NorthWestern® Energy

Plan Document/Summary Plan Description

HEALTH BENEFIT PLAN

Retirees Age 65 or Older

Effective January 1, 2025


BlueCross
BlueShield
of Montana
Live Smart. Live Healthy.®

FOR CUSTOMER SERVICE
Call (855) 258-3489

FOR APPEALS
Urgent Care Appeals Only: (800) 447-7828
Other Appeals: Send via fax to (406) 437-7875 or mail to BCBSMT at address below

FOR CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 7982
Helena, MT 59604- 7982

Blue Cross and Blue Shield of Montana
3645 Alice Street PO Box 4309
Helena, MT 59604-4309

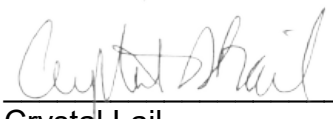
COVER/SIGNATURE PAGE

Effective January 1, 2025, NorthWestern Corporation dba NorthWestern Energy restates its self-funded **HEALTH BENEFIT PLAN FOR RETIREES AGE 65 OR OLDER OF NORTHWESTERN CORPORATION DBA NORTHWESTERN ENERGY,** (the ”Plan”).

The purpose of this Plan is to provide reimbursement for eligible expenses incurred for covered services, treatment or supplies as a result of Medically Necessary treatment for Illness or Injury of the Company’s eligible Retirees and their eligible Dependent Spouse.

The Company has caused this instrument to be effective January 1, 2025 and executed as of the date of signature.

NORTHWESTERN CORPORATION DBA NORTHWESTERN ENERGY

BY: 

Crystal Lail

TITLE: VP & CHIEF FINANCIAL OFFICER

DATE: 12/9/2024

GRANDFATHERED PLAN UNDER AFFORDABLE CARE ACT

The Plan Sponsor believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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INTRODUCTION

Effective January 1, 2025, NorthWestern Corporation dba NorthWestern Energy, hereinafter referred to as “NWE”, the “Company” or “Employer”, reinstates the benefits, rights and privileges which pertain to participating Retirees and their eligible Dependent Spouse as defined in the Plan. The Plan is a component of the NorthWestern Energy Employee Benefit Plan. The Plan described in this summary (referred to herein as the “Plan Document”) pertains to benefits in effect as of January 1, 2025.

Coverage provided under the Plan for Retirees and their Dependent Spouse will be in accordance with the Eligibility, Effective Date of Coverage, Termination, and other applicable provisions as stated in this Plan and the NorthWestern Energy Employee Benefit Plan. Except as otherwise expressly set forth in this Plan Document, in the event of a conflict between the terms of the Plan and those of the NorthWestern Energy Employee Benefit Plan, the terms of the NorthWestern Energy Employee Benefit Plan, shall control.

This Plan Document, when read together with the NorthWestern Energy Employee Benefit Plan Summary Plan Description (the “Wrap SPD”), is intended to serve as the Summary Plan Description for the Plan. Except as otherwise expressly set forth in this Plan Document, in the event of a conflict between the terms of the Plan and those of the Wrap SPD, the terms of the Wrap SPD shall control.

Certain terms in this Plan are defined within the document or in the Definitions section. Defined terms are capitalized.

NorthWestern Corporation dba NorthWestern Energy, (the Plan Sponsor) has retained the services of an independent Claim Administrator, experienced in claims processing, to handle health claims.

The Claim Administrator for the Plan is:

Blue Cross and Blue Shield of Montana
3645 Alice Street PO Box 4309
Helena, MT 59604-4309
(855) 258-3489
Normal Business Hours: 8 a.m.–5 p.m. Mountain), Monday through Friday, excluding holidays

After you have reviewed this document, if you have questions, please contact Blue Cross and Blue Shield of Montana’s Customer Service Department at the phone number listed above.

RETIREE COVERAGE OPTIONS

ALL SERVICES ELIGIBLE UNDER THIS PLAN MUST BE ELIGIBLE FOR MEDICARE. IF MEDICARE EXCLUDES A SERVICE, THIS PLAN EXCLUDES THAT SERVICE ALSO. IT IS RECOMMENDED TO READ THIS DOCUMENT ALONG WITH YOUR MEDICARE PLAN INFORMATION.

ALL BENEFITS PAYABLE ARE SUBJECT TO THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

Medicare Benefits listed in this Plan Document are reflective of benefits at the time of this writing and may change. For a complete list of Medicare benefits, please access the Medicare website at www.medicare.gov

There are three Benefit Options available for Retiree Coverage
All three options are designed to supplement Medicare coverage

The three Benefit Options are:

POWER PLUS

POWER SILVER

POWER GOLD

SCHEDULE OF BENEFITS - POWER PLUS

PLEASE REFER TO THE **BENEFITS** SECTION FOR A LIST OF THE SERVICES COVERED UNDER EACH SERVICE CATEGORY.

SERVICE	MEDICARE PAYS	POWER PLUS PAYS
HOSPITAL STAYS (Medicare Part A)		
Days 1-60 each Benefit Period	100% of Medicare approved amount after Medicare deductible	Medicare deductible
Days 61-90 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Days 91-150 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Beyond 150 days of confinement each Benefit Period	$0.00	100% for 365 additional days of confinement
SKILLED NURSING FACILITY (SNF) CARE (Medicare Part A)		
First 20 days each Benefit Period	100% of Medicare approved amount	$0.00
Days 21-100 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Beyond 100 days of confinement each Benefit Period	$0.00	$0.00
BLOOD (Medicare Part A)	80% of Medicare approved amount after the first three pints as part of inpatient hospital stay	First three pints and 20% of additional pints approved by Medicare.

SERVICE	MEDICARE PAYS	POWER PLUS PAYS
MEDICAL AND OTHER SERVICES (Medicare Part B)	80% of Medicare approved amount after Medicare Part B deductible is satisfied	Medicare Part B deductible and 20% of Medicare's approved amount for all Medicare-covered services.
BLOOD (Medicare Part B)	80% of Medicare approved amount after the first three pints received as an outpatient	First three pints plus Medicare deductible and 20% for any additional pints approved by Medicare.
ADDITIONAL SERVICES Services Received While Traveling Outside of 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. The "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. All other care received outside of the United States is not covered.	None
Inpatient Private Duty Nursing	None	

BENEFITS - POWER PLUS

The following Benefits are payable as stated in the Schedules of Benefits for each Plan Option, subject to all terms and conditions of this Plan including the specific limitations of each Plan Option.

1. **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.

2. **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.

3. **Blood (Medicare Part A)** - Pints of blood received at a hospital or skilled nursing facility during a covered stay.

4. **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.

   *Hospital outpatient services include surgery, emergency care, lab tests, x-rays, and other services not requiring hospitalization.

5. **Blood (Medicare Part B)** - Pints of blood received as an outpatient or as part of a Medicare Part B-covered service.

LIMITATIONS AND EXCLUSIONS - POWER PLUS

LIMITATIONS

Benefits for the following services are limited. The Plan will pay only 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

EXCLUSIONS

The following services, treatments or supplies are excluded:

1. Charges not considered eligible by Medicare, including charges over Medicare's approved amount.
2. Services Medicare does not cover and services provided outside 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).
3. Prescription drugs.
4. Hospital inpatient confinement days longer than 515 continuous days.
5. Skilled nursing facility (SNF) care after 100 days.
6. Private duty nursing.
7. Inpatient and outpatient psychiatric care, physical therapy and chiropractic services above Medicare maximum allowances.
8. Drugs and self-administered injectables outside the hospital.
9. Custodial or intermediate nursing home care.
10. Home health care above the number of visits covered by Medicare.
11. Eye refractions and eyeglasses.
12. Radial keratotomy.

13. Hearing aids and hearing aid examinations.

14. Dental care and dentures.

15. Cosmetic surgery, unless the surgery is the result of trauma, infection, or disease.

16. Routine physical examinations and immunizations, except as approved by Medicare.

17. Surgery for weight reduction except as pre-approved by Medicare.

18. Travel.

19. Acupuncture.

20. Sexual dysfunction.

21. Experimental/Investigational procedures and procedures that are not accepted medical practice.

22. Routine foot care.

23. Personal comfort items.

24. Care or services not related to an active Illness or Injury.

25. Rehabilitation or rehabilitation therapy and related services and supplies, except as approved by Medicare.

26. Occupational, visual, speech, recreational, educational, or milieu therapy, except as approved by Medicare.

27. Treatment of chemical dependency or mental illness, except as approved by Medicare.

28. 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.

29. U.S. Armed Service-connected disabilities and Illness or Injury resulting from war.

30. 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).

SCHEDULE OF BENEFITS - POWER SILVER

PLEASE REFER TO THE **BENEFITS** SECTION FOR A LIST OF THE SERVICES COVERED UNDER EACH SERVICE CATEGORY.

