Disability Plans

Nicor Gas

Disability Plans for Collectively Bargained Employees

- Short-term Disability
- Long-term Disability

Summary Plan Descriptions
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SHORT-TERM DISABILITY (STD) INTRODUCTION

Short-term disability (formerly referred to as Employee Benefit Association (EBA)) is designed to provide collectively bargained employees with access to disability benefits.

If an illness or a non-work related accident disables you, it could mean an absence from work and a significant income reduction while your living expenses continue. Your voluntary participation in short-term disability can help protect you and your family against this risk.

Short-term disability benefits are administered by Nicor Gas.

This document is your Summary Plan Description for the Nicor Gas Short-term Disability plan for Collectively Bargained Employees (the plan). It provides a non-technical description that summarizes the key features of the plan, including how you may qualify to receive benefits, based on the provisions of the plan in effect on March 1, 2010.

While every effort has been made to make this summary as accurate as possible, it’s not feasible to cover each detail of the plan. If there is a discrepancy between the description in this summary and the applicable plan document, the plan document governs.

Note: The Company reserves the right to terminate, suspend, or amend this plan at any time for any reason in a manner consistent with any collective bargaining agreement covering plan members.

ELIGIBILITY

You are considered eligible if:

- You are a regular, hourly employee who works at least 20 scheduled hours per week,
- You are represented by a collective bargaining agent who has an agreement with the Company that provides for your participation, and
- You have successfully completed six months of service.

A regular employee means that you are not classified as a temporary employee.

ENROLLMENT

You may enroll in STD when eligible and each year during the annual open enrollment period.

To enroll you must complete the appropriate forms to authorize the necessary payroll deduction for short-term disability dues which are deducted from your pay check on a pre-tax basis. Forms are available through the HR Administration.

If you do not enroll in the plan within 31 days of your initial eligibility (after you have completed six months of service), your next enrollment opportunity is the next annual enrollment window. If you are enrolling during an annual open enrollment period, evidence of insurability will be required and approval is not guaranteed.
When Coverage Begins
If you are a regular, collectively bargained employee who works at least 20 hours per week and you elect to enroll upon initial eligibility, coverage will begin on the day after you complete six months of service.

If, after your initial eligibility, you enroll during the annual open enrollment period, coverage will begin on the date specified in the open enrollment communication materials, only after your application has been approved under evidence of insurability.

Making Changes during the Year
You may enroll or terminate your participation only during the annual enrollment window. The enrollment window runs concurrently with the health care open enrollment window. During this time, you may enroll in STD if you are not participating, or cancel your participation in STD.

If during the annual open enrollment window you elect to cancel your participation in STD, you will not be eligible to rejoin STD until the following year’s annual open enrollment window and at that time, evidence of insurability will be required and approval is not guaranteed.

COMPANY PROVIDED BENEFIT FOR SHORT DURATION ILLNESS (SICK PAY)
Upon successful completion of your probationary period, the company’s sick pay policy may provide your base pay within the first 40 consecutive hours (prorated for part-time employees) of a non-work related illness or injury.

- Sick pay benefits provide that employees will be paid for no more than eight scheduled work days during a rolling 12-month period and these eight days will be limited to four incidents during this period.
- During the rolling 12-month period, employees will not be paid for incidents in excess of four even if the employee did not use their eight day total in the first four incidents. In addition, during the rolling 12-month period employees will not be paid for more than eight days even if they did not use their four incidents.
- Absences, whether full or partial day, are counted as an incident and a full-day absence.
- Employees who have exhausted either their eight days or four incidents in any rolling 12-month period must be at work on the scheduled work day before and after a holiday to be paid for the holiday.
- The time an employee is off on short-term or long-term disability does not count towards refreshing eight day / four incidents.

SHORT-TERM DISABILITY BENEFITS
If you are absent because of an illness or injury, STD benefits will not begin until after the first 40 consecutive regularly scheduled hours of an absence. Sick pay benefits may provide you with base pay within the first 40 regularly scheduled hours of an absence. If you work part time, your sick pay benefits are prorated. See the collective bargaining agreement between the Company and Local Union 19 for details on sick pay benefits.

If you do not elect to participate in STD
If you do not elect to participate in STD, you will not have any short or long-term disability benefits available to you. If you are not able to work because of a non-work related illness or injury and are not eligible for an unpaid leave of absence under the Family Medical Leave Act (FMLA) and have exhausted benefits under any other absence related program, you will be subject to termination of employment.
**If you elect to participate in STD**
If you elect to participate in STD, after the first 40 consecutive hours of an absence (prorated for part-time employees), you may be eligible to receive up to 26 weeks of short-term disability benefits.

A disability is a medically supported off-the-job illness or accident that prevents you from being at work.

**Amount of STD benefit**
While you are disabled, STD benefits will be paid according to years of service completed:

<table>
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<th>Years of Completed Service</th>
<th>% of Base Rate of Pay</th>
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<tr>
<td>6 months – 10 years</td>
<td>60%</td>
</tr>
<tr>
<td>11 – 19 years</td>
<td>65%</td>
</tr>
<tr>
<td>20 or more years</td>
<td>75%</td>
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The base rate of pay is calculated using your regularly scheduled work hours. When you reach a service milestone, your STD benefit would be increased in the next following pay period.

**Benefit Maximum**
Each time you use STD, your 26-week benefit allotment is reduced by the time you have been paid from STD. STD benefits will automatically terminate when you exhaust your 26-week benefit allotment. Part-time employees have a prorated benefit maximum.

If you are a part-time employee, the 26-week benefit maximum is prorated based on your regularly scheduled hours.

