2025 BENEFITS ENROLLMENT GUIDE

Retirees 65+

Contents

Enrollment Process

NorthWestern Energy (company) gives you the opportunity to design your own benefits package by choosing from the available options and completing your enrollment either:

- During the Open Enrollment period from Oct. 9, 2024 through Oct. 25, 2024; or
- Within 31 days from the first of the month in which you reach age 65.

During the Open Enrollment Period

An enrollment form that displays the benefit options available to you along with the costs will be sent to you prior to the start of the Open Enrollment Period. An asterisk identifies the option and coverage level that you are enrolled in for the 2024 plan year.

- If you do not want to make any changes, you do not need to return the form. You will be automatically reenrolled.
- If you want to make changes, indicate your new elections on the enrollment form and return the form no later than 5:00 p.m. (MDT) on Friday, Oct. 25. If the form is not received when due, you will be reenrolled automatically in the same coverage that you were enrolled in for 2024.

When You Reach Age 65

When you reach age 65, Medicare will become the primary medical coverage available to you. Although Medicare covers a large portion of your health care costs, there are some costs not covered or fully paid by Medicare. A Medicare supplemental plan can help with these costs. There are several private insurance companies that sell Medicare supplement insurance. The company also offers its retirees a Medicare Supplement plan. If you are eligible, a Retirement Change of Status form along with a cost summary will be sent to you prior to reaching age 65. To enroll for coverage under the company's plan, you must complete the form and return it within 31 days from the first of the month in which you reach age 65. The eligibility requirements to participate in the company's plan are addressed later in this guide.

Notes:

1. If you decline coverage or enroll for coverage and allow coverage to lapse or otherwise terminate, you will not be eligible to enroll for coverage at a later date.
2. Retirees who enroll for coverage will have the opportunity to change their plan elections only during the Open Enrollment Period each year.

Eligibility

Retiree Eligibility

You are eligible to participate in the company's Medicare Supplement plan if you:

- Are age 65 or older; and
- Were participating in the company's medical plan for active employees or the medical plan for early retirees immediately prior to reaching age 65 or your date of retirement, if employed beyond age 65.

Dependent Eligibility

Your spouse is also eligible for coverage under the company's plan if he or she:

- Is a citizen, resident alien, or is otherwise legally present in the United States; and
- Is age 65 or older; and
- Is your legal spouse (unless you are legally divorced); and
- Was participating in the company's medical plan for active employees or the medical plan for early retirees immediately prior to reaching age 65.

Notes:

1. Children, of any age, are not eligible to participate in the company's plan.
2. If your spouse is over the age of 65 and participating in the company's plan when you reach age 65, he or she can continue coverage under the plan provided that you also enroll for coverage under the same option under the plan. If you do not elect coverage for yourself under the company's plan, your spouse's coverage under the plan will be terminated on the last day of the month immediately preceding the month in which you reach age 65.
3. A nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

Medicare Supplement Plan

Plan

Blue Cross Blue Shield of Montana (BCBSMT) is the administrator for the company's Medicare Supplemental plan. Information for BCBSMT can be found in the resource section of this guide.

Plan Options

The company's plan offers you three benefit options to choose from. All options are designed to supplement Medicare coverage. If you enroll for coverage, the company's plan will coordinate benefits with Medicare whether or not you are actually enrolled in and receiving Medicare Part A and B benefits. The company's plan does not provide for prescription drug coverage. The benefit options available include:

- Power Plus
- Power Silver
- Power Gold

Participation Tiers

Under each option, you can elect the coverage level appropriate for your circumstances. The coverage tiers available to you are: either:

- Single Coverage (retiree only)
- Two Party Coverage (retiree plus spouse)

Plan Benefits

In general, the benefits eligible for coverage under the company's plan are the same as those eligible for coverage under Medicare. If Medicare excludes a benefit, then the company's plan also excludes that same benefit. However, under the Power Gold plan option there is a Major Medical Endorsement that provides benefits not covered by Medicare including worldwide travel and inpatient private duty nursing. All benefits payable under the company's plan are subject to the Usual, Customary and Reasonable limits of the plan (UCR). The plan comparison chart that follows outlines the coverage provided under each plan option for the following benefits.