SERVICE	MEDICARE PAYS	POWER SILVER PAYS
HOSPITAL STAYS (Medicare Part A)		
Days 1-60 each Benefit Period	100% of Medicare approved amount after Medicare deductible	Medicare deductible
Days 61-90 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Days 91-150 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Beyond 150 days of confinement each Benefit Period	$0.00	100% for 365 additional days of confinement
SKILLED NURSING FACILITY (SNF) CARE (Medicare Part A)		
First 20 days each Benefit Period	100% of Medicare approved amount	$0.00
Days 21-100 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Beyond 100 days of confinement each Benefit Period	$0.00	$0.00
BLOOD (Medicare Part A)	80% of Medicare approved amount after the first three pints as part of inpatient hospital stay	First three pints and 20% of additional pints approved by Medicare.

SERVICE	MEDICARE PAYS	POWER SILVER PAYS
MEDICAL AND OTHER SERVICES (Medicare Part B)	80% of Medicare approved amount after Medicare Part B deductible is satisfied	Medicare Part B deductible and 20% of Medicare's approved amount for all Medicare-covered services and 100% of the difference between Medicare's approved amount and the UCR for the eligible service received.
BLOOD (Medicare Part B)	80% of Medicare-approved amount after the first three pints received as an outpatient	First three pints plus Medicare deductible and 20% for any additional pints approved by Medicare.
ADDITIONAL SERVICES Services Received While Traveling Outside of 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. The "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. All other care received outside of the United States is not covered.	After $250 Calendar Year deductible ▪ 80% of the UCR for the eligible service received. ▪ $50,000 lifetime maximum. None
Inpatient Private Duty Nursing	None	

BENEFITS - POWER SILVER

The following Benefits are payable as stated in the Schedules of Benefits for each Plan Option, subject to all terms and conditions of this Plan including the specific limitations of each Plan Option.

1. **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.

2. **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.

3. **Blood (Medicare Part A)** - Pints of blood received at a hospital or skilled nursing facility during a covered stay.

4. **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.

   *Hospital outpatient services include surgery, emergency care, lab tests, x-rays, and other services not requiring hospitalization.

5. **Blood (Medicare Part B)** - Pints of blood received as an outpatient or as part of a Medicare Part B-covered service.

6. **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.

LIMITATIONS AND EXCLUSIONS - POWER SILVER

LIMITATIONS

Benefits for the following services are limited. The Plan will pay only 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

EXCLUSIONS

The following services, treatments or supplies are excluded:

1. Charges not considered eligible by Medicare.
2. Services Medicare does not cover.
3. Prescription drugs.
4. Hospital inpatient confinement days longer than 515 continuous days.
5. Skilled nursing facility (SNF) care after 100 days.
6. Private duty nursing.
7. Physician's charges above Medicare's approved amount, except as stated in the Schedule of Benefits under the Medical and Other Services Benefit.
8. Inpatient and outpatient psychiatric care, physical therapy and chiropractic services above Medicare maximum allowances.
9. Drugs and self-administered injectables outside the hospital.
10. Custodial or intermediate nursing home care.
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.

SCHEDULE OF BENEFITS - POWER GOLD

PLEASE REFER TO THE BENEFITS SECTION FOR A DESCRIPTION OF THE SERVICES COVERED WITHIN EACH SERVICE CATEGORY.

SERVICE	MEDICARE PAYS	POWER GOLD PAYS
HOSPITAL STAYS (Medicare Part A)		
Days 1-60 each Benefit Period	100% of Medicare approved amount after Medicare deductible	Medicare deductible
Days 61-90 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Days 91-150 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Beyond 150 days of confinement each Benefit Period	$0.00	100% for 365 additional days of confinement
SKILLED NURSING FACILITY (SNF) CARE (Medicare Part A)		
First 20 days each Benefit Period	100% of Medicare approved amount	$0.00
Days 21-100 each Benefit Period	100% of Medicare approved amount after Medicare daily copayment	Medicare daily copayment
Beyond 100 days of confinement each Benefit Period	$0.00	$0.00
BLOOD (Medicare Part A)	100% of Medicare approved amount after the first three pints as part of inpatient hospital stay	First three pints and 20% of additional pints approved by Medicare.

SERVICE	MEDICARE PAYS	POWER GOLD PAYS
MEDICAL AND OTHER SERVICES (Medicare Part B)	80% of Medicare approved amount after Medicare Part B deductible is satisfied	Medicare Part B deductible and 20% of Medicare's approved amount for all Medicare-covered services. After $500 Major Medical deductible, 80% of the difference between Medicare's approved amount and the UCR for the eligible service received.
BLOOD (Medicare Part B)	80% of Medicare-approved amount after the first three pints received as an outpatient	First three pints plus Medicare deductible and 20% for any additional pints approved by Medicare.
ADDITIONAL SERVICES Services Received While Traveling Outside of 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. The "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. All other care received outside of the United States is not covered.	After $500 Calendar Year deductible: ▪ 80% of the UCR for the eligible service received. ▪ $250,000 lifetime maximum.
Inpatient Private Duty Nursing	None	Included in Additional Services above for Power Gold Plan.

BENEFITS - POWER GOLD

The following Benefits are payable as stated in the Schedules of Benefits for each Plan Option, subject to all terms and conditions of this Plan including the specific limitations of each Plan Option.

1. **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.

2. **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.

3. **Blood (Medicare Part A)** - Pints of blood received at a hospital or skilled nursing facility during a covered stay.

4. **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.

   *Hospital outpatient services include surgery, emergency care, lab tests, x-rays, and other services not requiring hospitalization.

5. **Blood (Medicare Part B)** - Pints of blood received as an outpatient or as part of a Medicare Part B-covered service.

6. **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.

POWER GOLD MAJOR MEDICAL ENDORSEMENT

Deductible per Covered Person per Calendar Year $500

Maximum Lifetime Benefit per Covered Person $250,000

The deductible is met by accumulating $500 of charges for the services listed below.

SERVICE	BENEFITS
MAJOR MEDICAL $500 deductible per Calendar Year Worldwide coverage, inpatient private duty RN Charges above Medicare's Approved Charge	After the $500 deductible is met, payment is made at 80% of UCR.

Deductibles will be applied to charges in the chronological order in which they are adjudicated by the Plan. Expenses will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and charges are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

LIMITATIONS AND EXCLUSIONS - POWER GOLD

LIMITATIONS

Benefits for the following services are limited. The Plan will pay only 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

EXCLUSIONS

The following services, treatments or supplies are excluded:

1. Charges not considered eligible by Medicare, unless specifically covered under the Major Medical Endorsement.

2. The Major Medical Endorsement deductible plus 20 percent coinsurance on major medical services.

3. Prescription drugs.

4. Hospital inpatient confinement days longer than 515 continuous days.

5. Skilled nursing facility (SNF) care after 100 days.

6. Private duty nursing, except as stated in the Schedule of Benefits for inpatient private duty nursing if the services are provided by an RN other than a relative or hospital employee.

7. Physician's charges above Medicare's approved amount, except as stated in the Schedule of Benefits under the Medical and Other Services Benefit.

8. Inpatient and outpatient psychiatric care, physical therapy and chiropractic services above Medicare maximum allowances.

9. Drugs and self-administered injectables outside the hospital, except as stated under the Major Medical Benefits of this Option.

10. Skilled nursing home care beyond days allowed by Medicare.

11. Custodial or intermediate nursing home care.

12. Home health care above the number of visits covered by Medicare.

13. Eye refractions and eyeglasses.

14. Radial keratotomy.

15. Hearing aids and hearing aid examinations.

16. Dental care and dentures.

17. Cosmetic surgery, unless the surgery is the result of trauma, infection, or disease.

18. Routine physical examinations and immunizations, except as approved by Medicare.

19. Surgery for weight reduction except as pre-approved by Medicare.

20. Travel.

21. Acupuncture.

22. Sexual dysfunction.

23. Experimental/Investigational procedures and procedures that are not accepted medical practice.

24. Routine foot care.

25. Personal comfort items.

26. Care or services not related to an active Illness or Injury.

27. Rehabilitation or rehabilitation therapy and related services and supplies, except as approved by Medicare.

28. Occupational, visual, speech, recreational, educational, or milieu therapy, except as approved by Medicare.

29. Treatment of chemical dependency or mental illness, except as approved by Medicare.

30. 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.

31. U.S. Armed Service-connected disabilities and Illness or Injury resulting from war.

DISCOUNT PHARMACY CARD BENEFIT

The Discount Pharmacy Card Benefit is available with all three Retiree Coverage Options.

Prescription drugs are not covered under this Plan. However, a Participant can receive a discounted price on prescription drug purchases when made at a Participating Pharmacy. To receive the discount, the Participant must present their Plan identification card (Blue Cross and Blue Shield of Montana medical identification card) at the point of purchase.

A Participating Pharmacy is a pharmacy that has entered into an agreement with the pharmacy benefit manager selected by the Company to provide prescription drug products and accept specified reimbursement rates. To find a Participating Pharmacy call the Express Scripts, Inc. Customer Service number at (866) 892-0071 or access their website at www.express-scripts.com.