**Benefit Reinstatement**
Upon your return to work, to reinstate the maximum STD benefit of 26 weeks, you must be actively at work for one year without any absence beyond 40 consecutive hours (prorated for part-time employees).

**Disability Relapse**
Consecutive absences are considered as one disability in determining your benefit if they are related to the same illness or accident and occur within 30 days of each other or occur within one year of each other, if the first absence lasted for more than six months.

**SHORT-TERM DISABILITY’S COORDINATION WITH LONG-TERM DISABILITY BENEFITS**

**If you do not elect to participate in STD**
You will not be eligible for benefits under the Long-term Disability Plan for Collectively Bargained Employees. If you are not able to work because of a non-work related illness or injury and are not eligible for an unpaid leave of absence under the Family Medical Leave Act (FMLA) and have exhausted benefits under any other absence related program, you will be subject to termination of employment.

**If you elect to participate in STD**
You will be eligible to participate in the Long-term Disability Plan for Collectively Bargained Employees. Long-term disability (LTD) benefits are designed to provide additional financial protection for you and your family if you should remain disabled and are unable to work for a longer period of time. Unum, our insurance provider, determines eligibility for LTD benefits.
CONTRIBUTORY COST

Your biweekly STD membership dues are currently equal to 1.3% of your regular biweekly rate of pay based on your regularly scheduled hours.

Your regular rate of pay refers to your base hourly rate, excluding overtime or other forms of compensation. For example, if your regular rate of pay is $15 per hour, or $1,200 biweekly, your dues, deducted from each paycheck, would be $15.60 ($1,200 times 1.3%).

Short-term disability (EBA) membership dues continue during a short-term disability absence and during most unpaid leaves of absence. Short-term disability membership dues are not required from employees who are approved for and being paid long-term disability benefits.

The company reserves the right to change the amount of membership dues.

SHORT-TERM DISABILITY PAYMENTS

STD benefits are paid to you through your biweekly paycheck. Between 2009 and 2012, a portion of the benefits paid to you are taxable income and a portion of the STD benefits paid to you are not taxable. Beginning in 2013, all of the STD benefits paid to you will be taxable to you as ordinary income.

You are eligible for payment from STD if:

- You are an STD member in good standing, and
- You have a non-work related illness or injury that has kept you off from work for a period longer than 40 consecutive regularly scheduled hours (prorated hours for part-time employees).

While disabled, you will be paid from STD after 40 consecutive regularly scheduled hours (prorated for part-time employees) as long as you:

- Have a remaining STD benefit, and
- Continue to provide the required medical proof of disability.

STD CLAIM PROCEDURES

If you are absent for more than 40 hours (prorated hours for part-time employees), you will receive an STD Proof of Claim form that your doctor must complete to provide medical documentation supporting your absence from work.

The STD Proof of Claim form must be returned to the Medical Department within 15 days from your first day off. The STD Proof of Claim form will be reviewed and payment will be determined. Additional STD Proof of Claim forms will be required if your disability continues.

If you do not provide the required medical documentation of your absence, your pay will be suspended and your continued employment may be at risk.

Suspension of Benefits

If you fail to submit a properly completed STD Proof of Claim form, or if a STD Proof of Claim form is submitted but covers a period of time less than the period of absence, either all or a portion of disability benefits paid to you from STD will be considered forfeited and repayment of the unsubstantiated amount paid to you is required.
If a member refuses to repay a forfeited amount, he or she shall be suspended from membership indefinitely until such amount is repaid and will not be able to rejoin STD until the next open enrollment window and will be subject to evidence of insurability.

**Claims Appeals**
If you do not receive benefits from the plan to which you feel you are entitled, or if your claim is denied, you should appeal first to Human Resources who will work with union leadership to resolve your claim. (See the *Your Right under ERISA* section for more detail.)

**CONDITIONS AFFECTING YOUR BENEFITS**

You may not receive any disability benefits, or you may receive less than you expected under the following conditions:

- You are not eligible for any disability benefits including sick pay benefits and STD benefits during your probationary period.
- You will not receive STD benefits if you are disabled while you are on a leave of absence or during a layoff.
- You will not receive benefits if your disability is:
  - Covered under the Workers' Compensation Act or a similar act due to an on-the-job illness or injury, or
  - The result of intemperance, a self-inflicted injury, intentional negligence, undue exposure to danger, or an unlawful or immoral act.
- Disability benefits will be discontinued, if:
  - You do not provide the required medical documentation supporting your absence,
  - You do not provide the required medical documentation in the required time frame,
  - A physician declares you no longer disabled,
  - You do not follow competent medical advice toward recovery, or
  - You leave the territory without consent from the STD Committee.
- If you are awarded Social Security disability insurance benefits, your STD payment will be reduced by the monthly amount of your primary Social Security benefit. This reduction will not include any retroactive lump-sum payments you may receive from Social Security.
- STD benefits will automatically discontinue if:
  - You exhaust your 26-week benefit allotment,
  - Your disability continues beyond 26 weeks,
  - The plan is discontinued, or
  - Your employment ends.
- STD reserves the right to seek reimbursement of overpayments or to reduce future benefit payments in an amount equal to the overpayment to the extent permitted by law due to:
  - Fraud, and
  - Any error the Company makes in processing a claim.
- In the event of plan termination, any remaining plan assets would be used, until exhausted, to provide benefits for participants.
DISABILITY BENEFIT ACCOUNT

The Company makes contributions equal to the amount of your dues. Together, your membership dues and the Company’s matching contributions are invested by Nicor Gas’ Assistant Treasurer in the Nicor Gas Employee Benefit Association’s Fund. The Assistant Treasurer can be contacted at:

Nicor Gas
Assistant Treasurer
P. O. Box 190
Aurora, IL 60507-0190

Plan funds are held exclusively for plan participants. The treasurer makes all payments from assets held in the Employee Benefit Association Fund.

