2023 BENEFITS ENROLLMENT GUIDE

All Employees

Contents

What is New in 2023?

NorthWestern Energy (NorthWestern) evaluates its plan designs and carrier partnerships annually to ensure your benefits package is competitive and easy to navigate. To that end, NorthWestern is adding value-added benefits, as well as making changes to several benefits effective January 1, 2023, or as noted below. Many of these changes are to offer the same benefits to all employees.

Medical Plan Options

- All employees will be eligible to enroll in the HSA-Qualified Plan and, if eligible, enroll in a HSA. NorthWestern contributes to an employee's HSA. See pages 4-8 for more information.

Dental Plan Design Change

- All employees will be subject to the same deductible for dental services. See pages 12-13 for more information.

Vision Plan Design Change

- All employees will be subject to the same copay for vision services. Additionally, all employees will be eligible to enroll in the Premier (buy up) option, which provides for enhanced benefits. See pages 14-15 for more information.

Wellbeing Program Design Change

- Effective October 1, 2022, the 2023 Energize Your Life wellbeing program will change from a quarterly to an annual structure, with exciting new opportunities to earn significant points See page 21 for more information.

FSA Administrator Change

- Fidelity will administer the Flexible Spending Accounts. See page 31 for more information.

New! Chronic Care Management Solution

- Livongo will be available to you and your dependents at no cost to you. Livongo combines advanced technology with coaching support to help manage multiple chronic conditions including prediabetes, diabetes and hypertension. Additional information regarding the program is available in the benefit materials on iConnect.

New! Chronic Musculoskeletal Solution

- Hinge Health will be available to you and your dependents at no cost to you. Hinge Health utilizes their innovative digital platform and technology to manage chronic back, knee, hip, shoulder and neck pain. Additional information regarding the program is available in the benefit materials on iConnect.

2023 ID Cards

- Blue Cross and Blue Shield of Montana provides new enrollees and employees that enroll in a different plan, a member ID card. If you were enrolled in a medical plan in 2022, and do not change your election, you will not receive a new card.
- Delta Dental provides new enrollees a member ID card. If you were enrolled in a dental plan in 2022, you will not receive a new card.
- VSP does not provide ID cards to members.

Enrollment Process

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

- During the Open Enrollment period from Oct. 5, 2022 through Oct. 21, 2022; or
- Within 31 days of your eligibility date (1st of the month following your date of hire).

Online Enrollment:

All active employees must enroll online for their benefits. To do so:

1. Select the **Employee Services** link on the **iConnect** homepage.
2. Select the **iSelfService** link from the Employee Services landing page.
3. On the **iSelfService** home page, expand the **My Services** lane by clicking on the full screen icon (the double arrows in the top right hand corner).
4. Select the **Benefits** tab and click on the **Annual Open Enrollment** link.
5. Make your benefit elections (see note below regarding Flexible Spending Accounts).
6. Before exiting, “Save” your changes and print a copy of your Benefits Elections Summary for your records.

Important Benefits Enrollment Reference Documents and Forms:

A Job Aid providing detailed instructions for completing your online enrollment along with other important benefit enrollment reference documents and forms are also available on iConnect. To access the information:

1. Follow the online enrollment process described above.
2. Under the **Benefits** tab, click on the **Benefits Material** link and a directory page will open.
3. Select the **Annual Enrollment** link for the work group that you belong to.

A Current Employee Who Does Not Enroll by Oct. 21 Will:

- Be reenrolled automatically into the medical, dental, vision and life insurance plans that they were enrolled in for 2022.
- **Note:** If your benefits changed through the 2022 negotiations process, your current medical plan may no longer be available to you. If you want medical coverage in 2023, you will need to make your election through the online enrollment process. Your medical coverage will be waived for 2023, if you do not make your election.

A New Employee Who Does Not Enroll within 31 Days from Their Eligibility Date Will:

- Not be eligible for benefit coverage or participation in the Health Care or Dependent Care Flexible Spending Accounts until the next Open Enrollment Period or, if after the start of the plan year, due to a qualifying event that provides a special enrollment right, as summarized in this guide and defined in the governing plan document.

Notes:

1. If you are enrolled in the Health Care and/or Dependent Care Flexible Spending Accounts in 2022 and you want to participate in these accounts in 2023, you are required to enroll in the accounts and indicate your annual contribution amount through the online enrollment process. Your election for 2022 will not automatically be defaulted, or carried over, into 2023.

2. If you want to enroll in a Health Savings Account (HSA), you will not enroll through iSelfService at the same time you elect your other benefits. Instead, if you enroll in the HSA-Qualified Plan, the Benefits department will send an email to you with the instructions for confirming your eligibility for a HSA and activating your account through Fidelity.

Medical Plan

Eligibility

All regular full-time, regular part-time and seasonal employees who are scheduled to work at least 20 hours per week, or for a minimum of 1,000 hours per year, are eligible to participate in the company's medical plan. An employee is eligible to be covered under the plan as either a Participant or a Dependent.

A regular part-time employee will receive a prorated company contribution towards their medical premium cost that is based on the number of hours actually worked during a pay period.

Your family members (Dependents) are also eligible for coverage under the company's medical plan. Eligible Dependents include your:

- Legal spouse (unless you are legally divorced); and
- Children who are:
  - Less than age 26, regardless of marital status; and
  - Your natural child; step-child; legally adopted child; a child placed with you for adoption and for whom, as part of such placement, you have a legal obligation for the partial or full support of the child, including providing coverage under the company's plan pursuant to a written agreement; or a child for whom you have been appointed the legal guardian by a court of competent jurisdiction prior to the child reaching age 19.

Notes:

1. Your Dependent Child's spouse or children are not eligible for coverage under the company's medical plan.
2. The age requirement is waived if your Dependent Child is mentally handicapped/challenged or physically handicapped/challenged, provided that the Child is incapable of self-supporting employment and is chiefly dependent upon you for support and maintenance. Proof of incapacity must be furnished upon request and additional proof may be required from time to time.
3. Your Dependent Spouse or Child on active military duty for more than thirty-one (31) consecutive days is not eligible for coverage under the company's medical plan.
4. A leased employee, independent contractor, or nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

Coverage by More than One Plan

When coverage is provided by more than one medical plan, the company's plan will coordinate payment of an incurred expense with the other plan using a method called Maintenance of Benefits (MOB). MOB limits the total payment provided to no more than what the company's plan would have paid had it been the only plan that provides coverage.