MEDICAL EXPENSE SELF-AUDIT BONUS

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. 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. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

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 employee 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 this 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 Claim Administrator 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
3645 Alice Street P.O. Box 4309
Helena, MT 59604-4309

COORDINATION OF BENEFITS

COORDINATION WITH MEDICARE

Medicare will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare benefits.

1. **For Retired Persons**

   Medicare is primary and the Plan will be secondary for the covered Retiree if he/she is an entitled individual age 65 and over and retired.

   Medicare is primary and the Plan will be secondary for the covered Retiree's Dependent Spouse who is an entitled individual if both the covered Retiree and their covered Dependent Spouse are age 65 and over and retired.

2. **For Covered Persons with End Stage Renal Disease**

   Except as stated below*, for Retirees and their Dependent Spouse, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above:

   A. The Covered Person has no dialysis for a period of twelve (12) consecutive months and then resumes dialysis, at which time this Plan will again become primary for a period of thirty (30) months; or

   B. The Covered Person undergoes a kidney transplant, at which time this Plan will again become primary for a period of thirty (30) months.

   *If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and this Plan will be secondary.

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, this Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH CHAMPUS

"CHAMPUS" means the medical benefits and programs provided by the Civilian Health and Medical Program of the Uniformed Services.

If a Covered Person is also entitled to and covered under CHAMPUS, this Plan will always be primary and CHAMPUS will always be secondary coverage. CHAMPUS coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

PROCEDURES FOR CLAIMING BENEFITS

HOW TO FILE A CLAIM

If it is necessary for the Covered Person to file a claim, the Covered Person should complete a Blue Cross and Blue Shield of Montana claim form and send the claim form with the provider's itemized bill(s) to the address on the form. To obtain a claim form, contact Blue Cross and Blue Shield of Montana on their customer service number listed on the inside cover of this Plan Document or at www.bcbsmt.com. In certain instances, the Claim Administrator may require that additional documents or information be submitted, including, but not limited to, accident reports and medical records. This information must be submitted within the time frame requested when the additional documentation is requested, before payment can be made for the services.

Claims must be submitted no later than 12 months from the date of service.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE CLAIM ADMINISTRATOR.

COMPLAINTS AND GRIEVANCES

The Claim Administrator has established a complaint and grievance process. A complaint involves a communication from the Participant expressing dissatisfaction about the Claim Administrator's services or lack of action or disagreement with the Claim Administrator's response. A grievance will typically involve a complaint about a provider or a provider's office, and may include complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Plan Document. The Participant may also file a written complaint or grievance with the Claim Administrator. The fax number, email address, and mailing address of the Claim Administrator appears on the inside cover of this Plan Document. Written complaints or grievances will be acknowledged within 10 days of receipt. The Participant will be notified of the Claim Administrator's response within 60 days from receipt of the Participant's written complaint or grievance.

TYPES OF CLAIMS

Claims are classified by type of claim and the timeline in which a decision must be decided and a notice provided depends on the type of claim involved. The initial benefit claim determination notice will be included in the Participant's explanation of benefits (EOB) or in a letter from the Plan, whether adverse or not. There are five types of claims:

1. **Pre-Service Claims**

   A pre-service claim is any claim for a Benefit that, under the terms of this Plan, requires authorization or approval from the Claim Administrator.

2. **Urgent Care Claims**

   An urgent care claim is any pre-service claim where a delay in the review and adjudication of the claim could seriously jeopardize the Participant's life or health or ability to regain maximum function or subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

3. **Post-Service Claims**

   A post-service claim is any claim for payment filed after a Benefit has been received and any other claim that is not a pre-service claim.

4. **Rescission Claims**

A rescission of coverage is considered a special type of claim. A rescission is defined as any cancellation or discontinuation of coverage that has a retroactive effect based upon the Participant's fraud or an intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a rescission if and to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage or to routine changes, such as eligibility updates, that are not based on fraud or a misrepresentation of a material fact. A cancellation or discontinuance with a prospective effect only is not a rescission.

5. **Concurrent Care Claim**

A concurrent care decision represents a decision of the Claim Administrator approving an ongoing course of medical treatment for the Participant to be provided over a period of time or for a specific number of treatments. A concurrent care claim is any claim that relates to the ongoing course of medical treatment (and the basis of the approved concurrent care decision), such as a request by the Participant for an extension of the number of treatments or the termination by the Claim Administrator of the previously approved time period for medical treatment.

INITIAL CLAIM DETERMINATION BY TYPE OF CLAIM

1. **Pre-Service Claim Determination and Notice**

a. Notice of Determination

Upon receipt of a pre-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim.

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 15-day time period for an additional 15 days for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the

Participant will be given 45 days from receipt of the notice within which to provide the specified information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

c. Notice of Improperly Submitted Claim

If a pre-service claim request was not properly submitted, the Claim Administrator will notify the Participant about the improper submission as soon as practicable, but no later than 5 days after the Claim Administrator's receipt of the claim and will advise the Participant of the proper procedures to be followed for filing a pre-service claim.

2. **Urgent Care Claim Determination and Notice**

a. Designation of Claim

Upon receipt of a pre-service claim, the Claim Administrator will make a determination if the claim involves urgent care. If a physician with knowledge of the Participant's medical condition determines the claim involves urgent care, the Claim Administrator will treat the claim as an urgent care claim.

b. Notice of Determination

If the claim is treated as an urgent care claim, the Claim Administrator will provide the Participant with notice of the determination, either verbally or in writing, as soon as possible consistent with the medical exigencies but no later than 72 hours from the Claim Administrator's receipt of the claim. If verbal notice is provided, the Plan will provide a written notice within 3 days after the date the Claim Administrator notified the Participant.

c. Notice of Incomplete or Improperly Submitted Claim

If an urgent care claim is incomplete or was not properly submitted, the Claim Administrator will notify the Participant about the incomplete or improper submission no later than 24 hours from the Claim Administrator's receipt of the claim. The Participant will have at least 48 hours to provide the necessary information. The Claim Administrator will notify the Participant of the initial claim determination no later than 48 hours after the earlier of the date the Claim Administrator receives the specific information requested or the due date for the requested information.

3. **Post-Service Claim Determination and Notice**

a. Notice of Determination

In response to a post-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial **determination, but no later than 30 days after receiving the claim.**

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 30-day timeframe for an additional 15-day period for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which the Claim Administrator expects to render a decision in such case.

2. For receipt of information from the Participant to decide the claim

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Participant will be given 45 days from receipt of the notice to provide the information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator receives the specific information requested, or the due date for the information.

4. **Concurrent Care Determination and Time Frame for Decision and Notice**

a. Request for Extension of Previously Approved Time Period or Number of Treatments

1. In response to the Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves urgent care, the Claim Administrator will review the claim and notify the Participant of its determination no later than 24 hours from the date the Claim Administrator received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant's claim will be treated as and decided within the timeframes for an urgent care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."

3. If the Participant's claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as

applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, the Claim Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Participant has received prior approval unless the Claim Administrator provides the Participant with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Participant to appeal the determination and obtain an decision before the reduction or termination occurs.

5. **Rescission of Coverage Determination and Notice of Intent to Rescind**

If the Claim Administrator makes a decision to rescind the Participant's coverage due to a fraud or an intentional misrepresentation of a material fact, the Claim Administrator will provide the Participant with a Notice of Intent to Rescind at least thirty (30) days prior to rescinding coverage. The Notice of Intent to Rescind will include the following information:

a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;

b. A statement that the Participant will have the right to appeal any final decision of the Claim Administrator to rescind coverage after the thirty (30) day period and a description of the Claim Administrator's appeal procedures;

c. A reference to the Plan provision(s) on which the rescission is based;

d. A statement that the Participant is entitled to receive upon request and free of charge reasonable access to, and copies of all documents and records and other information relevant to the rescission.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

An "adverse benefit determination" is defined as a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit. If the Claim Administrator's determination constitutes an adverse benefit determination, the notice to the Participant will include:

1. Information sufficient to identify the benefit or claim involved, including, if applicable, the date of service, the health care provider, and the claim amount;

2. The reason(s) for the adverse benefit determination. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;

3. A reference to the applicable Plan provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a Medical Necessity standard), on which the adverse benefit determination is based;

4. A description of the Claim Administrator's internal appeal and external review procedures (and for urgent care claims only, a description of the expedited review process applicable to such claims), a description of and contact information for a consumer appeal assistance program, and if applicable, a statement of the Participant's right to file a civil action under Section 502(a) of ERISA;

5. If applicable, a description of any additional information necessary to complete the claim and why the information is necessary;

6. If applicable, a statement that any internal Medical Policy or guideline or other medical information relied upon in making the adverse benefit determination, and an explanation for the same, will be provided, upon request and free of charge;

7. If applicable, a statement that an explanation for any adverse benefit determination that is based on an Experimental/Investigational/Unproven treatment or similar exclusion or limitation or a Medical Necessity standard will be provided, upon request and free of charge;

8. If applicable, a statement that diagnosis and treatment codes will be provided, and their corresponding meanings, upon request and free of charge; and

9. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

HOW TO FILE AN INTERNAL APPEAL OF AN ADVERSE BENEFIT DETERMINATION

1. Time for Filing an Internal Appeal of an Adverse Benefit Determination

If the Participant disagrees with an adverse benefit determination (including a rescission), the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of urgent care claims, the Participant's appeal must be made in writing, should list the reasons why the Participant does not agree with the adverse benefit determination, and must be sent to the address or fax number listed for appeals on the inside cover of this Plan. If the Participant is appealing an urgent care claim, the Participant may appeal the claim verbally by calling the telephone number listed for urgent care appeals on the inside cover of this Plan Document.