The disability benefit account is set up to record all contributions and investment results. The Assistant Treasurer can invest the Disability Benefit Account assets in United States government securities and federal government agency securities, with up to one year maturity dates, short-term promissory notes issued by United States companies that are rated prime; and time deposits with major banks in the United States.

The Company pays the full cost of the Employee Benefit Association’s administrative expenses.

LONG-TERM DISABILITY PLAN INTRODUCTION

If, because of an illness or a non-work related accident, you are unable to work for a long period of time, Long-term disability (LTD) benefits are designed to provide you with income for a period of time.

The Long-term Disability Plan for Collectively Bargained Employees is a fully insured plan and is administered by Unum. They determine your eligibility for benefits based on medical documentation. You will only be eligible for LTD benefits if you are an STD member in good standing. If you do not participate in STD, you are not eligible for any LTD benefits.

The Long-Term Disability Plan for Collectively Bargained Employees (the plan) is a part of the Nicor Companies Disability Plan which is sponsored by Nicor Gas. This is a welfare benefit plan providing disability benefits.

This document is your Summary Plan Description for the plan. It provides a non-technical description that summarizes the key features of the plan, including how you may qualify to receive benefits, based on the provisions of the plan in effect on March 1, 2010.

While every effort has been made to make this summary as accurate as possible, it’s not feasible to cover each detail of the plan. If there is a discrepancy between the description in this summary and the applicable plan document, which includes the official insurance policy certificate, the plan document governs.

Note: The Company reserves the right to terminate, suspend, or amend this plan at any time for any reason in a manner consistent with any collective bargaining agreement covering plan members.
ELIGIBILITY

You are considered eligible if:

- You are a regular, hourly employee who works at least 20 scheduled hours per week,
- You are represented by a collective bargaining agent who has an agreement with the Company that provides for your participation,
- You have successfully completed your probationary period, and
- You have elected to participate in the Short-term Disability Plan (EBA). (See the STD Introduction section for more detail.)

A regular employee means that you are not classified as a temporary employee.

ENROLLMENT

Enrollment in LTD benefits is automatic if you enroll in STD.

- You are not eligible to enroll in LTD benefits if you do not enroll in STD.
- You may enroll in STD when eligible and each year during the annual open enrollment period. (See the STD Enrollment and STD Benefits sections for more detail.)

When Coverage Begins
Coverage begins immediately upon eligibility unless you are absent from work on this date. If you are absent from work due to injury, sickness, temporary layoff, or leave of absence, your coverage will begin on the date you return to active employment.

COST

The Company currently pays the entire cost of long-term disability insurance.

Taxation of Benefits
Because the Company pays the full cost of this insurance, any benefit you receive from the plan would be considered taxable income.

LONG-TERM DISABILITY BENEFITS

Long-term disability (LTD) benefits are calculated using your base rate of pay (based on regularly scheduled hours) at the onset of your disability. LTD benefits are reduced by the amount of any sources of deductible income. (See the Deductible Sources of Income section for more detail.)

LTD benefits are equal to:

- 60% of your pre-disability monthly earnings for the first six months,
- 50% of your pre-disability monthly earnings thereafter, and
- LTD benefits are subject to a monthly maximum of $3,500.

Your pre-disability monthly earnings amount is income before any income before taxes are withheld. It also includes any amounts deducted from your pay for pre-tax contributions to a qualified deferred compensation plan and any pre-tax premiums you pay for your benefits.
Your pre-disability monthly earnings do not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources outside of the Company.

**Elimination Period**
The elimination period is a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

You must be continuously disabled through your elimination period. Unum will treat your disability as continuous if your disability stops for 90 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

If you are working while you are disabled, the days you are disabled will count toward your elimination period.

The elimination period is the later of:

- 182 days (26 weeks), or
- The cessation of your salary continuation benefits, including earned vacation and excluding benefits paid under the Company’s extended disability plan.

**Definition of Long-term Disability**
You are disabled when Unum determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and
- You have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 12 months of payments, you are disabled when Unum 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 fit by education, training, or experience. The loss of a professional or occupational license does not, in itself, constitute disability.

Unum may require you to be examined by a physician, other medical practitioner and/or vocational expert of its choice. Unum will pay for this examination and may require other examinations as often as it is reasonable to do so. Unum may also require you to be interviewed by its authorized representative.

**To Qualify for Payments**
You will be eligible to receive payments when Unum approves your claim. To start receiving LTD payments, you must satisfy your elimination period as defined by the plan and continue to be considered disabled under the terms of the plan.

**Deductible Sources of Income**
Unum will subtract from your gross disability amount any payments you receive from certain other sources of income during the period you are disabled. These other income sources include:

- The amount that you receive or are entitled to receive under a Workers’ Compensation law, an occupational disease law, or any other act or law with similar intent.
- The amount that you receive or are entitled to receive as disability income payments under any state compulsory benefit act or law, other group insurance plans, or governmental retirement system as a result of your employment with the Company.
• The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.

• The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.

• The amount that you receive as disability payments from the Nicor Companies Pension and Retirement Plan (the Pension Plan).

• The amount that you voluntarily elect to receive as retirement payments from the Pension Plan.

• The amount that you receive as retirement payments when you reach the later of age 62 or normal retirement age as defined in the Pension Plan.

• The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

Retirement payments will be those benefits from the Pension Plan. Benefits payable under a disability retirement from the Pension Plan will also be considered as a retirement benefit.