Example: Both the employee and his/her spouse are enrolled for coverage under the company's plan (80/20 coinsurance plan) and the spouse also has coverage under his/her employer's plan (70/30 coinsurance plan). The spouse incurs a medical expense of $100. Under both plans, the individual deductible amount has been met. Here is how the claim will be processed using MOB:

	Spouse's Plan	Company's Plan
Claim	$100	
Coinsurance	70/30	80/20
Payment	$70	$10

In this example, if both plans had been 80/20 coinsurance plans, the company's plan would not have made a payment on this claim.

Medical Plan (continued)

Plan

Blue Cross and Blue Shield of Montana (BCBSMT) is the administrator for the company's medical plans. Express Scripts, Inc. (ESI) is the administrator for the pharmacy benefits. Information for BCBSMT and ESI can be found in the resource section of this guide.

Plan Options

Participants can elect coverage under the Premier $500 Plan or the HSA-Qualified Plan. Both plans have deductibles, coinsurance and out-of-pocket maximums.

Participant Tiers

Under each plan option, participants can elect coverage under any of the following tiers:

- Single (employee only)
- Two Party (employee plus spouse or child)
- Family (employee plus spouse and/or children)

Allowable Fee

The company's medical plan makes claims based on an allowable fee for a given procedure or service. Member providers are bound contractually to accept the plan's allowable fee as the appropriate amount to charge for a product or service. The deductible and coinsurance expenses are the participant's responsibility. Participants using a nonmember provider who bills more than the allowable fee may be responsible to pay the provider any amount that exceeds the plan's allowable fee.

Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART	Premier $500 Plan	HSA-Qualified Plan
General Provisions		
Deductible[1]	$500/individual $1,000/family	$1,500/single $3,000/family
Coinsurance[2]	80%/20%	80%/20%
Out-of-Pocket Maximum[3] (Includes deductible)	$2,000/individual $4,000/family	$3,000/single $6,000/family
Lifetime Maximum	Unlimited	Unlimited
At the Doctor's Office		
Office Visit	Subject to deductible & coinsurance	Subject to deductible & coinsurance
At the Hospital		
Inpatient/Outpatient	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Surgical Center	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Urgent Care	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Emergency Room	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Ambulance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Other Medical Care		
Chiropractic Benefits limited to 35 visits/year; $30/visit; $100 for x-rays/year	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Diabetes Education Benefits limited to $250 per year	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Routine Hearing Exams	Not covered	Not covered
Medical Hearing Exams (If ordered by a Physician)	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Hearing Aids (Employee only coverage)	Deductible waived; plan pays 50% up to $500 per 5 year period for each ear	Deductible applies; plan pays 50% up to $500 per 5 year period for each ear
Home Health Care	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Pregnancy		
Prenatal Office Visit	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Prenatal Lab	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Screening Ultrasound	Deductible waived, plan pays 100% for 1 ultrasound per pregnancy; all other charges, including additional ultrasounds, subject to deductible & coinsurance	Deductible waived, plan pays 100% for 1 ultrasound per pregnancy; all other charges, including additional ultrasounds, subject to deductible & coinsurance
Routine Newborn Exam	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Preventive Care - Children[4] (Birth through 18 years)	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
Routine Physical Exam	Routine physical exam and associated routine testing provided or ordered at the time of the exam	
Routine Immunization	Recommended immunizations adopted by the Centers for Disease Control and Prevention (CDC) • Hepatitis A • Hepatitis B • Tetanus, Diphtheria, Pertussis • Influenza – Type B • Influenza – Seasonal • Measles, Mumps and Rubella • Pneumococcal • Rotavirus • Inactivated Poliovirus • Varicella • Meningococcal • Human Papillomavirus Frequency established under CDC Recommended Immunization Schedule "For Persons Aged 0 Through 6 Years", "For Persons Aged 7 Through 18 Years" or "Catch-up Schedule For Persons Aged 4 Months Through 18 Years." See Resource section of this guide for website address to access these schedules	

Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART (continued)		
	Premier $500 Plan	**HSA-Qualified Plan**
Assessment & Screening	As recommended by the American Academy of Pediatrics and Bright Futures. **Assessment Screening** • Health History • Height, Weight and Body Mass • Blood Pressure • Developmental Surveillance • Alcohol and Drug Use • Psychosocial/Behavioral • Oral Health Risk • Anticipatory Guidance • Sensory - Vision and Hearing • Developmental • Autism • Metabolic • Hematocrit or Hemoglobin • Lead Exposure • Dyslipidema • Tuberculin Test • Sexually Transmitted Infection • Cervical Dysplasia Age and frequency established under "Periodicity Schedule - Recommendations for Preventive Pediatric Health Care" as adopted by the American Academy of Pediatrics and Bright Futures; see Resource section of this guide for website address to access the schedule	
Other Preventive Care	Services with a rating of A or B in the recommendations of the U.S. Preventive Services Task Force **Screening** • Visual acuity – children less than 5 years old • Obesity – children age 6 and older • Depression – children age 12-18 • Hearing loss - newborns • Hemoglobinopathies (sickle cell) - newborns • Phenylketonuria (PKU) – newborns • HIV – adolescent children at increased risk **Counseling** • Obesity – children age 6 and older • Sexually transmitted infections – adolescent children at increased risk **Other** • Iron supplements – As prescribed, for children age 6-12 months at increased risk for anemia • Oral Fluoride - As prescribed, for children age 6 months or older if water source is deficient in fluoride • Prophylactic medication for gonorrhea – newborns	
Preventive Care - Adults[4] (Age 19 and older)	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
Routine Physical Exam	Routine physical exam and associated routine testing provided or ordered at the time of the exam	
Routine Immunization	Recommended immunizations adopted by the Centers for Disease Control and Prevention (CDC). • Hepatitis A • Hepatitis B • Tetanus, Diphtheria, Pertussis • Influenza • Measles, Mumps and Rubella • Pneumococcal • Varicella • Meningococcal • Human Papillomavirus • Shingles Frequency established under CDC Recommended Adult Immunization Schedule; see Resource section of this guide for website address to access the schedule	
Mammogram	Routine exam and associated lab charges	
Pap Test	Routine exam and associated lab charges	
PSA Test	Routine exam and associated lab charges	
Colorectal Cancer Screening	Tests and procedures within the age and frequency guidelines established by the American Cancer Society (ACS); see Resource section of this guide for website address to access the ACS guidelines (Note: Pursuant to the Affordable Care Act, tests/procedures at any age if at high risk)	
Other Preventive Care (cont.)	Services with a rating of A or B in the recommendations of the U.S. Preventive Services Task Force **Screening** • Interventions to support breast feeding – pregnant women • High blood pressure • Cholesterol abnormalities - men age 35+ or age 20+, if at increased risk; women age 45+ or age 20+, if at increased risk • Diabetes - adults with sustained blood pressure (either treated or untreated) greater than 135/80 • Abdominal aortic aneurysm - men age 65-75 who have smoked • Depression • Obesity • Bacteriuria - pregnant women at 12 to 16 weeks gestation or at first prenatal visit, if later • Iron deficiency anemia - asymptomatic pregnant women • Hepatitis B - pregnant women. • Rh incompatibility- pregnant women • Osteoporosis - women age 65+ or age 60+ if increased risk of osteoporotic fractures • Chlamydial infection - women age <24 or age 19+, if at increased risk • Gonorrhea – women at increased risk • Syphilis – adults at increased risk • HIV - adults at increased risk	

Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART (continued)

	Premier $500 Plan			HSA-Qualified Plan
Other Preventive Care (cont.)	Services with a rating of A or B in the recommendations of the U.S. Preventive Services Task Force (continued) **Counseling** • BRCA screening – women with family history of BRCA 1 or BRCA 2 risk factors • Chemoprevention of breast cancer – women at high risk • Nutrition/Dietary – adults at increased risk for cardiovascular and diet-related chronic disease • Obesity • Tobacco use • Alcohol misuse • Sexually transmitted infections – adults at increased risk			**Other** • Aspirin to prevent cardiovascular disease – men age 45-79; women age 55-79, when prescribed by a physician • Folic acid supplements - women capable of pregnancy **Women's Preventive Services** • Well-woman visits - annually • Screening for gestational diabetes - women 24 to 28 weeks pregnant and those at high risk • Human papillomavirus testing - age 30+, every 3 years • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptives methods and counseling • Breastfeeding support, supplies, and counseling • Screening and counseling for interpersonal and domestic violence
Prescription Drugs	**Employee Co-Pay**			**Employee Coinsurance** **Drugs on HSA-Qualified Plan Preventive List** - coinsurance amount indicated below **All Other Covered Drugs** - 100% until medical deductible is met, then coinsurance amount indicated below
Retail - 30 day supply	%	Min	Max	
Generic[5]	10%	$20	$200	0%
Preferred Brand[6]	20%	$30	$200	10%
Non-Preferred Brand[7]	30%	$45	$200	20%
Retail - 90 day supply (maintenance drugs)				
Generic	10%	$60	$600	0%
Preferred Brand	20%	$90	$600	10%
Non-Preferred Brand	30%	$135	$600	20%
Mail Order - 90 day supply				
Generic	$30			0%
Preferred Brand	$50			10%
Non-Preferred Brand	$80			20%
Rx Out-of-Pocket Max[8]	$750 per family member			Medical Out-of-Pocket Max

Notes and definitions:

1. Deductible: The amount of eligible expenses that an employee must pay before the plan pays benefits.

a. Under the Premier $500 Plan, the plan will pay benefits under a Single coverage tier once the person has met the individual deductible amount and under a Two Party or Family coverage tier once two or more persons have met the individual deductible amount. **A covered person cannot receive credit toward the family deductible for more than the individual deductible amount.**

b. Under the HSA-Qualified Plan**,** the plan will pay benefits under a Single coverage tier once the person has met the individual deductible amount and under a Two Party or Family coverage tier once one or more persons have met the family deductible amount. **A covered person can receive credit toward the family deductible for more than the individual deductible amount.**

2. **Coinsurance:** The participant's share of the cost of eligible expenses after the deductible is met.

3. **Out-of-Pocket Maximum:** The maximum amount of eligible expenses that an employee pays per year through the deductible and coinsurance before the plan pays 100 percent. Note: Under the HSA-Qualified Plan for Two Party or Family coverage, the family out-of-pocket maximum must be met before the plan will pay 100% of the expenses for any family member. A covered person can receive credit toward the family out-of-pocket for more than the individual out-of-pocket.

4. **Preventive Care Benefits** - The preventive care benefits are based on services that have a rating of A or B as set forth in the recommendations of the United States Preventive Services Task Force, immunizations for routine use as set forth in the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. **The benefits are subject to change.** To view a current list of recommendations and guidelines, access the websites for the above agencies at the addresses listed in the resource section of this guide. (Note: The American Cancer Society recommends that men make an informed decision with their doctor about the PSA test.)

5. **Generic:** A generic drug is a Food and Drug Administration (FDA) approved copy of a brand name drug. Generic drugs (a) contain the same active ingredients as a brand name drug; (b) are identical in dose, form and administrative method; and (c) have the same indications, cautions and instructions. When a brand name drug has a patent that expires, drug companies can introduce, at a lower cost, competitive generic versions after the drug has been thoroughly tested and approved by the FDA.

6. **Preferred Brand:** A Preferred Brand drug is a brand name drug that has been placed on a preferred medication list as determined by the company's pharmacy benefit plan manager based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class.

7. **Non-Preferred Brand:** A Non-Preferred Brand drug is a brand name drug that has not been placed on a preferred medication list as determined by the company's pharmacy benefit plan manager.

8. **Rx Out-of-Pocket Max**: The maximum annual out-of-pocket cost for prescription drugs under the Premier $500 Plan is $750 per family member. The maximum annual out-of-pocket cost for prescription drugs under the HSA-Qualified Plan is the medical plan out-of-pocket maximum.

HSA

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-advantaged account established to pay for qualified health care expenses for those who are covered under the company's HSA-Qualified Plan. With money from this account, you can pay for health care expenses to meet your deductible and your coinsurance share of eligible expenses until the out-of-pocket maximum is met. Then, the plan pays 100% of eligible expenses. Any unused funds are yours to retain in your HSA and accumulate toward your future health care expenses or your retirement. There are no "use-it-or-lose-it" requirements under an HSA.

You own and control the money in your HSA. Decisions on how to spend the money are made by you. You will have the option to invest HSA dollars in a variety of short-term and long-term investment options including mutual funds, stocks, bonds, EFTs and CDs. Monies that you do not invest on your own will be invested in a FDIC insured interest bearing checking account.

Eligibility

You are eligible to take advantage of an HSA if you are covered under the company's HSA-Qualified Plan and you:

- are not covered under any other health plan that is not a high deductible health plan;
- are not currently enrolled in Medicare or TRICARE;
- have not received medical benefits through the Department of Veteran Affairs (VA) during the preceding three months;
- cannot be claimed as a dependent on another person's tax return.

