPENSE	(6,966,566)	0	0	(6,966,566)
CUSTOMER ACCOUNTS EXPENSE	(6,410,234)	0	0	(6,410,234)
GAS DISTRIBUTION OPERATING EXP	(23,144,563)	0	0	(23,144,563)
UNDERGROUND STORAGE OPERATING EXPENSES	(196,183)	0	0	(196,183)
OTHER EMPLOYEE BENEFITS	1,704,034	0	0	1,704,034
GENERAL ADVERTISING EXPENSE	(291,541)	0	0	(291,541)
OTHER TAXES	(27,594)	0	0	(27,594)
LICENSE / FRANCHISE	(3,245)	0	0	(3,245)
GROSS RECEIPTS/STORAGE	(2,092)	0	0	(2,092)
NET WORTH OR CAPITAL STOCK TAXES	(813,713)	0	0	(813,713)
UTILITY RENT EXPENSE	(688,677)	0	0	(688,677)
A&G - RENT EXPENSE	(2,780,224)	0	0	(2,780,224)

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GAS DISTRIBUTION MAINTENANCE EXP	(14,113,179)	0	0	(14,113,179)
GAS UNDERGROUND STORAGE MAINTENANCE EXP	(5,373)	0	0	(5,373)
A&G - SALARIES	(23,296,580)	0	0	(23,296,580)
INCOME ACCRUED ON REGULATORY LIABILITY	2,235,251	0	0	2,235,251
RENTS	113,430	0	0	113,430
SALES	559,541,358	0	0	559,541,358
Total	475,651,403	0	0	475,651,403

Form 1120, Schedule M-3, Page 3, Part III, Line 35, Research and development costs **Statement: 16**

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
RESEARCH AND DEVELOPMENT COSTS	1,272,743	0	0	1,272,743
Total	1,272,743	0	0	1,272,743

Form 1120, Schedule M-3, Page 3, Part III, Line 37, Other expense/deduction items with differences **Statement: 17**

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
INJURIES & DAMAGES	3,868,945	(375,445)	0	3,493,500
PROPERTY INSURANCE	179,353	(514,718)	0	(335,365)
PROPERTY COST OF REMOVAL	0	703,492	0	703,492
LOBBYING EXPENSES	100,930	0	(100,930)	0
EXPENSE ACCRUED ON REGULATORY LIABILITY	1,480,830	(76,812)	0	1,404,018
EXPENSE ACCRUED ON REGULATORY ASSET	3,098,981	(3,098,981)	0	0
ENVIRONMENTAL COSTS	0	474,719	0	474,719
EMPLOYEE INSURANCE PLANS	1,059,673	(6,874)	0	1,052,799
SALES/USE	512,116	239,634	0	751,750
PAYROLL TAXES	1,892,873	(25,918)	0	1,866,955
REAL ESTATE / PERSONAL PROPERTY TAXES	434,653	77,456	0	512,109
RENT EXPENSE: LEASED AUTOMOBILE	0	0	(854)	(854)
BUILDING LEASE WRITEDOWN/BUYOUTS	0	(166,709)	0	(166,709)

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REPAIRS OF GAS PIPELINE	0	36,179,169	0	36,179,169
Total	12,628,354	33,409,013	(101,784)	45,935,583

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Form 8916-A, Line 6, Other items with differences — Statement: 18

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
SYSTEM GAS LOSSES	4,641	(4,641)	0	0
PURCHSE GAS AD_USTMENT	1,711,865	(1,711,865)	0	0
EXCESS BANK PURCHASES	160,674	(160,674)	0	0
Total	1,877,180	(1,877,180)	0	0

Form 8916-A, Line 7, Other items with no differences, Other items with no differences — Statement: 19

Description	Expense per Income Statement	Temporary Difference	Permanent Difference	Deduction per Tax Return
OTHER GAS SUPPLY EXPENSES	10,660,228	0	0	10,660,228
EXCHANGE GAS EXPENSE	1,259,628	0	0	1,259,628
NATURAL GAS PURCHASES	303,406,527	0	0	303,406,527
Total	315,326,383	0	0	315,326,383

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Statement: 20

Form 4562, Page 2, Part V, Section A, Line 26, Listed property used more than 50

Row ID	Type of Property	Date Placed in Service	Business Use Percentage	Cost	Basis for Depreciation	Recovery Period	Method (200 DB) (150 DB) (DB) (S/L) Convention (HY) (MM) (MQ) (S/L) (PRE)	Depreciation Deduction	Elected Sec 179 Cost
1	Leased Vehicles	07/01/2004	100.0000000%	84					
2	Leased Vehicles	07/01/2005	100.0000000%	50					
3	Leased Vehciles	07/01/2006	100.0000000%	12,281					
4	Leased Vehicles	07/01/2007	100.0000000%	10,763					
5	Leased vehicles	07/01/2008	100.0000000%	10,186					
6	Leased Vehicles	07/01/2009	100.0000000%	15,923					
Total				49,287					