Regardless of how the retirement payments from the Pension Plan are distributed, Unum will consider payments as if they were distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of “eligible retirement plan” as defined in Section 402 of the Internal Revenue Code, including any future amendments which affect the definition.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

Unum will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

Any cost of living adjustment you receive will not further reduce your disability payment from Unum.

If Unum determines that you may qualify for any of the above defined deductible sources of income, Unum will estimate your expected benefits. If you are not awarded these benefits even though you have applied for them and appealed your denial to all administrative levels available, as determined by Unum, and you sign a form promising to pay Unum for any overpayment that would result in the event that any of these estimated benefits become payable, then Unum will not reduce the amount of your disability payment.

**Non-Deductible Sources of Income**
Unum will not subtract from your gross disability payment income you receive from, but not limited to:

• 401(k) plans including the Nicor Gas Thrift Plan,

• Profit sharing plans,

• Thrift plans,

• Tax sheltered annuities,

• Stock ownership plans,

• Non-qualified plans of deferred compensation,

• Pension plans for partners,

• Military pension and disability income plans,

• Credit disability insurance,

• Franchise disability income plans,
• A retirement plan from another employer,
• Individual retirement accounts (IRAs),
• Individual disability income plans,
• No-fault motor vehicle plans, and
• Salary continuation or accumulated sick leave plans.

_Minimum Monthly Payment_
If subtracting deductible sources of income results in a zero benefit, the minimum monthly payment is the greater of:

• $100, or
• 10% of your long-term disability payment.

Unum may apply this amount toward an outstanding overpayment.

_WHEN BENEFITS ARE PAYABLE_

_When Payments Begin_
You will begin to receive payments when Unum approves your claim, providing the elimination period has been met and you are disabled.

• Unum will send you a payment each month for any period for which Unum is liable.
• Payments will be made directly to you.

_Your Status at Nicor Gas While on Long-term Disability_
If you are unable to perform duties of your job occupation and your disability is approved by Unum, you will receive disability benefit payments from Unum during the first 12 months of your disability.

The Company will place you on a leave of absence during those 12 months. You will be able to continue coverage in Company provided medical, dental, and life insurance as long as you continue to pay your required premium payments. You do not accrue any vacation days while you are on an LTD leave of absence.

If, after 12 months of disability, you are unable to return to your regular occupation, your employment will be terminated. You may, if eligible, continue to receive LTD payments from Unum to the earlier of reaching the maximum payment period for LTD or ceasing to meet Unum’s eligibility criteria.

_When Payments End_
Unum will stop sending you payments and your claim will end on the earliest of the following:

• During the first 12 months of payments, when you are able to work in your regular occupation on a part-time basis but you choose not to;
• After 12 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to;
• If you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
• The end of the maximum period of payment;
• The date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum’s Rehabilitation and Return to Work Assistance program (rehabilitation program);
• The date you fail to cooperate with, or participate in, the rehabilitation program;
• The date you fail to submit proof of continuing disability;
• After 12 months of payments if you are considered to reside outside the United States or Canada (defined as being outside the United States or Canada for a total period of six months or more during any 12 consecutive months of benefits); or
• The date you die.

Working while Disabled

Unum will send you a monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same illness or injury. If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same illness or injury, Unum will figure your payment as follows:

While working, you will receive payments based on the percentage of income you are losing due to your disability. To determine the amount Unum will pay you each month:

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 above by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2 above.

Unum may require you to send proof of your monthly disability earnings at least quarterly. Unum will adjust your payment based on your quarterly disability earnings. As part of your proof of disability earnings, Unum can require that you submit appropriate financial records necessary to substantiate your income.

After the elimination period, if you are disabled less than one month, Unum will send you 1/30 of your payment for each day of disability.

If your disability earnings routinely fluctuate widely from month to month, Unum may average your disability earnings over the most recent three months to determine if your claim should continue. If Unum averages your disability earnings, they will not terminate your claim unless the average of your disability earnings from the last three months exceeds 80% of your indexed monthly earnings. Unum will not pay you for any month during which your disability earnings exceed 80% of your indexed monthly earnings.

Maximum Payment Period for LTD

Unum will send you a payment each month up to the maximum period of payment. Your maximum period of payment is based on your age at disability as follows:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Period of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 62</td>
<td>To Social Security Normal Retirement Age (see following chart)</td>
</tr>
<tr>
<td>Age 62</td>
<td>60 months</td>
</tr>
<tr>
<td>Age 63</td>
<td>48 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 65</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>30 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>18 months</td>
</tr>
<tr>
<td>Age 69 or older</td>
<td>12 months</td>
</tr>
</tbody>
</table>
Your Social Security Normal Retirement Age is determined according to the following chart:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Social Security Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937 or before</td>
<td>65 years</td>
</tr>
<tr>
<td>1938</td>
<td>65 years 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 years 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 years 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 years 8 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 years 10 months</td>
</tr>
<tr>
<td>1943–1954</td>
<td>66 years</td>
</tr>
<tr>
<td>1955</td>
<td>66 years 2 months</td>
</tr>
<tr>
<td>1956</td>
<td>66 years 4 months</td>
</tr>
<tr>
<td>1957</td>
<td>66 years 6 months</td>
</tr>
<tr>
<td>1958</td>
<td>66 years 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 years 10 months</td>
</tr>
<tr>
<td>1960 and after</td>
<td>67 years</td>
</tr>
</tbody>
</table>

No premium payments are required for your coverage while you are receiving payments. The total benefit payable to you under this plan will not exceed 100% of your monthly earnings.