Please see IRS Publication 969 at www.irs.gov for HSA information.

Contribution Limits

Under IRS limits, the maximum amount that can be contributed to your HSA from all sources for 2023 is:

- Up to $3,850 if enrolled for single coverage under the HSA-Qualified Plan; and
- Up to $7,750 if enrolled for two party or family coverage under the HSA-Qualified Plan

If you are age 55 or older (or will reach age 55 at any time during the year), you can contribute an additional $1,000 into your account as a catch-up contribution. These amounts may be increased for inflation in future years.

Employee Contributions

Subject to the IRS limits noted above, you can elect the amount that you want to contribute to your HSA through bi-weekly payroll deduction. You can change your election at any time during the plan year.

HSA (continued)

Employer Contributions

Unless otherwise provided under a collective bargaining agreement, the company's annual contribution into your HSA for 2023 is:

- Up to $500 if enrolled for single coverage under the HSA-Qualified Plan; and
- Up to $1,000 if enrolled for two party or family coverage under the HSA-Qualified Plan.

The company's contribution will be made on a bi-weekly basis. For new enrollees into the HSA after the start of the plan year, the company's contribution will be pro-rated based on the number of remaining payroll periods in the year.

For 2023, the company will make an additional discretionary contribution of up to $1,000 into your HSA if you are enrolled in the HSA-Qualified Plan and completed the requirements of the Wellbeing program in 2022. This contribution will be made in early January.

⚠ **Notes:**

1. If you reenroll in the HSA-Qualified Plan for 2023 and are enrolled in the HSA, the bi-weekly contribution amount that you have elected as in effect during the last pay period in 2022 will automatically carry over into the first pay period in 2023.
2. All contributions that you make through payroll deduction into your HSA, along with the company's contributions, are tax deductible and earnings along with withdrawals from an HSA are tax-free when used to pay for qualified health care expenses.
3. The annual IRS contribution limits include not only your contributions made through payroll but also the company's contributions and any contributions made to your HSA through any other source.

HSA and FSA

If you enroll in an HSA, you are not eligible to enroll in a Health Care Flexible Spending Account.

Eligible Expenses

You can use your HSA to pay for qualified medical, dental and vision expenses as defined in IRS Publication 502 located at www.irs.gov. Eligible expenses are the same as those eligible for reimbursement under a Flexible Spending Account (FSA).

How to Enroll

If you want to enroll in a HSA, you will not enroll through iSelfService at the same time you elect your other benefits. Instead, if you enroll in the HSA-Qualified Plan, the Benefits department will send an email to you with the instructions for confirming your eligibility for a HSA and activating your account through Fidelity.

⚠ **Notes:**

1. Health insurance premiums are generally not qualified medical expenses. Exceptions include premiums for qualified long-term care insurance, COBRA health care continuation coverage, any health plan maintained while receiving unemployment compensation under federal or state law, and Medicare for those who are age 65 or older.
2. The tax penalty for withdrawals from an HSA for non-qualified expenses is 20%.

MDLive Virtual Visits

Only offered under the HSA-Qualified Plan.

The MDLive virtual visit is a unique form of a telehealth benefit that provides a less expensive alternative to an office visit, urgent care visit or emergency room care for non-emergent medical conditions such as allergies, asthma, cold, flu, sinus infections, ear problems and pink eye.

The benefit is contracted by Blue Cross and Blue Shield of Montana (BCBSMT) with MDLIVE. Whether you're at home or traveling, the virtual visit benefit allows you to consult with a MDLIVE board-certified doctor available 24 hours a day, seven days a week through interactive video via your smartphone, tablet or computer with video and audio capabilities. Virtual visits are as easy as FaceTime® or Skype™. An online virtual visit can take place anywhere you have Wi-Fi or data access. To protect your privacy, access for a virtual visit is through a secure connection powered by MDLIVE. Consultation by telephone with a MDLIVE physician is also available in states other than Idaho, Montana and New Mexico.

Each time you have a virtual visit, you will receive assistance to determine if a virtual visit is appropriate to address your medical concerns and symptoms. If appropriate, you can then schedule an appointment with or be automatically connected to a MDLIVE physician that can diagnose your condition, provide treatment in many situations, send a prescription electronically to a pharmacy of your choice (when appropriate), or recommend any follow-up care if needed.

The medical claim cost for a virtual visit is $48 and is structured to process like an office visit. The claim is subject to the deductible and coinsurance. You pay what you owe for the visit with a credit card or your HSA debit card. The amount you pay is credited towards your deductible and out-of-pocket maximum under the plan.

Sometimes it's clear where to go when you need medical care, such as when you are experiencing severe chest pain or you have broken your leg. At other times, it's not so clear. For non-emergency minor medical conditions, a virtual visit can make a big difference in cost and time and may be your best choice for the care you need. The average wait time for a virtual visit is less than 10 minutes[1]. The cost of a virtual visit is, on average, $80 less than an office visit, $250 less than an urgent care visit and $985 less than an emergency room visit[1].

If you are enrolled in the HSA-Qualified Plan, you can register and activate your MDLIVE account through the BCBSMT member portal or the MDLIVE website. Information for BCBSMT and MDLIVE can be found in the resource section of this guide.

[1] Information provided by BCBSMT

Dental Plan

Eligibility

All regular full-time, regular part-time and seasonal employees who are scheduled to work at least 20 hours per week, or for a minimum of 1,000 hours per year, are eligible to participate in the company's dental plan. An employee is eligible to be covered under the plan as either a Participant or a Dependent.

A regular part-time employee will receive a prorated company contribution towards their dental premium cost that is based on the number of hours actually worked during a pay period.

Your family members (Dependents) are also eligible for coverage under the company's dental plan. Eligible Dependents include your:

- Legal spouse (unless you are legally divorced); and
- Children who are:
  - Unmarried;
  - Less than age 24; and
  - Your natural child; step-child; legally adopted child or a child placed with you for adoption prior to reaching age 19.

Notes:

1. The age requirement is waived if your Dependent Child is mentally handicapped/challenged or physically handicapped/challenged, provided that the Child is incapable of self-supporting employment and is chiefly dependent upon you for support and maintenance. Proof of incapacity must be furnished upon request and additional proof may be required from time to time.
2. Your Dependent Spouse or Child on active military duty for more than thirty-one (31) consecutive days is not eligible for coverage under the company's dental plan.
3. A leased employee, independent contractor, or nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

Plan

Delta Dental is the administrator for the company's dental plans. Information for Delta Dental can be found in the resource section of this guide.