1. Authorized Representative

The Participant may name another individual to act on the Participant's behalf for purposes of an appeal or review of an adverse benefit determination, by filing a written designation with the Claims Administrator. Contact the Claims Administrator at the number listed on the inside cover of this Plan Document for information on how to designate an authorized representative.

3. Access to Plan Documents

The Participant may at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays.

4. Submission of Information and Documents

The Participant may present written evidence and written testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by the Claim Administrator until a final determination of the Participant's appeal has been made.

5. Consideration of Comments

The review of the claim on appeal will take into account all evidence, testimony, new and additional records, documents, or other information the Participant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

If the Claim Administrator considers, relies on or generates new or additional evidence in connection with its review of the Participant's claim, the Claim Administrator will provide the Participant with the new or additional evidence free

of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Plan. If the Claim Administrator relies on a new or additional rationale in denying the Participant's claim on review, the Claim Administrator will provide the Participant with the new or additional rationale as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Plan.

6. **Scope of Review**

The person who reviews and decides the Participant's appeal will be a different individual than the person who decided the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The Claim Administrator will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

7. **Consultation with Medical Professionals**

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination (nor have been a subordinate of any person previously consulted). The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant's claim.

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

The time period for deciding an appeal of an adverse benefit determination and notifying the Participant of the final internal adverse benefit determination depends upon the type of claim. The chart below provides the time period in which the Claim Administrator will notify the Participant of its final internal adverse benefit determination for each type of claim.

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Urgent Care Claim	No later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date the Claim Administrator received the Participant's appeal.
Post-Service Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.
Concurrent Care Claim	• If the Participant's claim involved urgent care, no later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency. • If the Participant's claim did not involve urgent care, the time period for deciding a pre-service (non-urgent care) claim and a post-service claim, as applicable, will govern.
Rescission Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.

Content of Notice of Final Internal Adverse Benefit Determination

If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will include the following information:

1. Information sufficient to identify the claim involved in the appeal, including, as applicable, the date of service, the health care provider, and the claim amount;

2. The title and qualifying credentials of each health care professional participating in the appeal;

3. A statement from each health care professional participating in the appeal of his/her/their understanding of the basis for the Participant's appeal;

4. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;

5. A reference to the applicable Plan Document provision(s), including identification of any standard relied upon in the Plan to deny the claim (such as a Medical Necessity standard), on which the final internal adverse benefit determination is based;

6. If applicable, a statement describing the Participant's right to request an external review and the time limits for requesting an external review;

7. If applicable, a statement that any internal Medical Policy or guideline or medical information relied on in making the final internal adverse benefit determination will be provided, upon request and free of charge;

8. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a Medical Necessity or an Experimental/Investigational/Unproven treatment or similar exclusion or limitation as applied to the Participant's medical circumstances;

9. If applicable, a statement that diagnosis and treatment codes will be provided, with their corresponding meanings, upon request and free of charge;

10. A description of contact information for a consumer appeal assistance program and a statement of the Participant's right to file a civil action under Section 502(a) of ERISA;

12. A statement that reasonable access to and copies of all documents and records and other information relevant to the final internal adverse benefit determination will be provided, upon request and free of charge.

The Covered Person must exhaust the internal appeal process through the Claim Administrator before he or she may exercise his or her right to bring a civil action under Section 502(a) of ERISA.

LIMITATIONS ON LAWSUITS

Once a Participant has exhausted, or is deemed to have exhausted, the internal appeal process, the Participant may file suit under section 502(a) of ERISA. However, the time and location for filing suit is limited as described in the **General Provisions** section, subsection **Legal Proceedings** of this Plan.

ELIGIBILITY PROVISIONS

RETIREE ELIGIBILITY

An eligible Retiree under this Plan is a former Employee of the Company who:

1. Is age 65 or older; and

2. Was participating in the Company's health benefit plan for active employees or the Company's health benefit plan for retirees under age 65 immediately prior to his or her 65th birthday or his or her date of retirement, if employed beyond age 65.

An eligible Retiree does not include a Nonresident Alien (as defined in the Company's Employee Benefit Plan).

DEPENDENT ELIGIBILITY

An eligible Dependent is any person who is a citizen, resident alien, or is otherwise legally present in the United States, and who:

1. Is age 65 or older; and

2. Is the Retiree's legal spouse of the opposite sex or the same sex to whom the Retiree is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared; and

3. Was participating in the Company's health benefit plan for active employees or the Company's health benefit plan for retirees under age 65 immediately prior to his or her 65th birthday.

An eligible Dependent does not include:

1. A spouse who is divorced from the Retiree and has a court order or decree stating such from a court of competent jurisdiction. **See "Termination of Coverage"**; or

2. A child of any age; or

3. A Nonresident Alien (as defined in the Company's Employee Benefit Plan).

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective, provided that application for such coverage is made on the Plan's enrollment form within thirty-one (31) days of the effective date.

RETIREE COVERAGE

Coverage for a Retiree who meets the eligibility requirements of this Plan will become effective upon the earlier of the following:

1. The first day of the month in which the Retiree attains the age of 65 years; or

2. The date of retirement if employed beyond age 65.

DEPENDENT COVERAGE

Coverage for a Dependent Spouse who meets the eligibility requirements will become effective upon the earlier of the following:

1. The first day of the month in which the Dependent Spouse attains the age of 65 years; or

2. The date that the Retiree becomes eligible for coverage under this Plan.

Except as provided in the Surviving Spouse Continuation Coverage provision of this Plan, a Dependent Spouse is only eligible for coverage under this Plan if the Retiree is enrolled for coverage under this Plan or the Company's health benefit plan for retirees under age 65.

SURVIVING SPOUSE CONTINUATION COVERAGE

Subject to the following eligibility requirements, the surviving spouse of a Retiree covered under this Plan or the surviving spouse of a participant covered under the Company's health benefit plan for active employees or the Company's health benefit plan for retirees under age 65 may elect coverage under this Plan until he or she remarries. The surviving spouse will be considered a Dependent Spouse under this Plan provided he or she:

1. Is age 65 or older; and

2. Was participating in this Plan at the time of the Retiree's death or was participating in the Company's health benefit plan for active employees or the Company's health benefit plan for retirees under age 65 immediately prior to his or her 65th birthday.

Coverage for the surviving spouse who meets the above eligibility requirements will be effective upon:

1. The first day of the month in which he or she reaches age 65; or

2. The date of the Retiree's death.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be a period of time established by the Plan Administrator between October 1st and November 30th of each year, or such other times, as determined by the Plan Administrator. This Plan offers multiple coverage options. A Covered Person under this Plan may change their coverage option during the Open Enrollment Period. Such change must be requested on a form approved by the Plan. A change in the coverage option will become effective on the first day of the Calendar Year immediately following the Open Enrollment Period.

CHANGE IN STATUS EVENTS

As described in the Termination of Coverage provision of this Plan, a Retiree may, at any time, revoke their elections under this Plan to terminate coverage or change their elections to terminate coverage for their Dependent Spouse. However, a Retiree is not permitted to make any other change to their elections under this Plan outside of the Open Enrollment Period except in the event of any of the following:

1. A change in the Retiree's legal marital status, including marriage, death of his or her Spouse, divorce or annulment;

2. A change in the Retiree's legal marital status, including marriage, death, divorce or annulment from the Retiree's Spouse;

3. A change in the employment status of the Retiree or the Retiree's Spouse;

4. A change in the place of residence for the Retiree or the Retiree's Spouse, if such change affects coverage under this Plan; or

5. Any other event that the Plan Administrator determines will constitute a Change in Status Event under regulations and rulings of the Internal Revenue Code.

Notwithstanding the foregoing, in the event that a Change in Status Event would permit a Retiree to add his or her Spouse to this Plan (for example, through a new marriage), his or her Spouse must still meet the requirements in the "Dependent Eligibility" provision of this Plan. In certain circumstances, the occurrence of a Change in Status Event might otherwise permit a Retiree to add his or her Spouse to this Plan under the Change in Status Events provision, but the Retiree may nonetheless be prohibited from doing so because his or her Spouse does not meet the Dependent Eligibility provision of the Plan.