**Special Limits for Certain Conditions**

Disabilities, due to sickness or injury, which are primarily based on self-reported symptoms, and disabilities due to mental illness have a limited lifetime cumulative pay period up to 24 months. Only 24 months of benefits will be paid even if the disabilities are not continuous; and/or are not related.

Disabilities which are due to alcoholism or drug abuse are payable for a lifetime cumulative maximum of up to six months. Only six months of benefits will be paid even if the disabilities are not continuous and/or are not related.

Unum will continue to send you payments beyond the 24-month or six-month lifetime cumulative period if you meet one or both of these conditions:

- If you are confined to a hospital or institution at the end of the lifetime cumulative maximum benefit period and are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days. If you become re-confined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period of up to 90 more days.
- In addition, if after the lifetime cumulative maximum benefit period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Unum will send payments during the length of the re-confinement.

Unum will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Unum will not apply the mental illness limitation to dementia if it is a result of:
- Stroke,
- Trauma,
- Viral infection,
- Alzheimer’s disease, or
- Other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.
**What’s Not Covered**
This plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- Intentionally self-inflicted injuries,
- Active participation in a riot,
- Loss of a professional license, occupational license, or certification,
- Commission of a crime for which you have been convicted under state or federal law,
- Pre-existing conditions (see more about this exception below),
- Disability due to war, declared or undeclared, or any act of war, or
- Disability during a time in which you are incarcerated.

**Pre-existing Condition Restrictions**
If you become disabled during the first 12 months after your effective date of coverage, benefits will not be payable under the plan if your condition is pre-existing. A pre-existing condition for the purpose of LTD benefits is any illness or injury, including all related conditions and complications for which, during the three months before the start of your coverage by the plan, you:

- Received medical treatment, consultation, care or services including diagnostic measures,
- Took prescribed drugs or medicines, or
- Had symptoms for which an ordinarily prudent person would have consulted a health care provider.

**If the Insurance Company Overpays Your Claim**
Unum has the right to recover any overpayments due to:

- Fraud,
- Any error Unum makes in processing a claim, or
- Your receipt of deductible sources of income.

You must reimburse Unum in full. They will determine the method by which the repayment is to be made. Unum will not recover more money than the amount paid to you.

**Recurrent Disability Provisions**
If you have a recurrent disability, Unum will treat that disability as part of your prior claim and you will not have to complete another elimination period if you were continuously insured under the plan for the period between your prior claim and your recurrent disability and your recurrent disability occurs within six months 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 that occurs after six months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions. If you become entitled to payments under any other group LTD plan, you will not be eligible for payments under this plan.

**OTHER SERVICES PROVIDED BY UNUM**

**Vocational Rehabilitation and Return to Work Assistance Program**
Unum has a Vocational Rehabilitation and Return to Work Assistance program (the rehabilitation program) available to assist you in returning to work. Unum will determine whether you are eligible for this program, at their sole discretion. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.
Your claim file will be reviewed by one of Unum’s rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine whether a return to work program is appropriate for you.

If Unum determines you are eligible to participate in a rehabilitation program, you must participate in order to receive disability benefits. Unum will make the final determination of your eligibility to participate in the program.

Unum will provide you with a written rehabilitation program plan developed specifically for you. You must comply with the terms of the plan in order to receive disability benefits.

At Unum’s sole discretion, the rehabilitation program may include, but is not limited to, the following services and benefits:

- Coordination with the Company to assist you to return to work,
- Adaptive equipment or job accommodations to allow you to work,
- Vocational evaluation to determine how your disability may impact your employment options,
- Job placement services,
- Resume preparation,
- Job seeking skills training, and
- Education and retraining expenses for a new occupation.

Additional Benefits while Participating in Rehabilitation and Return to Work Assistance Program
Unum will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month. The benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount, such as deductible sources of income.

In addition, if Unum determines you are no longer disabled, you will continue to receive benefits from the plan for three months following the date your disability ends if you are participating in the rehabilitation program and you are not able to find employment.

Benefit payments will end on the earliest of the following dates:

- The date Unum determines that you are no longer eligible to participate in the rehabilitation program, or
- Any other date on which monthly payments would stop in accordance with the plan.

This benefit payment may be paid in a lump sum.

Child Care Benefits while Participating in Rehabilitation and Return to Work Assistance Program
When you are disabled and incurring child care expenses for your dependent child(ren) and participating continuously in the rehabilitation program, Unum will pay the Child Care Expense Benefit amount. Payment of the Child Care Expense Benefit amount will begin immediately after you start the rehabilitation program.

The Child Care Expense Benefit amount will be $250 per month, per child and will not exceed $1,000 per month for all eligible child care expenses combined.
Child Care Expense Benefit Rules
The Child Care Expense Benefit will be provided to reimburse your authorized expenses incurred for providing care for your dependent children who are:

- Under age 15, or
- Incapable of providing their own care on a daily basis due to their own physical or mental disability.

To receive this benefit, you must provide satisfactory proof that:

- You are incurring expenses for child care while participating in the rehabilitation program, and
- Payments for child care have been made to the child care provider.

If you are eligible for Child Care Expense Benefits, Unum can advise you how to submit proof.

Child Care Expense Benefits will end on the earlier of:

- The date the dependent child(ren) attain the age of 15,
- If the dependent child(ren) are mentally or physically disabled, the date they no longer are incapacitated or require daily care,
- The date a charge is no longer made by the child care provider,
- The date you no longer participate in the rehabilitation program, or
- Any other date payments would stop in accordance with the plan.

The following services are also available from Unum as part of the plan:

- **Work Life Assistance Program** to provide help to you and your dependents with problems of daily living. You can call and request assistance for virtually any personal or professional issue, from helping find a day care provider or transportation for an elderly parent to researching possible colleges for a child, and helping to deal with workplace stress. This program is available for everyday issues as well for crisis support.