- **Hospital Stays** - Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery rooms, and anesthesia.
- **Home Health Care Services** – Medically necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor or other health care provider enrolled in Medicare must order your care and a Medicare-certified home health agency must provide it. May also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home.

Medicare Supplement Plan (continued)

- **Hospice Care** – Coverage includes drugs for pain relief and symptom management; medical nursing and social services; certain durable medical equipment; spiritual and grief counseling. Hospice care doesn't pay for facility care (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that cannot be addressed at home.
- **Skilled Nursing Facility (SNF) Care** - In a facility approved by Medicare. You must have been in a hospital for at least three days and enter the facility for the same condition within 30 days after hospital discharge.
- **Blood (Medicare Part A)** - Pints of blood received at a hospital or skilled nursing facility during a covered stay.
- **Medical and Other Services** – Physicians' services, inpatient and outpatient medical services and supplies, physical therapy, chiropractic services, ambulance, durable medical equipment, prosthesis, medical supplies outside hospital (e.g. colostomy supplies, catheters), oxygen, outpatient hemodialysis, immunosuppressive drugs. Medicare-defined limitation on certain services such as chiropractic services and physical therapy will apply.
- **Preventive Services** – Abdominal aortic aneurysm screening; bone mass measurement (bone density); cardiovascular screenings; colorectal cancer screenings; diabetes screenings; diabetes self-management training; flu shots; glaucoma tests; hepatitis B shots; HIV screening; mammogram (screening); medical nutrition therapy services; pap tests and pelvic exams (includes clinical breast exam); physical exams; pneumococcal shot; prostate cancer screening; smoking cessation counseling.
- **Blood (Medicare Part B)** - Pints of blood received as an outpatient or as part of a Medicare Part B-covered service.
- **Services Outside of the United States** - Medically Necessary hospital, physician, and medical care. The "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
- **Inpatient Private Duty Nursing** – Provided only under the Power Gold option, inpatient private duty nursing if the services are provided by a Registered Nurse (RN) other than a relative or hospital employee.

Medicare Supplement Plan Comparison Chart

BENEFIT	MEDICARE PAYS	POWER PLUS PAYS	POWER SILVER PAYS	POWER GOLD PAYS
MEDICARE PART A				
BLOOD	All but the 1st three pints in a calendar year	1st three pints in a calendar year	1st three pints in a calendar year	1st three pints and 20% of additional pints approved by Medicare
HOSPITAL STAYS				
Days 1-60 each calendar year	100% of Medicare approved amount	Medicare deductible	Medicare deductible	Medicare deductible
Days 61-90 each calendar year	100% of Medicare approved amount after Medicare copayment	Medicare copayment	Medicare copayment	Medicare copayment
Days 91-150 each calendar year; max of 60 days per lifetime (Lifetime Reserve Days)	100% of Medicare approved amount after Medicare copayment	Medicare copayment	Medicare copayment	Medicare copayment
Beyond Lifetime Reserve Days	Nothing	100% for 365 additional days of confinement	100% for 365 additional days of confinement	100% for 365 additional days of confinement
SKILLED NURSING FACILITY				
First 20 days each calendar year	100% of Medicare approved amount	Nothing	Nothing	Nothing
Days 21-100 each calendar year	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment	Medicare daily copayment	Medicare daily copayment
Beyond 100 days each calendar year	Nothing	Nothing	Nothing	Nothing
HOME HEALTH CARE SERVICES	100% of Medicare approved amount for home health care services 80% of Medicare-approved amount for durable medical equipment	Nothing 20% of Medicare-approved amount for durable medical equipment	Nothing 20% of Medicare-approved amount for durable medical equipment	Nothing 20% of Medicare-approved amount for durable medical equipment
HOSPICE CARE	100% of Medicare-approved amount for hospice care	Nothing	Nothing	Nothing
MEDICARE PART B				
BLOOD	80% of Medicare approved amount after the 1st three pints received as an outpatient	1st three pints plus Medicare deductible and 20% of additional pints approved by Medicare	1st three pints plus Medicare deductible and 20% of additional pints approved by Medicare	1st three pints plus Medicare deductible and 20% of additional pints approved by Medicare
MEDICAL AND OTHER SERVICES	80% of Medicare approved amount after Medicare Part B deductible is satisfied	Medicare deductible and 20% of Medicare's approved amount for all covered services	Medicare deductible and 20% of Medicare's approved amount for all Medicare-covered services. 100% of the difference between Medicare's approved amount and the UCR for the eligible service received	Medicare deductible and 20% of Medicare's approved amount for all Medicare-covered services. After the Major Medical deductible is met, 80% of the difference between Medicare's approved amount and the UCR for the eligible service received