A Retiree may change an election pursuant to a Change in Status Event by notifying the Plan Administrator within sixty (60) days from the date of the event. The change will become effective on the date of the event, provided that an application reflecting the change is submitted within sixty (60) days of the event.

Any change of an election under this Plan as a result of one of the above events must be consistent with the event.

A Retiree who declines coverage or enrolls in coverage and terminates or revokes coverage at the end of or during a Plan Year will not be eligible to enroll in coverage under the Plan at a later date.

CONTINUATION COVERAGE AFTER TERMINATION

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled Dependents of Retirees may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more employees.

The name, address and telephone number of the Plan Administrator is NorthWestern Corporation d/b/a NorthWestern Energy, 11 E. Park St., Butte, Montana 59701-1711, 888-236-6656. The Plan Administrator is responsible for administering COBRA Continuation Coverage.

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date coverage terminates under the Plan.

1. Qualifying Events for Dependents who are Qualified Beneficiaries, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:
   A. Death of the Retiree.
   B. The divorce of the Retiree from his or her spouse.

2. Qualifying Events for covered Retirees, for purposes of this section, are:
   A. Bankruptcy, if the covered Retiree retired on or before the date of any substantial elimination of group health coverage due to bankruptcy.

3. Qualifying Events for the Dependents of Covered Retirees, for purposes of this section are:
   A. Bankruptcy, if the Dependent was a Qualified Beneficiary of a covered Retiree on or before the day before the bankruptcy-qualifying event.

<u>TERMINATION OF COVERAGE IN ANTICIPATION OF A QUALIFYING EVENT</u>

If a Qualified Beneficiary's coverage is terminated prior to and in anticipation of a Qualifying Event, and the Qualified Beneficiary subsequently elects COBRA Continuation Coverage, that coverage will begin as of the date of the Qualifying Event. The Plan Administrator, taking into consideration the facts and circumstances, shall have the discretion to determine whether a termination of coverage was done in anticipation of a Qualifying Event. The Plan Administrator has the authority to request that the Participant and/or Dependent provide such information, signed declaration, or other documentation as the Plan Administrator deems necessary to make that determination.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Plan Administrator in writing as described below within sixty (60) days after the divorce of the Retiree from his or her spouse.

The notice must be provided by completing a benefits change of status form, which is available free of charge upon request from the Benefits department of NorthWestern Corporation d/b/a NorthWestern Energy (the "Benefits Department"), and providing supporting documentation to confirm the date of the Qualifying Event. For example, a divorce decree could be provided to confirm the date of a divorce.

The benefits change of status form and supporting documentation must be sent to the Benefits Department either by email to benefits@northwestern.com or via mail or hand delivery to NorthWestern Energy Benefits Department, 11 E. Park St., Butte, Montana 59701-1711.

If the Covered Person does not provide a completed benefits change of status form and the supporting documentation within sixty (60) days after the date of the Qualifying Event, the Covered Person will not lose his or her rights to COBRA coverage if the Covered Person provides at least the following information in writing to the Benefits Department as described above within sixty (60) days after the date of the Qualifying Event:

1. The name of the Qualified Beneficiary.

2. The name of the Retiree (if the Retiree is not the Qualified Beneficiary).

3. The Qualifying Event.

4. The date of the Qualifying Event.

In that case, the Benefits Department will ask the Covered Person for the missing information and documentation. If the information and documentation is not provided within 30 days of the request (or, if later, by the end of the 60-day notice period), the Covered Person will not be eligible for COBRA coverage.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator receives the completed benefits change of status form and the supporting documentation.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage plus an additional administrative expense of up to a maximum of two percent (2%). Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Plan Administrator of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Plan Administrator.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance, unless the other group health plan contains a provision excluding or limiting coverage for a pre-existing condition applicable to a condition of the Qualified Beneficiary under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, COBRA continuation coverage ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable.

This exception applies to all Qualified Beneficiaries.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, B or D);

3. As of the first day of any period for which timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator. (Example: If a premium payment is due by March 1 for COBRA continuation coverage for March, and the payment is not made within the 30-day grace period, the Qualified Beneficiary will lose coverage (retroactively) for March (and all future months)).

4. On the date the Employer ceases to provide any group health plan coverage to any Retiree.

5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:

C. Thirty-six (36) months for Qualified Beneficiaries due to divorce of the Retiree from his or her spouse or the death of the Retiree.

D. In the case of a Qualifying Event that is a bankruptcy, the earlier of the date of the Qualified Beneficiary's death or the thirty-six (36) months following the retired employee's death for the Qualified Beneficiary who is the surviving spouse of the retired employee.

7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to NorthWestern Corporation d/b/a NorthWestern Energy, 11 E. Park St., Butte, Montana 59701-1711, or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Retiree's family's rights, the Retiree should keep the Plan Administrator informed of any changes in the addresses of family members. The Retiree should also keep a copy for his/her records, of any notices sent to the Plan Administrator.

TERMINATION OF COVERAGE

By electing coverage under this Plan, a Participant agrees that the Plan Administrator is entitled to collect any premium contributions owed by the Participant from the Participant for the entire Plan Year in which the election applies, unless a change or revocation is otherwise permitted.

Any benefit elections made under this Plan, and Participant premium contribution obligations for those elections, are effective for the entire Plan Year and may not be changed or revoked during the Plan Year, except in the following circumstances:

1. An event that allows for an election to be changed as described in the "Change in Status Events" provisions of this Plan.

2. Coverage for the Retiree and/or covered Dependent Spouse is terminated as described in this "Termination of Coverage" provision of this Plan.

Coverage for a Retiree will terminate immediately upon the earliest of the following dates:

1. The date the Plan is terminated; or

2. The date the Company terminates the Retiree's coverage (including, but not limited to, termination as a result of the Company's unsuccessful attempts to obtain any required premium contributions. If a Participant fails to make a required premium contribution, the Participant's coverage under the Plan will be terminated effective as of the first day of the month for which the contribution was due (no coverage exists for that first day); or

3. On the last day of the month in which the Retiree submits a request to voluntarily terminate coverage; or

4. The date the Retiree dies.

Coverage for a Dependent Spouse will terminate immediately upon the earliest of the following dates:

1. Except as provided in the Surviving Spouse Continuation Coverage provision of this Plan, on the date the Retiree's coverage terminates; or

2. On the last day of the month in which the Dependent Spouse ceases to be an eligible Dependent, as defined in the Plan. Termination of coverage due to divorce will be based on the date of decree or order issued by a court of competent jurisdiction; or

3. The date the Company terminates the Dependent Spouse's coverage (including,

but not limited to, termination as a result of the Company's unsuccessful attempts to obtain any required premium contributions. If a Participant fails to make a required premium contribution for the Dependent Spouse, the Dependent Spouse's coverage under the Plan will be terminated effective as of the first day of the month for which the contribution was due (no coverage exists for that first day); or

4. On the last day of the month in which the Retiree submits a request to voluntarily terminate the Dependent Spouse's coverage; or

5. The date the Dependent Spouse dies.

A Retiree or Dependent Spouse who declines coverage or enrolls in coverage and terminates or revokes coverage at the end of or during a Plan Year will not be eligible to enroll for coverage under the Plan at a later date.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan, or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent to get or continue coverage for that Dependent when not otherwise eligible for coverage;

2. Falsifying or withholding medical history or information required to calculate benefits;

3. Falsifying or altering documents to get coverage or benefits;

4. Permitting a person not otherwise eligible for coverage to use a Plan identification card to get Plan benefits; or

5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

The Plan Administrator, in its sole discretion, may take additional action against the Retiree or Covered Person, including, but not limited to terminating the Retiree or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of a Covered Person's age in an enrollment form or claims filing, the Covered Person's eligibility or amount of benefits, or both, will be adjusted in accordance with the Covered Person's true age. Upon the discovery of a Covered Person's misstatement of age, benefits affected by such misstatement will be adjusted immediately. If the Covered Person's true age is such that the person was not eligible for coverage or the amount of benefits received, the Plan is entitled to recover any such benefits paid as outlined in the Right of Recovery provision of the Plan. Any misstatement of age will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If there is a misrepresentation of eligibility criteria (including, but not limited to marital status or age, to obtain coverage for a person who would not meet the Plan's eligibility criteria if the true facts were known, coverage for that person will be terminated as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not an eligible Covered Person to use any identification card issued, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the coverage of the Covered Person who permits such usage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Retiree or Dependent Spouse. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Retiree or Dependent Spouse.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefited from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for a Retiree's Spouse or ex-spouse who is not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, erroneous, false information or omissions of information provided or omitted by the Retiree will be reimbursed to the Plan by the Retiree. The Retiree's failure to reimburse the Plan after demand is made may result in an interruption in or loss of benefits to the Retiree, and could be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of benefits under this Plan, each Covered Person authorizes the deduction of any excess payment from such benefits or other present or future compensation payments.