  To access this service, call (800) 854-1446 or log on to their website at www.lifebalance.net (user ID and password: lifebalance). For more information about the Work Life Assistance Program, see the Employee Assistance Program section in the Medical Summary Plan Description

- **Worksite Modification Assistance** when necessary to allow you to perform the material and substantial duties of your regular occupation at the Company. Unum has designated professionals who can assist you and the Company identify a modification that Unum agrees is likely to help you remain at work or return to work. Under this feature, Unum will reimburse the Company for the cost of the modification up to the greater of $1,000 or the equivalent of two months of your monthly benefit. This benefit is available to you one time during your lifetime.

- **Social Security Claimant Advocacy Program** to help you with your Social Security application or appeal if you are receiving monthly benefits from Unum. Unum can provide expert advice regarding your claim and assist you with your application or appeal for Social Security disability benefits.

**Survivor Benefits**
When Unum receives proof that you have died, it will pay your eligible survivor a lump-sum payment benefit equal to three 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, unless there is none. In this case, no payment will be made. However, Unum will first apply the survivor benefit to any overpayment which may exist on your claim.

CLAIMS PROCEDURES

When to Notify Unum of a Claim for LTD
To file a claim for LTD benefits, you will work with the Nicor Gas Medical department so that there is a smooth transition from short-term to long-term disability benefits.

You are encouraged to notify Unum of your claim as soon as possible so that a claim decision may be made in a timely manner. Written notice of a claim can be sent as early as 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required except in the absence of legal capacity.

Note: You must notify Unum immediately when you return to work in any capacity.

How to File a Claim
The Nicor Gas Medical Department will be able to provide you with a Unum claim form. You can contact the Nicor Gas Medical Department at (630) 983-2701 to request a claim form.

You (or your authorized representative), your attending physician, and the Company must complete the appropriate individual sections of the claim form.

The Company will send its completed sections of the claim form directly to Unum. You will also send your portion of the claims form directly to Unum. After your physician completes his or her section of the form, he or she should forward it directly to Unum according to instructions on the form.

Proof of Your Claim
Proof of your claim, which must be provided at your expense, must show:

- That you are under the regular care of a physician,
- The appropriate documentation of your monthly earnings,
- The date your disability began,
- The cause of your disability,
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation, and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

Unum may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by Unum.

In some cases, you will be required to give Unum authorization to obtain additional medical information and provide non-medical information as part of your proof of claim, or proof of continuing disability.
Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

**Time Limits for Legal Proceedings**
You can start legal action regarding your claim 60 days after proof of claim has been given and up to three years from the time proof of claim is required, unless otherwise provided under federal law.

**Claims Appeals**
Please see the *Your Right to Appeal* section of this document for details about claim appeals.

**WHEN LTD COVERAGE ENDS**
Your coverage under the LTD plan will end on the earliest of the following events:

- The policy is cancelled by Unum or the Company.
- You retire,
- You terminate employment,
- You are no longer classified as a regular employee,
- The last day of the period for which required contributions have been made, or
- The last day you are in active employment except as provided under the covered layoff or leave of absence provisions.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

**IMPORTANT DISABILITY COVERAGE TERMS**

**Active Employment** — You are working for the Company 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 the minimum number of hours as described in the *Eligibility* section.

**Deductible Sources of Income** — Income from deductible sources listed in the plan, which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment from the plan.

**Elimination Period** — A period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

**Evidence of Insurability** (EOI) — A statement of your medical history, which Unum will use to determine if you are approved for coverage. Unum will pay the cost of any necessary medical examination or test required to provide EOI.

**Gainful Occupation** — An occupation 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 indexed monthly earnings, if you are not working.

**Gross Disability Payment** — The benefit amount before Unum subtracts deductible sources of income and disability earnings.
Hospital or Institution — An accredited facility licensed to provide care and treatment for the condition causing your disability.

Indexed Monthly Earnings — Your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index (CPI). Indexing is only used to determine your percentage of lost earnings while you are disabled and working. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Injury — A bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

Material and Substantial Duties — Duties that are normally required for the performance of your regular occupation and cannot be reasonably omitted or modified.

Mental Illness — A psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality 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.

Self-Reported Symptoms — The manifestations of your condition which you tell your physician that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Total Benefit Cap — The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings.

FAMILY AND MEDICAL LEAVE ACT LEAVE OF ABSENCE

Eligibility
In accordance with the Family and Medical Leave Act of 1993 (FMLA), all employees that have been employed with the Company for a minimum of one year, work in a location where at least 50 employees are employed within 75 miles of that location, and have worked at least 1,250 hours in the 12 months prior to the commencement of leave, may be eligible for unpaid leave for the following reasons:

- The birth, adoption, or foster care placement of the employee’s child and to care for the child after such birth, adoption, or placement (must be completed within the first 12 months after the birth, adoption, or placement),
- A serious health condition which renders the employee unable to perform the function of the employee’s position,
- To care for the employee’s spouse, child, or parent who has a serious health condition,
- To care for a covered servicemember who is an employee’s spouse, child, parent, or next of kin and is recovering from a serious injury or illness sustained in the line of duty on active military duty, or
- A qualifying emergency has occurred because an employee’s spouse, child, or parent has been called to, or is on active duty in support of, certain military operations.