Medicare Supplement Plan Comparison Chart

BENEFIT	MEDICARE PAYS	POWER PLUS PAYS	POWER SILVER PAYS	POWER GOLD PAYS
PREVENTIVE SERVICES				
Annual Wellness Exam	100% of Medicare-approved amount	Nothing	Nothing	Nothing
Flu Shots	100% of Medicare-approved amount; once per flu season in the fall or winter	Nothing	Nothing	Nothing
Mammogram Screening	100% of Medicare-approved amount	Nothing	Nothing	Nothing
Colorectal Cancer Screening Fecal Occult Blood Test Flexible Sigmoidoscopy; Colonoscopy Barium Enema	100% of Medicare-approved amount; you pay copayment and/or 20% for doctor/hospital services, if applicable	Medicare deductible and/or copayment and 20% of Medicare's approved amount	Medicare deductible and/or copayment and 20% of Medicare's approved amount	Medicare deductible and/or copayment and 20% of Medicare's approved amount
Pap Test & Pelvic Exam (includes clinical breast exam)	100% of Medicare approved amount	Nothing	Nothing	Nothing
Routine Annual Physical Exam	100% of Medicare approved amount	Nothing	Nothing	Nothing
Prostate Cancer Screening	100% of Medicare approved amount; you pay 20% for doctor services & hospital copayment	Medicare deductible and 20% of Medicare's approved amount and hospital copayment	Medicare deductible and 20% of Medicare's approved amount and hospital copayment	Medicare deductible and 20% of Medicare's approved amount and hospital copayment
All Other Preventive Services	100% of Medicare approved amount	If applicable, Medicare deductible, coinsurance or copayment	If applicable, Medicare deductible, coinsurance or copayment	If applicable, Medicare deductible, coinsurance or copayment
ADDITIONAL SERVICES				
Services Outside the United States	Coverage is limited to Medically Necessary services provided in Canada when traveling between Alaska and another state; Medicare also covers hospital, ambulance, and doctor services if you are in the United States but the nearest hospital that can treat you isn't in the United States **All other care received outside of the United States is not covered**	Nothing	For Medicare-covered services as described under "Medicare Pays", after a $250 annual deductible per covered person, plan pays 80% of the UCR for the eligible service received with a $50,000 lifetime benefit maximum **All other care received outside of the United States is not covered**	Worldwide coverage; after the $500 deductible is met under the Major Medical Endorsement, plan pays 80% of the UCR for the eligible service received
Inpatient Private Duty Nursing	Nothing	Nothing	Nothing	Covered under the Major Medical Endorsement

Medicare Supplement Plan (continued)

Major Medical Endorsement (Power Gold Option Only)

Under the Major Medical Endorsement, once a covered person meets an annual deductible of **$500**, the plan will pay 80% of the allowable fee under the plan for the following benefits:

- Major medical services received while traveling worldwide;
- Inpatient private duty nursing services provided by a Registered Nurse (RN) other than a relative or hospital employee; and
- Charges above Medicare's approved amount.
- All charges for the above benefits accumulate towards meeting the annual deductible. The maximum lifetime benefit per covered person is **$250,000.**

Plan Limitations

Under each of the plan options, benefits are limited for the following services. The plan will only pay the Medicare deductible and copayment up to the Medicare maximums.