The provisions of this subsection apply to any Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Licensed Health Care Provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the

Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from third parties who are legally responsible to the Covered Person for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Covered Person's accident, Injury, condition or Illness, which the Plan paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect, the Plan has the right to "stand in the shoes" of the Covered Person for whom benefits were paid, and to take any action the Covered Person could have undertaken to recover the money paid.

The Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Claim Administrator is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Claim Administrator not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through

Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.

2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any third party responsible for an accident, Injury, condition or Illness, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Covered Person receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.

3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any monies paid by the Plan from any party other than the Covered Person who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the accident, Injury, condition or Illness; all efforts by any person to recover any such monies; providing the Plan Administrator with any and all documents, papers, reports and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.

5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.

6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

RIGHT OF OFF-SET

The Plan has a right of off-set to satisfy reimbursement claims against Covered Persons for money received by the Covered Person from a third party, including any insurer. If the Covered Person fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Covered Person, up to the full amount paid by the Plan and subject to reimbursement for such claims. This right of off-set applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and notwithstanding any anti-subrogation, ”common fund,” ”made whole” or similar statutes, regulations, prior court decisions or common law theories.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan that provide for the payment or reimbursement of expenses. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Retirees and a covered Dependent Spouse.

It is the intention of the Employer to establish a program of benefits constituting an ”Employee Welfare Benefit Plan” under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

EFFECTIVE DATE

The effective date of the Plan is January 1, 2003.

PLAN YEAR

The Plan Year will commence January 1st and end on the last day of December of each year.

PLAN SPONSOR

The Plan Sponsor is NorthWestern Corporation dba NorthWestern Energy.

CLAIM ADMINISTRATOR

The Claim Administrator of the Plan is Blue Cross and Blue Shield of Montana.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Company’s Board of Directors has delegated the Company’s Employee Benefits Administration Committee (EBAC) to act in the role of Named Fiduciary and Plan Administrator, with the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

OTHER CLAIM APPEALS

This section applies to all claims under the Plan except claims that are subject to a claims administrator's or third party administrator's claims procedures. If a Participant believes he/she is being denied rights or benefits under the Plan, the Participant may file a claim in writing with the Plan Administrator. The Plan Administrator will notify the Participant in writing if any such claim is wholly or partially denied. Such notification will be written in a manner calculated to be understood by the Participant and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary to perfect such claim and an explanation of why such material or information is necessary and (iv) information as to the steps to be taken if the Participant wishes to submit a request for review. Such notification will be given within ninety (90) days after the claim is received by the Plan Administrator (or within one hundred eighty (180) days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to the Participant within the initial ninety (90) day period).

Within sixty (60) days after the date on which a Participant receives written notice of a denied claim, the Participant (or his/her duly-authorized representative) may (i) file a written request with the Plan Administrator for a review of the denied claim and of pertinent documents, and (ii) submit written issues and comments to the Plan Administrator. The Plan Administrator will notify the Participant of its decision in writing. Such notification will be written in a manner calculated to be understood by the Participant and will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The decision on review will be made within sixty (60) days after the request for review is received by the Plan Administrator (or within one hundred twenty (120) days, if special circumstances require an extension of time for processing the request, and if written notice of such extension and circumstances is given to the Participant within the initial sixty (60) day period).

A claim must be filed within one (1) year after a Participant knew or should have known of the principal facts on which the claim is based.

The Plan Administrator has full discretion to determine benefit claims under the Plan. Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. If a Participant wants to seek further review of the Plan Administrator's decision in court, he/she must first exhaust the administrative reviews and appeals procedures under the Plan before bringing a lawsuit in state or federal court.

Any such review must be initiated by a filing made in federal court in Sioux Falls, South Dakota within one (1) year from exhaustion of the administrative reviews and appeals procedures under the Plan.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amounts of contributions to the Plan are to be made on the following basis:

1. The Company will from time to time evaluate the costs of the Plan and determine the amount to be contributed by each Retiree. The Company will pay the difference between the Plan costs and the Retiree contribution.

2. The Retiree and the Company share the cost of Retiree coverage. Specific information regarding the actual amount of any contribution for coverage under this Plan may be obtained from the Plan Sponsor, by contacting the NWE Benefits department at (888) 236-6656 and requesting that information. The amount of any contribution for coverage may be increased, decreased or modified at any time by the Plan.

3. If the Company terminates the Plan, the Company and the Retirees will have no obligation to contribute to the Plan after the date of termination.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

This Plan Document contains terms applicable to this Plan, which is a component of the NorthWestern Energy Employee Benefit Plan. A separate plan document has been prepared for the NorthWestern Energy Employee Benefit Plan and contains terms applicable to this Plan. The terms of this Plan Document and the plan document for the NorthWestern Energy Employee Benefit Plan may be amended at any time by the Plan Sponsor or its delegate. Any changes to the terms of the Plan will be binding on each Participant and on any other Covered Persons referred to in this Plan Document. The authority to amend the Plan has been delegated by the Board of Directors to the Employee Benefit Administration Committee (EBAC) of the Company. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the Chairman of the EBAC, pursuant to a corporate resolution, granting that individual the authority to amend, modify, revoke or terminate the Plan. A copy of the executed resolution will be supplied to the Claim Administrator. Written notification of any amendments, modifications, revocations or terminations will be given to Participants in accordance with federal law.

NOTICE OF REDUCTION OF BENEFITS

All changes or amendments to this Plan that directly or indirectly reduce any benefit or coverage under the Plan, including any increase in contribution for coverage required from a Retiree, will be reported to all eligible Retirees and covered Dependent Spouses in accordance with federal law.

TERMINATION OF PLAN

The Company reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the Company will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

SUMMARY PLAN DESCRIPTION

Each Participant covered under this Plan will be issued a Summary Plan Description (SPD) describing the benefits, to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan. **This document and the NorthWestern Energy Employee Benefit Wrap SPD together serve as the SPD for the Plan.**

GENERAL PROVISIONS

CLERICAL ERRORS

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or benefits of any Participant covered under this Plan. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of this Plan in strict accordance with its terms.

NOTICES

Any notice required by this Plan may be given by United States mail, postage paid. **Notice to the Participant will be mailed to the address appearing on the records of the** Plan. Notice to the Plan should be sent to the Plan Sponsor. Any time periods included in a notice shall be measured from the date the notice was mailed.

RESCISSION

In general, the Plan Sponsor is not allowed to rescind (*i.e*., cancel or terminate with a retroactive effective date) a Participant's coverage once the Participant becomes covered under the Plan. However, a Participant's coverage under the Plan may be rescinded if such individual performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited under the terms of this Plan. For example, if the Plan Administrator determines that a Retiree has enrolled an individual who does not meet the Plan's eligibility requirements under the Plan, which are set forth in this Plan Document, the enrollment of such ineligible individual(s) will be treated as an intentional misrepresentation of a material fact, or fraud, and the Plan Administrator reserves the right to rescind the Retiree's (and/or the ineligible individual's) Plan coverage. Blue Cross and Blue Shield of Montana will provide notice of any rescission, and a Participant may appeal the rescission as described in this Plan Document

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of the claim hereunder. The Plan will also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

Claim Payment Assignment

All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any provider furnishing benefits under the Plan for which such payment is due, and the Claim Administrator is authorized by such Covered Person to make such payments directly to such providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or provider furnishing benefits under the Plan. If any

benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate.

Claim Dispute

Once benefits under the Plan are rendered by a provider, the Covered Person has no right to request the Claim Administrator not to pay the claim submitted by such provider and no such request by a Covered Person or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

Plan Coverage Assignment

Neither the Plan nor a Covered Person's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

LEGAL PROCEEDINGS

No action at law or equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within one (1) year from the exhaustion or deemed exhaustion of the applicable appeals process (excluding any external review process), described in the Plan. Any such action must be filed only in federal court in Sioux Falls, South Dakota.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person

with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any legally qualified Physician, Licensed Health Care Provider or surgeon and the Physician-patient relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

IDENTIFICATION OF FUNDING

Your benefits under this plan will be paid from employee or employer contributions up to the limits defined in the Plan Document and Summary Plan Description (SPD).

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer,

pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Retiree, the Plan Administrator, in its sole discretion, may terminate the interest of such Retiree or former Retiree in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Retiree or covered Dependent Spouse or former Retiree, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Retiree of the Company the right to be retained in the service of the Company, or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Retiree.

PROTECTED EMERGENCY AND AMBULANCE SERVICES

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact a Participant's benefits. The Claim Administrator for the medical benefits provided under the Plan will apply federal requirements where applicable, as summarized in this section. If there is any conflict between this section and the other provisions of this Plan, the provisions of this section shall control. However, this section should not be interpreted to provide greater protections than those required under federal law.

For the following types of care, the Participant's health care provider may not bill the Participant more than an amount determined under federal law.

1. Emergency services; and
2. Air ambulance services.

Payment to be made under this Plan to a provider of the care listed above will be determined as described in this Plan unless the provider objects to the payment amount. In that case, the payment will be the amount agreed upon by the provider and the Claim Administrator or, if no agreement is reached, the amount prescribed by a certified arbitrator.