Plan Options

Participants can elect coverage under one of two options that provide different levels of benefit coverage for dental services. Both options have deductibles, coinsurance and annual/lifetime benefit maximums.

Participant Tiers

Under each plan option, participants can elect coverage under any of the following tiers:

- Single (employee only)
- Two Party (employee plus spouse or child)
- Family (employee plus spouse and/or children)

Coverage by More than One Plan

If coverage is provided by more than one dental plan, the company will use the Maintenance of Benefits (MOB) method to coordinate payment of an incurred expense with the other plan. Refer to the explanation of how MOB works under the Medical Plan section of this guide.

Dental Plan (continued)

Allowable Fee

The company's dental plan makes claim payments based on an allowable fee for a given procedure or service. Member providers are bound contractually to accept the plan's allowable fee as the appropriate amount to charge for a product or service. The deductible and coinsurance expenses are the participant's responsibility. Participants using a nonmember provider who bills more than the allowable fee may be responsible to pay the provider any amount that exceeds the plan's allowable fee.

Benefit Feature	Option I	Option II
Deductible[1]		
Per Person	$25	$25
Per Family	$75	$75
Coinsurance[2]	**Plan/Employee**	**Plan/Employee**
Preventive/Diagnostic[3]	100% / 0%	100% / 0%
Restorative[4]	80% / 20%	80% / 20%
Other[5]	80% / 20%	50% / 50%
Orthodontic[6]	60% / 40%	50% / 50%
Annual Maximum		
All Except Orthodontics	$2,000	$1,000
Orthodontic Lifetime Max[7]	$2,000	$2,000

Notes and definitions:

1. **Deductible:** The amount of eligible claims a participant pays per person or family per year before the plan pays benefits. All covered services, including preventive, are subject to the plan deductible.
2. **Coinsurance:** The participant's share of the cost of covered health care services or supplies after the deductible is met expressed as a percentage or dollar amount.
3. **Preventive/Diagnostic:** Procedures such as oral exams, cleaning, X-rays, and topical fluoride for those participants under age 19 and dental sealants for participants under age 16.
4. **Restorative:** Fillings for the treatment of decay.
5. **Other:** All other dental services such as periodontal treatment, oral surgery, extractions, endodontic treatment of dental pulp, root canals, caps, crowns, bridges and dentures.
6. **Orthodontic:** Includes necessary services, supplies and appliances for straightening irregularly spaced teeth.
7. **Orthodontic Lifetime Max:** The maximum amount that the plan will pay for specific orthodontic procedures.

Vision Plan

Eligibility

All regular full-time, regular part-time and seasonal employees who are scheduled to work at least 20 hours per week, or for a minimum of 1,000 hours per year, are eligible to participate in the company's vision plan. An employee is eligible to be covered under the plan as either a Participant or a Dependent.

A regular part-time employee will receive a prorated company contribution towards their vision premium cost that is based on the number of hours actually worked during a pay period.

Your family members (Dependents) are also eligible for coverage under the company's vision plan. Eligible Dependents include your:

- Legal spouse (unless you are legally divorced); and
- Children who are:
  - Unmarried;
  - Less than age 24; and
  - Your natural child; step-child; legally adopted child or a child placed with you for adoption prior to reaching age 19.

Notes:

1. The age requirement is waived if your Dependent Child is mentally handicapped/challenged or physically handicapped/challenged, provided that the Child is incapable of self-supporting employment and is chiefly dependent upon you for support and maintenance. Proof of incapacity must be furnished upon request and additional proof may be required from time to time.
2. Your Dependent Spouse or Child on active military duty for more than thirty-one (31) consecutive days is not eligible for coverage under the company's vision plan.
3. A leased employee, independent contractor, or nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

Plan

Vision Service Plan (VSP) is the administrator for the company's insurance plan. Benefits are provided under the VSP signature plan. Information for VSP can be found in the resource section of this guide.

Plan Options

Participants can elect coverage under one of two options that provide different levels of benefit coverage for vision services. The Premier option provides enhanced benefits. If you elect this option, you and your covered dependents can individually choose one covered upgrade when you receive services from a VSP network provider. The enhanced benefits under the Premier option are shown in the following table. **The enhanced benefits are only available through a VSP network provider.**

Participant Tiers

Participants can elect coverage under any of the following tiers:

- Single (employee only)
- Two Party (employee plus spouse or child)
- Family (employee plus spouse and/or children)

Extra Discounts and Savings

In addition to the benefits shown in the following table, participants can receive extra discounts and savings through a VSP network provider including:

- Average 35-40% savings on all non-covered lens
- 30% off additional glasses and sunglasses, including lens options from the same Member Provider on the same day as your WellVision Exam or 20% off from any Member Provider within 12 months of your last WellVision Exam
- Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details
- No more than a $39 co-pay on routine retinal screening as an enhancement to a WellVision Exam
- 15% off cost of contact lens exam (fitting and evaluation)
- Average 15% off the regular price or 5% off the promotional price for laser vision correction. Discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any Member Provider

Vision Plan (continued)

Benefit	Coverage		
	VSP Provider[1]		Non-VSP Provider[2]
	Premier Option	Standard Option	
WellVision Exam *Every 12 months*	$20 co-pay	$20 co-pay	Up to $40
Prescription Glasses[3]	$20 co-pay	$20 co-pay	
Lenses *Every 12 months*	• Single vision, lined bifocal and lined trifocal lenses • Standard progressive lenses (additional co-pay for premium and custom progressive lenses) • Impact-resistant lenses for dependent children	• Single vision, lined bifocal and lined trifocal lenses • Standard progressive lenses (additional co-pay for premium or custom progressive lenses) • Impact-resistant lenses for dependent children	Single vision lenses - Up to $48 Lined bifocal lenses - Up to $60 Lined trifocal lenses - Up to $75 Progressive lenses - Up to $75
Frames *Premier Option – Every 12 Months* *Standard Option – Every 24 Months*	Retail - Up to $130 Wholesale - Up to $70	Retail - Up to $130 Wholesale - Up to $70	Retail - Up to $64 Wholesale - NA
Contact Lens *Every 12 months*	No co-pay; $120 allowance that applies to the cost of the contact lens only Contact lens exam (fitting and evaluation); covered in full after co-pay, not to exceed $60 The contact lens allowance is in lieu of the benefit for prescription glasses	No co-pay; $120 allowance that applies to the cost of the contact lens only Contact lens exam (fitting and evaluation); covered in full after co-pay, not to exceed $60 The contact lens allowance is in lieu of the benefit for prescription glasses	No co-pay; $120 allowance that applies to the cost of the contacts and the contact lens exam (fitting and evaluation) The Contact Lens allowance is in lieu of the benefit for prescription glasses
VSP EasyOptions *Every 12 months* *Only available through a VSP network provider*	Participants can choose **one** of the following upgrades at the time of service: • An additional $120 frame allowance; **or** • Fully covered premium or custom progressive lenses; **or** • Fully covered light-reactive lenses; **or** • Fully covered anti-glare coating; **or** • An additional $80 contact lens allowance		