1. Outpatient psychiatric care
2. Hospital charges for psychiatric hospitalization
3. Physical therapy
4. Chiropractic services

Plan Exclusions

Unless otherwise specified, the following services, treatments or supplies are excluded for coverage under each of the plan options:

1. Charges not considered eligible by Medicare or services that Medicare does not cover, unless specifically covered under the Major Medical Endorsement.
2. Charges over Medicare's approved amount, unless specifically provided under the Power Silver and Power Gold options. Refer to the plan Comparison Chart.
3. The Major Medical Endorsement deductible and the 20% coinsurance on major medical services.
4. Prescription drugs.
5. Hospital inpatient confinement days longer than 515 continuous days.
6. Skilled nursing facility care after 100 days.
7. Private duty nursing, unless specifically covered under the Major Medical Endorsement.
8. Inpatient and outpatient psychiatric care, physical therapy and chiropractic services above Medicare maximum allowances.
9. Drugs and self-administered injectables outside the hospital, unless specifically covered under the Major Medical Endorsement.
10. Custodial or intermediate nursing home care.

Medicare Supplement Plan (continued)

Plan Exclusions (continued)

11. Home health care above the number of visits covered by Medicare.
12. Eye refractions and eyeglasses.
13. Radial keratotomy.
14. Hearing aids and hearing aid examinations.
15. Dental care and dentures.
16. Cosmetic surgery, unless the surgery is the result of trauma, infection, or disease.
17. Routine physical examinations and immunizations, except as approved by Medicare.
18. Surgery for weight reduction except as pre-approved by Medicare.
19. Travel.
20. Acupuncture.
21. Sexual dysfunction.
22. Experimental/Investigational procedures and procedures that are not accepted medical practice.
23. Routine foot care.
24. Personal comfort items.
25. Care or services not related to an active Illness or Injury.
26. Rehabilitation or rehabilitation therapy and related services and supplies, except as approved by Medicare.
27. Occupational, visual, speech, recreational, educational, or milieu therapy, except as approved by Medicare.
28. Treatment of chemical dependency or mental illness, except as approved by Medicare.
29. Charges covered by Medicare, Medicaid, Workers' Compensation, or any governmental agency, except services received in a Montana State Institution that would have been covered if provided outside the institution.
30. U.S. Armed Service-connected disabilities and Illness or Injury resulting from war.
31. Unless specifically covered under the Major Medical Endorsement, services received outside of the United States (the "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).

Medicare Supplement Plan (continued)

Discount Pharmacy Card Benefit

A discount pharmacy card benefit is provided under each of the plan options. The covered person must present their pharmacy program member ID card at a network pharmacy at the point of sale to receive the discount.

Medical Expense Self-Audit Bonus

Under the company's plan, a covered person is offered an incentive to encourage examination and self-auditing of medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received. The covered person should review all charges and verify that each itemized goods or service has been received and that the bill does not represent either an overcharge or a charge for goods or services never received. In the event a self-audit results in elimination or reduction of charges, fifty percent (50%) of the amount eliminated or reduced will be paid directly to the covered person as a bonus, provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the plan (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus shall only apply to erroneous charges that have been submitted to and paid by the plan. Erroneous charges corrected by the plan during the claims adjudication process are not eligible for this bonus. Rewards are subject to the following:

- A minimum reward of $25 (on overcharge of $50)
- A maximum reward of $600 (on overcharge of $1,200 or more).

This self-audit is a bonus in addition to the benefits of the plan. The covered person must indicate on the corrected billing statement "This is a claim for the Medical Expense Self-Audit Bonus" and submit to the Plan Supervisor at the following address a copy of the incorrect bill and a copy of the corrected billing in order to receive the bonus:

Blue Cross and Blue Shield of Montana
Plan Supervisor
P.O. Box 7982
Helena, MT 59604
(855) 258-3489

COBRA

COBRA in General

The company's Employee Benefits Administration Committee (EBAC) is the Plan Administrator for NorthWestern's benefit plans.

This notice 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. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's Summary Plan Description or contact the Benefits department at **(888) 236-6656**.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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 notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Who is Entitled to COBRA Continuation Coverage?

If you are a retiree, you will become a qualified beneficiary if a proceeding in bankruptcy is filed with respect to the company, and that bankruptcy results in the loss of your coverage under the plan.
If you are the spouse of a retiree, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- You become divorced or legally separated from your spouse. Also, if your spouse (the retiree) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
- Bankruptcy.

When Will COBRA Continuation Coverage Be Offered?