Any claims involving the care described above, including whether a claim is eligible for the protections described in this section, shall be eligible for the external review process under this Plan.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ADVERSE BENEFIT DETERMINATION

”Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Retiree’s or beneficiary’s eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

CALENDAR YEAR

”Calendar Year” means a period of time commencing on January 1 and ending on December 31 of the same year.

CLAIM ADMINISTRATOR

“Claim Administrator” means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Claim Administrator is Blue Cross and Blue Shield of Montana. The Claim Administrator provides ministerial duties only, exercises no discretion over plan assets and will not be considered a fiduciary as defined by ERISA (Employee Retirement Income Security Act) or any other State or Federal law or regulation.

COMPANY

“Company” means NorthWestern Corporation dba NorthWestern Energy, or any affiliated company that has adopted this Plan for its Retirees and which is a “controlled group” as defined by applicable state and federal law, as amended.

COSMETIC

“Cosmetic” means services, surgery or treatment provided to improve appearance.

COVERED PERSON

"Covered Person" means any Retiree or Dependent Spouse meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

DEPENDENT SPOUSE OR SPOUSE

"Dependent Spouse" or "Spouse" means a spouse who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

EMPLOYEE

"Employee" means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer's W-2 payroll, unless otherwise not eligible under the Plan's provisions.

EMPLOYER

"Employer" means the Company or any affiliated entity that has adopted this Plan for its Retirees and which is a "controlled group" as defined by applicable state and federal law, as amended.

ERISA

"ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

Experimental/Investigational/Unproven means a drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if the Plan determines that:

1. The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or

2. The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

3. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

HIPAA

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

ILLNESS

"Illness" means an alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

INJURY

"Injury" means physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

LICENSED HEALTH CARE PROVIDER

"Licensed Health Care Provider" means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

MEDICAID

"Medicaid" means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY/MEDICAL NECESSITY

"Medically Necessary" means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;

2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and

3. not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services

at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Covered Person receives the services, supplies, or medications and a claim is submitted to the Claim Administrator. The Claim Administrator may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

"Medical Necessity" refers to a determination that a particular item or service is Medically Necessary.

MEDICAL POLICY

"Medical Policy" means the Claim Administrator's policy which is used to determine whether health care services, including medical and surgical procedures, medication, medical equipment and supplies, processes and technology, meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;

2. Scientific studies showing conclusive evidence of improved net health outcome; and

3. Are in accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as is necessary.

MEDICARE

"Medicare" means the programs established under the Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those age 65 or older, those with end-stage renal disease, or with disabilities.

NAMED FIDUCIARY

"Named Fiduciary" means the Company's Employee Benefits Administration Committee (EBAC).

PARTICIPANT

"Participant" means a Retiree of the Company and his or her Dependent Spouse who are eligible and enrolled for coverage under this Plan. Participant shall also include a Dependent Spouse of a Retiree who is eligible for coverage under a continuation provision of this Plan.

PHYSICIAN

"Physician" means a person licensed to practice medicine in the state where the service is provided.

PLAN

"Plan" means the Health Benefit Plan for Retirees Age 65 or Older of the Company, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

"Plan Administrator" means the Company's Employee Benefits Administration Committee (EBAC).

PRIVACY OFFICER

"Privacy Officer" means the individual overseeing the development, implementation, maintenance of and adherence to privacy policies and procedures regarding the safe use and handling of protected health information (PHI) in compliance with federal and state HIPAA regulation.

RETIREE

Except as provided in this paragraph, "Retiree" means a former covered Employee of the Employer who terminates employment while in Active Service, meets the Plan's Retiree eligibility requirements, and is enrolled for coverage under this Plan. For purposes of clarity, an Employee who utilizes paid time off after his or her last day worked and terminates employment immediately thereafter will be considered to have terminated employment while in Active Service. A Retiree does not include an Employee who otherwise is not in Active Service on the date his or her employment terminates.

USUAL/CUSTOMARY/REASONABLE (UCR)

"UCR" means the amount established by the commercially published database utilized by the Claim Administrator and adopted by the Plan Administrator which commercial database provides published UCR fees for expenses.

ERISA STATEMENT OF RIGHTS

As a Participant in your Employer's Health Benefit Plan you are entitled to certain rights and protections under the Employees Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. 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 upon request.

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right receive a written explanation of the reason why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial for a full and fair review and reconsideration by the Plan Administrator, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred and ten dollars ($110.00) 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 (an Adverse Benefit Determination), you may file suit in a state or federal court once you have exhausted your appeal rights under the Plan's claims and appeals procedures. If you believe the Plan fiduciaries have misused Plan assets, or that you have been discriminated against for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide which party will pay the court costs and legal fees. The court may order the losing party to pay these court costs and fees. You may be ordered to pay these costs and fees if you lose and the court finds your claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, you should contact the nearest office of the U.S. Department of Labor, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210, (866) 444-3272, or www.dol.gov/ebsa.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION 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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your Plan Administrator for more information.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

"Protected Health Information" (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the physical or mental health of an individual; health care that individual has received; or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an employer.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the zip code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY NOTICE

The Plan Sponsor's HIPAA Privacy Notice describes the health information practices for the benefits provided under this Plan and that of any third party that assists in the administration of claims under this Plan. Questions regarding this notice should be directed to the Plan Sponsor's Privacy Officer identified in the Plan Summary section of this Plan.

The Plan Sponsor is committed to protecting personal health information regarding a Participant in this Plan. This notice applies to all of the health records the Plan Sponsor and the Plan maintain. A health care provider may have different policies or notices regarding their use and disclosure of a Participant's health information created in their health care facility.

This notice describes the ways in which the Plan Sponsor may use and disclose health information about a Participant. It also describes the Plan Sponsor's obligations and a Participant's rights regarding the use and disclosure of health information.

The Plan Sponsor is required by law to:

1) Make sure that health information that identifies a Participant is kept private;

2) Give notice to a Participant of its legal duties and privacy practices with respect to health information about a Participant;

3) Notify a Participant following a breach of the Participant's unsecured electronic health information; and

4) Follow the terms of the privacy notice that is currently in effect.

A. Use and Disclosure of Health Information About a Participant

The Plan Sponsor has established "firewalls" to ensure that a Participant's health information remains as private as possible and is not used for employment-related decisions or other unlawful purposes.

There are nevertheless several circumstances under which it is necessary and lawful for the Plan Sponsor to use and disclose a Participant's health information. These are described by category in this section under the headings "**Permitted Disclosures of Health Information"** and "**Special Disclosure Situations"**.

B. A Participant's Rights Regarding Personal Health Information

A Participant has the following rights regarding the Participant's health information that the Plan Sponsor maintains:

1. **Right to Inspect and Copy.** A Participant has the right to inspect and copy health information that may be used to make decisions about his or her Plan benefits. To inspect and copy health information that may be used to make decisions about a Participant, the Participant must submit a request in writing to the Privacy Officer. The Plan Sponsor may charge a fee for the costs of copying, mailing or other supplies associated with satisfying a request. A Participant may request an electronic copy of the information. The Plan Sponsor will provide the information in electronic form if it is readily producible in such format.

   The Plan Sponsor may deny a Participant's request to inspect and copy in certain very limited circumstances. If a Participant's request to access health information is denied, the Participant may request that the denial be reviewed.

2. **Right to Amend.** If a Participant believes that the health information the Plan Sponsor has regarding him or her is incorrect or incomplete, the Participant may ask the Plan Sponsor to amend the information. A Participant has the right to request an amendment for as long as the information is kept by or for the Plan.

   To request an amendment, a Participant's request must be made in writing and submitted to the Privacy Officer. In addition, the Participant must provide a reason that supports the request.

   The Plan Sponsor may deny a Participant's request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny a Participant's request if the request is to amend information that:

   1) Is not part of the health information kept by or for the Plan;

2) Was not created by the Plan Sponsor or the Plan, unless the person or entity that created the information is no longer available to make the amendment;

3) Is not part of the information that a Participant would be permitted to inspect and copy; or

4) Is accurate and complete.

3. **Right to an Accounting of Disclosures**. A Participant has the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than payment or health care operations.

   To request this list or accounting of disclosures, a Participant must submit the request in writing to the Privacy Officer. The Participant's request must state a time period, which may not be longer than six years. The request should indicate in what form the Participant wants the list (for example, paper or electronic). The first list a Participant requests within a 12 month period will be free. For additional lists, the Plan Sponsor may charge the Participant for the costs of providing the list. The Plan Sponsor will notify the Participant of the cost involved and he or she may choose to withdraw or modify the request at that time before any costs are incurred.

4. **Right to Request Restrictions.** A Participant has the right to request a restriction or limitation on the health information the Plan Sponsor uses or discloses about the Participant for treatment, payment or health care operation. A Participant also has the right to request a limit on the health information the Plan Sponsor discloses about the Participant to someone who is involved in their care or the payment for their care, like a family member or friend. For example, a Participant could ask that the Plan Sponsor not use or disclose information about a surgery the Participant had. The Plan Sponsor is not required to agree to the Participant's request.