Notes and definitions:

1. **VSP Provider:** Members can receive vision services through a **VSP contracted private practice provider** or retail chain affiliate provider such as Costco® and Walmart After any applicable co-pay, the benefits for vision services received through a retail chain affiliate provider are the same as those provided under the plan for a **VSP private practice provider**. The only exception is that the allowance for frames when received through Costco® is up to $70. When a member uses a retail chain affiliate provider, they will inform the provider that they are insured through VSP and their claim will be processed/billed to VSP directly. A list of **VSP participating providers**, including retail chain affiliates, can be found on VSP's website. Refer to the resource section of this guide for additional information.

   Vision benefits provided through **VSP member providers** take advantage of the power of group purchasing, offering greater value than can be obtained outside the plan.

2. **Non-VSP Provider:** The company's plan pays **non-VSP providers** a scheduled amount for services and hardware. Employees will pay the provider and file a claim for reimbursement by sending VSP a copy of an itemized invoice along with the employee's name, mailing address and social security number. The VSP address and website can be found in the resource section of this guide.

3. Additional costs for frames in excess of the allowed amount and/or lens enhancements (e.g. tinting, scratch resistant coating or progressive lenses) are the employee's responsibility. VSP provides a discount on these additional costs of 20 percent.

Life Insurance

Eligibility

All regular full-time, regular part-time and seasonal employees who are scheduled to work at least 20 hours per week, or for a minimum of 1,000 hours per year, are eligible to participate in the company's life insurance plan.

Your family members (Dependents) are also eligible for coverage under the company's life insurance plan. Eligible Dependents include your:

- Lawful spouse (unless you are legally divorced); and
- Children who are:
  - Unmarried;
  - From live birth to age 24; and
  - Your natural child, step-child, legally adopted child or a child placed with you for adoption.

Notes:

1. The age requirement is waived if your Dependent Child is mentally handicapped/challenged or physically handicapped/challenged, provided that the Child is incapable of self-supporting employment. Proof of incapacity must be furnished upon request and additional proof may be required from time to time.
2. Your Dependent Spouse or Child who is a full-time member of the armed forces of any country is not eligible for coverage under the company's life insurance plan.

Basic Life Insurance

The company's life insurance plan provides basic term life insurance coverage at no cost to the employee according to the following table.

Montana Employees	1 x annual base pay
South Dakota and Nebraska Employees	
• New employees hired after 7/1/03	1 x annual base pay
• Employees with less than 10 years of service on 7/1/03	2 x annual base pay
• Employees with 10 or more years of service on 7/1/03	3 x annual base pay

Life Insurance (continued)

Additional Life Insurance

The company's life insurance plan also offers a variety of options for an employee to purchase additional life insurance for him or herself, his or her spouse and his or her dependent children as well as Accidental Death & Dismemberment (AD&D) insurance for him or herself and his or her spouse. The following chart shows these options.

Type of Coverage	Coverage Amount[4]
Employee-purchased additional life insurance[1]	Coverage increments of 1/2x pay up to 4x pay; rate based on employee's age
Employee-purchased AD&D insurance	Coverage increments of 1/2x pay up to 5x pay
Employee-purchased basic spouse life insurance[2]	Coverage of flat $10,000
Employee-purchased additional spouse life insurance[2]	Increments of 1/2x employee's pay up to the lesser of 2x pay or $75,000; rate based on spouse's age
Employee-purchased spouse AD&D insurance *Employee must enroll in AD&D insurance in order to purchase spouse AD&D*	Increments of 1/2x employee's pay up to the lesser of 2x pay or $75,000
Employee-purchased dependent child life insurance[3]	$10,000 coverage for each dependent child

Notes and definitions:

1. The combined maximum amount of company paid and employee-purchased insurance that an employee can be covered for is the lesser of 5 times pay or $1,300,000 without evidence of insurability (EOI).
2. **An employee cannot purchase Spouse Life coverage if his or her spouse is also an employee or a retiree of the company**. The maximum amount of insurance that an employee can purchase on his or her spouse is $85,000. An employee cannot purchase more insurance on his or her spouse than he or she has elected for him or herself.
3. **If an employee is married to another employee or a retiree of the company, only one of them can elect Dependent Child Life coverage.**
4. An employee may increase the amount of additional life insurance for him or herself or his or her spouse during the open enrollment period each year by increments of 1/2x basic pay (up to the maximum amounts noted above) without completing an EOI. An employee can request additional amounts of coverage, but the employee must complete an EOI and receive approval by the insurance company. **Any increase in coverage elected by an employee for him or herself or his or her spouse or child will be subject to the active service provisions of the life insurance policy.**

FSA

Flexible Spending Accounts (FSA)

Types of Accounts

Health care and dependent care spending accounts may be set up to pay for health care expenses and day care expenses with pre-tax money.

Employee Contributions

You may contribute up to $2,850 to the Health Care FSA and up to $5,000 to the Dependent Care FSA. You must specify the annual contribution amount to each account during enrollment. The amount will be deducted in equal amounts from your paycheck each pay period. IRS regulations state that once you've decided how much to contribute, you cannot change your rate of contribution until the next plan year unless you have a qualifying change in status as defined by the IRS.

Eligible Expenses

IRS regulations determine the types of expenses that are eligible for reimbursement through the FSAs; a brief overview of these eligible expenses is provided below. Additional details can be found at your local IRS office or on the IRS website at www.irs.gov (look for Publications 502 and 503 for health care and dependent care information, respectively).

Examples of eligible expenses are:

Out-of-pocket Medical Expenses

- Health insurance deductibles
- Health insurance coinsurance
- Eligible medical, prescription, dental, and vision expenses not paid by insurance

Dependent Care Expenses for Dependents

- Day Care
- Elder Care

Payment Options

- Direct deposit is available for fund reimbursement.
- Debit card is available to pay for qualified expenses at the point of purchase.