For leave taken under the fourth bullet above, an employee may take a combined total of up to 26 weeks in a single 12-month period. The amount of leave time available to an employee for other types of leave is a combined total of 12 work weeks in a rolling 12-month period. The 12-month period is measured backward from the date an employee uses FMLA leave.
In the case of FMLA leave for a serious health condition, serious injury, or illness of a covered servicemember, an employee’s leave may be taken intermittently or on a reduced hour basis only if taking leave on such a basis is certified by a health care provider as being medically necessary. If intermittent or reduced hours leave is required, the Company may, in its sole discretion, temporarily transfer the employee to another position with equivalent pay and benefits that better accommodates that type of leave.

FMLA leave runs concurrently with all periods of leave related to short-term disability, workers' compensation, and child care (where offered).

**Employee’s Duty to Give Notice**
If the need for leave is foreseeable, an employee must give 30 days notice before taking FMLA leave under this policy. In the case of a leave arising from a qualifying emergency due to a family member’s active military duty, the employee must provide notice as is reasonable and practicable.

If the leave is not foreseeable, notice must be given as soon as practicable under the facts and circumstances of the particular case. Where 30 days notice is not possible, an employee is expected to give notice to the Company within one or two business days of when the need for leave becomes known.

**Benefits during Leave**
During FMLA leave, the employee’s group health insurance benefits will continue either for the 12-week leave period, 26 weeks in the event that leave is to care for a covered servicemember, or until the employee states his or her intention not to return to work. If the leave is unpaid, and other paid leave is not substituted, the employee will be billed for his or her premiums for continued benefit coverage.

Failure of the employee to make the required premium payments may result in an interruption in coverage. However, if the employee returns from the leave within the 12-week FMLA leave period (or 26 weeks in the event that leave to care for a covered servicemember is taken), coverage will be reinstated in accordance with the FMLA. An employee who fails to return to work at the conclusion of an FMLA leave will be required to repay to the Company all Company contributions to group health insurance during the FMLA leave, unless a legal exception to this requirement exists. If the employee fails to re-pay the premium payments, the Company will follow the normal process to collect amounts due.

Contact your Human Resources representative for a copy of the FMLA policy.

**MILITARY LEAVE POLICY (USERRA)**

The Company will grant military leave to eligible employees to meet any commitment for United States military duty. An employee who leaves the Company to enter the armed forces of the United States will be entitled to those reemployment rights provided by federal law, including the Uniformed Services Employment and Reemployment Rights Act (USERRA), and applicable provisions of state law.

The USERRA guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (e.g., Army, Navy, Air Force, Marines Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.
Upon reinstatement, you are entitled to the seniority, status, and rate of pay associated with the position that you would have attained with reasonable certainty if not for the absence due to uniformed service.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24 months after the leave begins or the day the leave ends and you fail to return to work.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the re-employment rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days,
- Reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days, and
- Reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Contact your Human Resources representative for a copy of the military leave policy.

**SUBROGATION AND RIGHT OF REIMBURSEMENT**

Subrogation and reimbursement rights entitle the plan to repayment of benefits paid for accidental injury or illness. These rights require payment to be made to the plan when settlement, medical expense payment, or other payment arising out of an accidental injury or illness is made to or for the benefit of you or your dependents.

Subrogation is a legal right the plan asserts to recover benefits it pays from the parties who caused the injury or their insurers and from other insurers that provide coverage for the accidental injury or illness. The plan can initiate a claim and seek repayment from many sources.

Reimbursement is a legal right the plan can assert to recover its benefit payments from you or your dependents. There is a duty to reimburse the plan when a settlement or payment arising out of an accidental injury or illness has been made without providing for repayment to the plan.

The first step is to determine whether subrogation applies to your claim. To determine who is liable and to identify available insurance coverages, you will be asked for information about your accidental injury or illness. As a plan participant, you are required to furnish any information or assistance or provide any documents that the Claims Administrator may require in order to obtain your rights under this provision.

The plan’s rights of subrogation and reimbursement are subject to regulation by federal law.
RESOURCES FOR QUESTIONS

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information and Hours of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR Administrative Support</td>
<td>(630) 983-8676, ext. 82000 During regular business hours</td>
</tr>
<tr>
<td>Nicor Gas Medical Department</td>
<td>(630) 983-8676, ext. 82701 During regular business hours</td>
</tr>
<tr>
<td>Employee Benefit Association</td>
<td>(630) 983-8676, ext. 82000 During regular business hours</td>
</tr>
<tr>
<td>Unum</td>
<td>(800) 858-6843 8:00 a.m. – 8:00 p.m</td>
</tr>
<tr>
<td>EAP, Work-Life Balance</td>
<td>(800) 854-1446 24 hours a day, 7 days a week <a href="http://www.LifeBalance.net">www.LifeBalance.net</a> (user ID and password: LifeBalance)</td>
</tr>
</tbody>
</table>

PLAN SPONSOR AND PLAN ADMINISTRATOR

Nicor Gas is the Plan Sponsor and Plan Administrator for the short-term disability (EBA) and can be contacted at:

Nicor Gas
1844 Ferry Road
Naperville, IL 60563-9600
(630) 983-8676

The Nicor Gas Medical department handles day-to-day operation of short-term disability (EBA) and can be contacted at:

Nicor Gas
P. O. Box 190
Aurora, IL 60507-0190
(630) 983-8676, extension 2701

Nicor Gas is the Plan Sponsor and Plan Administrator for the Nicor Gas Long-term Disability Plan and can be contacted at:

Nicor Gas
1844 Ferry Road
Naperville, IL 60563-9600
(630) 983-8676

The Nicor Gas Medical department handles day-to-day operation of long-term disability benefits and can be contacted at:

Nicor Gas
P. O. Box 190
Aurora, IL 60507-0190
(630) 983-8676, extension 2701
The Employee Benefit Association plan operates on a calendar-year basis (January 1 through December 31).