   A Participant has the right to restrict the disclosure of health information about themselves to the Plan if the disclosure is for the purpose of carrying out payment or health care operations and the Participant paid for the service in full. The Participant must make that request to the person or entity that provided the care. A provider who is covered by HIPAA must agree to such a request.

   To request restrictions, a Participant must make the request in writing to the Privacy Officer. In the request, the Participant must tell the Plan Sponsor (1) what information they want to limit; (2) whether they want to limit the use, disclosure or both; and (3) to whom they want the limits to apply, for example, disclosures to a spouse.

5. **Right to Request Confidential Communications.** A Participant has the right to request that the Plan Sponsor communicate with them about health matters

in a certain way or at a certain location. For example, a Participant can ask that the Plan Sponsor only contact them at work or by mail.

To request confidential communications, a Participant must make their request in writing to the Privacy Officer. The Plan Sponsor will not ask the Participant the reason for their request. The Plan Sponsor will accommodate all reasonable requests. The Participant's request must specify how or where they wish to be contacted.

6. **Right to a Paper Copy of the Plan Sponsor's Privacy Notice.** A Participant has the right to a paper copy of the Plan Sponsor's Privacy Notice. A Participant may request a copy of this notice at any time. Even if a Participant agreed to receive this notice electronically, the Participant is still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Plan Sponsor's Benefits department at (888) 236-6656.

C. Changes to The Plan Sponsor's Privacy Notice

The Plan Sponsor reserves the right to change its privacy notice in its sole discretion and from time to time. The Plan Sponsor reserves the right to make the revised or changed notice effective for health information it already has about a Participant as well as any information received in the future. The Plan Sponsor will provide a paper copy of the notice to a Participant in this Plan within sixty (60) days after a material change to the notice. The Plan Sponsor will also post a copy of the current notice on its intranet site.

D. Complaints

If a Participant believes that their privacy rights have been violated, they may file a written complaint with the Plan's Privacy Officer (or with the Plan Administrator if the Participant's complaint relates to conduct of the Privacy Officer). A Participant may also file a complaint with the U.S. Department of Health and Human Services. The Participant will not be penalized for filing a complaint.

E. Other Uses of Health Information

The Plan Sponsor will obtain a Participant's written permission before making any uses and disclosures of health information not covered by its privacy notice or applicable laws. If the Participant provides the Plan Sponsor with permission to use or disclose health information about them for the reasons covered by their written authorization, the Participant understands that the Plan Sponsor is unable to take back any disclosures it has already made with the Participant's permission.

F. Permitted Disclosures of Health Information

For each category of uses or permitted disclosures the Plan Sponsor will explain what it means and present some examples. Not every use or disclosure in a

category will be listed. However, all of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the following categories:

1. **For Benefit Payment (as described in applicable regulations).** The Plan Sponsor may use and disclose health information about a Participant to determine eligibility for Plan benefits, to facilitate payment for the treatment and services a Participant receives from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan Sponsor may share health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

2. **For Health Care Operations (as described in applicable regulations).** The Plan Sponsor may use and disclose health information about a Participant for other Plan operations necessary to run the Plan. For example, the Plan Sponsor may use health information in connection with: conducting quality assessment and improvement activities; underwriting; premium rating; and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. Note: the Plan will not use genetic information for underwriting purposes.

3. **As Required By Law**. The Plan Sponsor will disclose health information about a Participant when required to do so by federal, state or local law. For example, the Plan Sponsor may disclose health information when required by a court order in a litigation proceeding such as a malpractice action.

4. **To Avert a Serious Threat to Health or Safety**. The Plan Sponsor may use and disclose health information about a Participant when necessary to prevent a serious threat to the Participant's health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan Sponsor may disclose health information about a Participant in a proceeding regarding the licensure of a physician.

G. Special Disclosure Situations

1. **Disclosure to the Plan Sponsor's other Health Plans.** The Plan Sponsor may disclose a Participant's health information to another one of its health plans for purposes of facilitating claims payments under that plan. In addition, the Plan Sponsor may disclose health information to its personnel solely for purposes of administering benefits under the Plan.

2. **Organ and Tissue Donation**. If a Participant is an organ donor, the Plan Sponsor may release health information to organizations that handle organ

procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

3. **Military and Veterans.** If a Participant is a member of the armed forces, the Plan Sponsor may release health information about the Participant as required by military command authorities.

4. **Workers' Compensation.** The Plan Sponsor may release health information about a Participant for workers' compensation or similar programs providing benefits for work-related injuries or illness.

5. **Public Health Risks.** The Plan Sponsor may disclose health information about a Participant for public health activities. These activities generally include the following:

    1) To prevent or control disease, injury or disability;

    2) To report births and deaths;

    3) To report child abuse or neglect;

    4) To report reactions to medications or problems with products;

    5) To notify people of recalls of products they may be using;

    6) To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

    7) To notify the appropriate government authority if the Plan Sponsor believes a patient has been the victim of abuse,

    8) Neglect or domestic violence. The Plan Sponsor will only make this disclosure if the Participant agrees or when required or authorized by law.

6. **Health Oversight Activities.** The Plan Sponsor may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

7. **Lawsuits and Disputes**. If a Participant is involved in a lawsuit or a dispute, the Plan Sponsor may disclose health information about the Participant in response to a court or administrative order. The Plan Sponsor may also disclose health information about a Participant in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the Participant about the request or to obtain an order protecting the information requested.

8. **Law Enforcement.** The Plan Sponsor may release health information if asked to do so by a law enforcement official:

    1) In response to a court order, subpoena, warrant, summons or similar process;

    2) To identify or locate a suspect, fugitive, material witness, or missing person;

    3) About the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain that person's agreement;

    4) About a death the Plan Sponsor believes may be the result of criminal conduct;

    5) About criminal conduct at the hospital; and

    6) In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

9. **Coroners, Medical Examiners and Funeral Directors**. The Plan Sponsor may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

10. **National Security and Intelligence Activities.** The Plan Sponsor may release health information about a Participant to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

11. **Inmates.** If a Participant becomes an inmate of a correctional institution or under the custody of a law enforcement official, the Plan Sponsor may release health information about the Participant to the correctional institution or law enforcement official. This release would be limited to the extent necessary (1) for the institution to provide the Participant with health care; (2) to protect the Participant's health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of plan administration, including but not limited to, the following:

    A. Operational activities such as quality assurance and utilization

management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.

B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for medical necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.

C. For purposes of this certification, plan administration does not include disclosing Summary Health Information to help the plan sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health plan.

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return

or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or employees designated by the Plan Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information. When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.

4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

PLAN SUMMARY

HEALTH BENEFIT PLAN FOR RETIREES AGE 65 OR OLDER OF NORTHWESTERN CORPORATION DBA NORTHWESTERN ENERGY

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

   The name of the Plan is the HEALTH BENEFIT PLAN FOR RETIREES AGE 65 OR OLDER OF NORTHWESTERN CORPORATION dba NorthWestern Energy, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Retirees.

2. PLAN BENEFITS

   This Plan provides benefits for covered expenses incurred by eligible Retirees and their Dependent Spouse for:

   Hospital, Surgical, Medical, Maternity, other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

   This Plan was established effective January 1, 2003.

4. PLAN SPONSOR

   Name: NorthWestern Corporation dba NorthWestern Energy
   Address: 11 E Park St
   Butte, MT 59701-1711
   Phone: 406-497-4610

5. NAMED FIDUCIARY AND PLAN ADMINISTRATOR

   Name: NorthWestern Corporation dba NorthWestern Energy
   Attn: Employee Benefits Administration Committee
   Address: 11 E Park St
   Butte, MT 59701-1711
   Phone: (406) 497-4610

6. PLAN FISCAL YEAR

   The Plan fiscal year ends December 31st.

7. PLAN TERMINATION

The right is reserved by the Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

8. IDENTIFICATION NUMBER

Plan Number:	530
Group Number:	X15474
Employer Identification Number:	46-0172280

9. CLAIM ADMINISTRATOR

Name: Blue Cross and Blue Shield of Montana
Address: P.O. Box 4309
Helena, MT 59604-4309

10. ELIGIBILITY

Retirees of the Plan Sponsor and Dependent Spouses may participate in the Plan based upon the eligibility requirements set forth by the Plan.

11. PLAN FUNDING

The Plan is funded by contributions from the employer and Participants...

12. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator has authority to control and manage the Plan and is the agent for service of legal process.

13. PRIVACY OFFICER

Name: Director, Compensation and Benefits
Address: NorthWestern Energy
11 E Park Street
Butte, MT 59701
Phone: (406) 497-4610

****

Blue Cross and Blue Shield of Montana
3645 Alice Street P.O. Box 4309
Helena, MT 59604-4309