Incurring Expenses

Qualifying expenses incurred during the Plan Year or Grace Period will be eligible for reimbursement. The Plan Year begins January 1 and ends December 31. There is a Grace Period immediately following the end of the Plan Year that allows participants additional time to incur expenses against the previous year's contribution. The Grace Period ends March 15 of the following year. Participants have 90 days immediately following the end of the Grace Period, or until June 13, to submit claims for reimbursement. Any funds remaining after that time will be forfeited.

FSA Worksheet

HEALTH CARE SPENDING ACCOUNT WORKSHEET

The key to using the Health Care Spending Account is planning. Estimate your eligible expenses for the next year and enroll for that amount in advance. Review the health care expenses you incurred last year to give you an idea of predictable expenses. This worksheet can help you plan.

Eligible Expenses:

MEDICAL

- ☐ Medical deductibles/coinsurance $_____
- ☐ Routine exams and physicals $_____
- ☐ Chiropractor expenses
- ☐ Other eligible medical expenses not covered by benefit plans $_____

PRESCRIPTIONS

- ☐ Prescription co-pays/mail order costs not covered by benefit plans $_____

DENTAL

- ☐ Dental deductibles/coinsurance $_____
- ☐ Orthodontia expenses not covered by benefit plans $_____
- ☐ Other eligible dental expenses not covered by benefit plans $_____

VISION

- ☐ Exam costs not covered by benefit plans $_____
- ☐ Eye glasses $_____
- ☐ Laser eye surgery $_____
- ☐ Contact lenses $_____

HEARING

- ☐ Exams $_____
- ☐ Hearing aids $_____

OTHER ELIGIBLE EXPENSES $_____

TOTAL ANNUAL AMOUNT $_____

AMOUNT PER PAY PERIOD (Annual Divided by 26) $_____

Remember, the total amount allocated may not exceed the annual maximum of $2,850 for a Health Care FSA and $5,000 for a Dependent Care FSA.

DEPENDENT CARE SPENDING ACCOUNT WORKSHEET

List your weekly daycare expenses.

$_____ x _____ = $ _____ /26 = $ _____

Weekly Expenses	Number of weeks	Annual Total	Bi-Weekly Amount

EAP

Employee Assistance Program (EAP)

The company provides an employee assistance program (EAP) through a third party. EAP services are designed to help employees and covered dependents address any personal concerns such as stress, anxiety, depression, family/marital relationships, substance abuse, difficulties at work, and other personal problems.

Help is available online or by telephone 24 hours a day, seven days a week, at no cost to you or your family members. The program also provides for face-to-face assessment and counseling visits. To access a provider, an employee must call the toll-free EAP number for a referral to a plan counselor.

In addition, online services are available to help with your everyday concerns, such as child care or elder care resources, estate planning, financial planning, wellness, home improvement ideas, tips to improve study habits and a wide range of other topics.

The toll-free number, website address and NorthWestern Energy company code for the EAP can be found in the resource section of this guide.

Wellbeing Program

NorthWestern Energy's ***Energize Your Life*** program is a voluntary wellbeing program offered in partnership with Virgin Pulse. The 2023 program is changing from a quarterly to an annual structure, with exciting new opportunities to earn significant points including:

- Primary Care Visit
- Routine Dental Exam/Cleaning
- Vision Exam
- Complete Fidelity's Financial Wellness Checkup
- Contribute to your 401(k)
- Contribute to your Health Savings Account (HSA)

The program is offered at no cost to you. The 2023 program year begins on Oct. 1, 2022 and will end on Sept. 30, 2023. The annual program has four levels to guide your journey from getting involved to rewarding you on sustained engagement, achievements and success.

Eligibility

- All regular full-time, regular part-time and seasonal employees; and
- A spouse who is enrolled in NorthWestern Energy's medical plan.

How the Program Works

The program offers something for everyone. When you log into your Virgin Pulse account, customize your preferences based broadly on four pillars of wellness - Energy, Focus, Drive and Health Situations. Within these pillars, focus on your own interests and goals by choosing activities and programs from core areas of wellbeing,

A full list of programs and activities can be found on the Virgin Pulse website or mobile app.

Rewards

By participating in the program, you can reap the rewards of healthy habits that deliver noticeable benefits, such as reducing your risk of certain diseases, increasing your focus and just making you feel great! Participants can also earn financial rewards in 2024 of up to $600 toward their medical insurance premium and an additional contribution to their HSA of up to $1,000.

How to Enroll

Enrolling in the program is easy. On iConnect, click on the Health & Wellbeing tile on the main page and then the "Click here" link under the Energize Your Life website heading. Your spouse can enroll in the program through join.virginpulse.com/northwestern. When you register, you will be asked for an email address that will become your username. NorthWestern recommends that you use a personal, rather than your NorthWestern email, address.

Questions?

Review the 2023 Wellbeing Program Brochure and FAQ which can be found on iConnect under the Health & Wellbeing tile on the main page.

If you need additional support, log into your Virgin Pulse account. Under the Support tab on the Virgin Pulse website or under your Profile, More and Help on the mobile app., you will find general information about the site, a list of Frequently Asked Questions and other helpful information. You can also contact the Virgin Pulse customer care center at:

Email: northwesternsupport@virginpulse.com

Phone: 888-317-0881

COBRA

COBRA in General

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

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For additional information about your rights and obligations under the plan and under federal law, you should review the plan's Summary Plan Description or contact the Benefits department at **(888) 236-6656.**

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Who is Entitled to COBRA Continuation Coverage?

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

COBRA (continued)

When Will COBRA Continuation Coverage Be Offered?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is for your spouse or dependent children (as defined above), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing, to:

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

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered employee may elect COBRA continuation coverage on behalf of a spouse or eligible child(ren).

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's loss of eligibility, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

COBRA (continued)

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll In Medicare Instead Of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact identified below.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

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

HIPAA

Health Insurance Portability and Accountability Act (HIPAA)

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

The company's Privacy Notice covers the medical, dental and vision plans and the EAP, health care FSA and HSA. HIPAA requirements do not apply to short or long-term disability or worker's compensation. The Privacy Notice also identifies the Privacy Officer who handles any privacy-related complaints.

For a copy of the HIPAA Privacy Notice, select the **Employee Services** link on the **iConnect** homepage. Select **Forms and Document Libraries**. On the **SharePoint** page, open the **Responsible Work Group: Health and Welfare**. Listed under the **Document Type: Policy** you will find the HIPAA related documents. You can also obtain a copy by contacting the Benefits department at **(888) 236-6656**.