The 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 for your spouse or dependent children (as defined above), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing, to:

Benefits Department
NorthWestern Energy
11 E Park St
Butte, MT 59701-1711

COBRA (continued)

How is COBRA 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. A covered retiree may elect COBRA continuation coverage on behalf of a spouse or eligible child(ren).

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, the retiree's entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's loss of eligibility, COBRA continuation coverage lasts for up to a total of 36 months.

Are There Other Coverage Options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (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. For more information about the Marketplace, visit www.healthcare.gov.

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

Plan Contact Information:

Benefits Department
NorthWestern Energy
11 E Park St
Butte, MT 59701-1711
(888) 236-6656

HIPAA and Women's Health Rights

Health Insurance Portability and Accountability Act (HIPAA)

Federal law requires the company to inform retirees where to locate the company's Privacy Notice regarding Protected Health Information (PHI) every three years. The notice is required by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The Privacy Notice describes what your individual rights are and how the company handles PHI. Please note that PHI passes directly from your health care providers to the company's third party administrators for claims processing.

The company's Privacy Notice covers the Medicare supplement plans. The Privacy Notice also identifies the Privacy Officer who handles any privacy-related complaints.

You may obtain a copy of the HIPAA Privacy Notice by calling the Benefits department at **(888) 236-6656**.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Notice

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

- all states of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the company's medical plans.

For more information regarding your WHCRA benefits, contact the Benefits department at **(888) 236-6656.**

Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)

Group health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Non Creditable Coverage Notice

Although the the company's medical plan does not include benefits for prescription drugs, this notice is issued because the plan provides a pharmacy discount card benefit.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The company has determined that the prescription drug coverage offered under its Health Benefit Plan for Retirees Age 65 And Older is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the company plan. This also is important because it may mean that you could pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage under the company's plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7, with changes effective January 1.

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

Since the coverage under the company's plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join, with changes effective January 1.

Medicare Non Creditable Coverage Notice (continued)

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

If you decide to join a Medicare drug plan, your current coverage under the company's plan will not be affected. You can continue to use the pharmacy discount card provided under the company's plan.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the company's Benefits department for further information at **(888) 236-6656**.

NOTE: You'll get this notice each year before the next period during which you can join a Medicare drug plan and if this coverage through the company's plan changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

Service Providers & Resources

Service Provider	Service(s) Provided	Phone Number	Web Address/E-mail
Blue Cross and Blue Shield of MT Medical Claims	Medical	(855) 258-3489 or (406) 437-7043 (local) Fax (claims): (855) 831-3249	www.bcbsmt.com
Benefits Department	General Benefits	**(888) 236-6656**	benefits@northwestern.com
Retiree Website	General Benefits		http://retirees.northwesternenergy.com

Resource	Phone Number	Web Address/E-mail
MT Commissioner of Securities & Insurance	(800) 332-6148	www.csi.mt.gov
Centers for Disease Control and Prevention	(800) 232-4636	www.cdc.gov
American Heart Association	(800) 242-8721	www.heart.org
American Cancer Society	(800) 227-2345	www.cancer.org
Diabetes Association	(800) 342-2383	www.diabetes.org
General Medical Topics		www.webmd.com
Medicare		www.medicare.gov
Wellness Topics		www.nationalwellness.org
MayoClinic.com		www.mayoclinic.com
MerckEngage.com		www.merckengage.com
AARP		www.aarp.org
Social Security Administration		www.ssa.gov

This booklet is intended to help retirees understand the main features of the company's health benefit plan for retirees age 65 and older (Plan). It should not be considered a substitute for the Plan document that governs the administration of the Plan. The Plan document sets forth all of the details and provisions concerning the Plan and is subject to amendment.

If any questions arise that are not covered in this booklet or if this booklet appears to be in conflict with the official Plan document or company policy, the text of the official Plan document will determine how questions will be resolved.

The benefit comparison chart of this guide is intended to provide a general description of the benefits covered by Medicare. It is not an all-inclusive list. If there are inconsistencies between this booklet and any official U.S. government Medicare document, the provisions of that document will govern in all cases. For a complete list of Medicare benefits as well as information regarding Medicare benefits, please access the Medicare website at www.medicare.gov.

Additional Notes

NorthWestern® Energy

Delivering a Bright Future