The Employer Identification Number for Nicor Gas is 36-2863847.

The Employer Identification Number for the Employee Benefit Association is 36-6067084.

The Nicor Companies Disability Plan operates from October through September 30.

The Employer Identification number for Nicor Gas is 36-2863847.

Nicor Gas is the agent for service of legal process for the plans and can be contacted at:

General Counsel
Nicor Gas
1844 Ferry Road
Naperville, IL 60563-9600

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, all documents governing the plan, including insurance contracts, 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 copies of the latest annual report (Form 5500 Series), and an 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.

**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 the 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 the Company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

**Enforce Your Rights**
If your claim for a plan benefit is denied or ignored in whole or in part, you or your beneficiary has the 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 plan documents or the latest annual report from the plan and do not receive them within 31 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 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, but only after you have exhausted the plan’s claims and appeals procedure, as described in the *Your Right to Appeal* section.

If plan fiduciaries misuse the 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 party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., the court finds that 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 summary 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. The EBSA can be contacted at:

Employee Benefits Security Administration  
U.S. Department of Labor  
Public Disclosure Room — Suite N-1513  
200 Constitution Avenue N.W.  
Washington, D.C. 20210  
(202) 693-8673

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publications hotline.

**YOUR RIGHT TO APPEAL**

*Time Frame for Claim Determinations*
If you receive an adverse benefit determination (e.g., denial, reduction or termination of a benefit, failure to provide or make a payment), the Claims Administrator will notify you of the adverse determination within a reasonable period of time, but not later than 45 days after receiving the claim.

This 45-day period may be extended for up to 30 days, if the Claims Administrator both determines the extension is necessary due to matters beyond the control of the plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator again determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days. In such case, the Claims Administrator must notify you, before the first 30-day extension period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision.
All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based,
- The unresolved issues that prevent a decision on the claim, and
- The additional information needed to resolve those issues.

You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the plan’s time frame for making a benefit determination is tolled (i.e., stopped) from the date the Claims Administrator sends you the extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination
The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- References to the specific plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary,
- A description of the plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse determination,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination will be provided free of charge to you upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Procedures for Appealing an Adverse Benefit Determination
You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial.

The Claims Administrator will notify you of the plan’s benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your request for review by the plan. If the Claims Administrator determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). If an extension of time is required, the Claims Administrator will notify you in writing if an additional 45 day extension is needed before the end of the initial 45-day period. The notice of the extension must indicate the special circumstances and the date by which the Claims Administrator expects to render the determination on review.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the
time specified, the 45-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the Claims Administrator may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the Claims Administrator and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, the Claims Administrator will consult with a health professional with appropriate training and experience.

The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, the Claims Administrator will provide you with the names of each such expert, regardless of whether the advice was relied upon.

The Claims Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination,
- References 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 the information about such procedures,
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request), and
- A statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, and
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

- A review that takes into account all comments, documents, records, and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor by that person's subordinate.
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual.
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.

You must use and exhaust this plan’s administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

The Claims Administrator has wide and absolute discretion to interpret and apply plan provisions and determine facts, benefits, and eligibility. All interpretations, decisions, and determinations of the Claims Administrator are intended to be final, conclusive, and binding on all parties having an interest in the plan.
ADDITIONAL PLAN INFORMATION

The chart below provides information about the plan and Claims Administrator and the insured status of the plans as required by ERISA.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Type of Administration</th>
<th>Plan Number</th>
<th>Insured by</th>
<th>Claims Administrator</th>
<th>Funded by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefit Association (Short-term disability)</td>
<td>Self-administered</td>
<td>501</td>
<td>Self insured</td>
<td>Nicor Gas</td>
<td>Company and voluntary employee contributions</td>
</tr>
<tr>
<td>Nicor Companies Disability Insurance Plan</td>
<td>Insured administration</td>
<td>515</td>
<td>Unum (fully insured)</td>
<td>Unum</td>
<td>Nicor Gas</td>
</tr>
<tr>
<td>Long term Disability Plan for Collectively Bargained Employees</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

STATE REQUIREMENTS

This is to advise you that if a complaint arises regarding the policy you may contact:

Deborah J. Jewett, Manager, Customer Relations
Unum Life Insurance Company of America
2211 Congress Street
Portland ME 04122
(207) 575-4568

Or, you may contact:

Consumer Service Section
Illinois Insurance Department
215 East Monroe Street
Springfield, IL 62767
YOUR EMPLOYMENT

The summary provides detailed information about short-term and long-term disability benefits and how the plans work. It does not constitute a contract or guarantee employment. Similarly, participation in a Company benefit plan does not constitute a contract of employment nor give you the right to remain in the employ of the Company or an affiliate. Employment decisions are made without regard to benefits to which you are entitled upon employment. The plan will not give any right or claim to any benefit under the plan unless that benefit has specifically accrued under the terms of the plan.

FUTURE OF THE PLAN

The Company reserves the right to terminate, suspend, or amend this plan at any time for any reason in a manner consistent with any collective bargaining agreement covering plan members.

In general, if a plan is terminated, you will not have any rights to any plan benefits (other than payment of claims incurred before the plan ended), subject to applicable law. The amount and form of any final benefit you may receive will depend on plan assets, any contract or insurance provisions vested in your interest in the plan management.

LIMITATION ON ASSIGNMENT

Your rights and benefits under these plans cannot be assigned, sold, or transferred to your creditors or anyone else.

COLLECTIVE BARGAINING AGREEMENT

The plans described in this summary are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the plan administrator. This agreement is also available for review during normal business hours at the address of the Plan Sponsor.