General Notices

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

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

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

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

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

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

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

General Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage under the company's medical plan, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for the company's plan.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP and you are not already enrolled in the company's plan, you will have the opportunity to enroll in the company's plan at that time. Refer to the "Special Enrollment Rights" section of this guide for additional information or contact the Benefits department at **(888) 236-6656**.

For further information on eligibility, you should contact your state at:

MONTANA – Medicaid
Website: http://medicaidprovider.mt.gov
Phone: 1-888-706-1535

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-605-773-3495

To see if any other states have a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Special Enrollment Rights

In general, you are allowed to enroll for coverage or change your level of coverage under the company's medical, dental, vision and life insurance plans only during the initial enrollment period upon your hire or during the open enrollment period each year. However, there are certain events that create special enrollment rights.

Under the Medical, Dental and Vision Plans, You Can:

- Change your coverage if you add or lose a dependent spouse or child as a result of marriage (including common law), divorce, adoption, placement for adoption, or death. In such event, you must submit a written special enrollment request and enroll for coverage within sixty (60) days of the event and provide documentation that validates the event such as marriage certificate, divorce decree, adoption certificate or death certificate. In the event of the birth of a child, you must submit a written special enrollment request and enroll for coverage within ninety (90) days of the date of birth and provide a copy of the child's birth certificate.
- Enroll for coverage for yourself and/or your eligible dependents if you declined enrollment because of other health insurance coverage and that coverage ends. In such event, you must submit a written special enrollment request and enroll for coverage within sixty (60) days of the date that coverage was terminated under the other plan and provide documentation that validates the loss of coverage.
- Enroll for coverage for yourself and/or your eligible dependents if either: (a) coverage under Medicaid or the Children's Health Insurance Program (CHIP) is lost because you are no longer eligible, or (b) you become eligible for a state's premium assistance program under Medicaid or CHIP. In such event, you must submit a written special enrollment request and enroll for coverage within sixty (60) days of the change in eligibility or entitlement for financial assistance under Medicaid or CHIP and provide documentation that validates the change.

Under the Life Insurance Plan, You Can:

- Change your coverage or enroll for coverage if you add or lose a dependent spouse or child as a result of marriage (including common law), divorce, birth, adoption, death, or commencement or termination of your spouse's employment. In such event, you must submit a written special enrollment request and enroll for coverage within thirty-one (31) days of the event and provide documentation that validates the event.

Medicare Creditable Coverage Notice

This notice is issued because the company's medical plans include benefits for prescription drugs.

If you or your covered family members are not Medicare eligible, no action is required on your part.

For those individuals currently eligible and those who become eligible for Medicare within the next 12 months, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The company has determined that the prescription drug coverage offered under its Health Benefit Plan for All Active Employees is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and may not have to pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage under the company's plan will be affected. You can keep your current coverage and the company's plan will coordinate benefits with Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage under the company's plan, be aware that you and your dependents may not be able to get this coverage back.

NOTE: Under the provisions of the company's plan, if you are eligible for Medicare, Medicare Part D will be considered a plan for the purposes of coordination of benefits. The company's plan will coordinate benefits with Medicare whether or not you are actually enrolled in and receiving Medicare Part D benefits. This means that the company's plan will only pay the amount that Medicare would not have paid, even if you do not elect to be covered under Medicare Part D. This is important because it may mean that you could pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

Please refer to the Summary Plan Document (SPD) for additional information regarding your prescription drug benefits and coordination with Medicare. You can request a copy of the SPD by contacting the company's Benefits department at **(888) 236-6656**.

Medicare Creditable Coverage Notice (continued)

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

You should also know that if you drop or lose your current coverage under the company's plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join, with changes effective January 1.

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Service Providers & Resources

Service Provider	Service(s) Provided	Phone Number	Web Address/E-mail
Blue Cross and Blue Shield of Montana	Medical	(855) 258-3489 Fax (claims): (855) 831-3249	www.bcbsmt.com
MDLIVE (HSA-Qualified Plan only)	Virtual Visit	(888) 684-4233	MDLIVE.com/bcbsmt
PeakOne (2022 plan year)	FSA Administrator	(866) 315-1777	www.mypeak1.com
Delta Dental	Dental	(800) 521-2651	www.deltadentalins.com
Vision Service Plan	Vision	(800) 877-7195	www.vsp.com
ComPsych	Employee Assistance Plan	(800) 340-6684	www.guidanceresources.com company code: nwe115
Express Scripts, Inc.	Prescription Drug Program	(866) 892-0071	www.express-scripts.com
Fidelity Investments	HSA Administrator	(800) 544-3716	www.netbenefits.com
	FSA Administrator Effective January 1, 2023	(866) 697-1048	FidelityFSAandRA@fmr.com
Benefits Department	General Benefits	**(888) 236-6656** (external) Ext. 74610 (internal)	benefits@northwestern.com
Lincoln Financial Group	Life Insurance	(888) 787-2129	GroupLifeClaims@lfg.com
Virgin Pulse	Wellbeing Program	(888) 317-0881	northwesternsupport@virginpulse.com
iConnect Intranet	Online Forms/Benefit Plan Documents		http://iconnect

Resource	Phone Number	Web Address/E-mail
American Heart Association	(800) 242-8721	www.heart.org
Diabetes Association	(800) 342-2383	www.diabetes.org
General Medical Topics		www.webmd.com
Wellness Topics		www.nationalwellness.org
MayoClinic.com		www.mayoclinic.com
MerckEngage.com		www.merckengage.com

Resource	Web Address/E-mail
Preventive Care Benefits	
U.S. Preventive Services Task Force	www.uspreventiveservicestaskforce.org
A&B Recommendations	www.uspreventiveservicestaskforce.org
Centers for Disease Control & Prevention	www.cdc.gov
Immunization Schedules	www.cdc.gov/vaccines/schedules
Health Resources and Services Administration	www.hrsa.gov
American Academy of Pediatrics	www.aap.org
Periodicity Schedule	http://brightfutures.aap.org
American Cancer Society	www.cancer.org
Screening Guidelines	www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/index

This booklet is intended to help employees understand the main features of the company's benefit plans. It should not be considered a substitute for the plan documents, which govern the plans. The plan document sets forth all of the details and provisions concerning the plan and is subject to amendment.

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

Additional Notes

NorthWestern® Energy

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