2023 BENEFITS ENROLLMENT GUIDE

Early Retirees

Contents

Enrollment Process

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

- During the Open Enrollment period from Oct. 5, 2022 through Oct. 21, 2022; or
- Within 31 days of your retirement date.

During the Open Enrollment Period

An enrollment form that displays the benefit options available to you along with the costs will be sent to you prior to the start of the Open Enrollment Period. An asterisk identifies the option and coverage level that you are enrolled in for the 2022 plan year.

- If you do not want to make any changes, you do not need to return the form. You will be reenrolled automatically in the same medical, dental, vision and life insurance plans that you were enrolled in for 2022.
- If you want to make changes, indicate your new elections on the enrollment form and return the form no later than 5:00 p.m. (MDT) on Friday, October 21. If the form is not received when due, you will be reenrolled automatically in the same medical, dental, vision and life insurance plans that you were enrolled in for 2022.

Upon Retirement

A Retirement Change of Status form along with a cost summary will be sent to you prior to your retirement date. If you want to enroll for retiree coverage under the company's medical, dental, vision and life insurance plans, you must complete the form and return it within 31 days of your retirement date. If the form is not received when due, you will be considered to have declined coverage and will not be eligible to enroll for retiree coverage at a later date.

Coverage under the company's early retiree health benefit plans is offered as alternative coverage. Upon termination of employment, you and your eligible dependents may elect either COBRA continuation coverage under the company's health benefit plans for active employees or coverage under the early retiree plans. By electing coverage under the early retiree plans, you and your eligible dependents will waive your rights, including any future rights, to COBRA coverage under the company's health benefit plans for active employees.

Notes:

1. Retirees who decline coverage or enroll in coverage and allow coverage to lapse or otherwise terminate will lose their eligibility for coverage and will not again become eligible to enroll for coverage at a later date.
2. Retirees who enroll for coverage will have the opportunity to change their plan elections only during the Open Enrollment Period or during any Special Enrollment Period, as described in the governing plan documents and summarized in this guide.

Medical Plan

Retiree Eligibility

A retiree is eligible to be covered under the plan as either a Participant or a Dependent.

Former employees whose employment terminated due solely to retirement are eligible to participate in the company's medical plan for early retirees, subject to the following eligibility requirements:

Montana Retirees

Termination Prior to January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 55 and 65; and
- Have completed at least 20 years of service with the company.

South Dakota/Nebraska Retirees

Termination Prior to November 1, 2009

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 55 and 65; and
- Had completed at least 15 years of service with the company.

Termination on or after November 1, 2009 and before January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 55 and 65; and
- Have completed at least 20 years of service with the company.

Dependent Eligibility

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;
  - Not eligible to enroll in his or her employer's health plan; 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 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 nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

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.

Coverage by More than One Plan

When coverage is provided by more than one medical plan, the plan administrator employs a specific process to determine which plan should pay first and how much each plan should pay in the event of an illness or injury for a participating member. This process helps to contain costs and to prevent over insurance. The company's plan uses 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: John Smith is a NorthWestern Energy retiree and covers his spouse Mary and himself under the company's medical plan. Mary also is covered by her employer's plan. When Mary incurs an expense, her plan provides primary coverage for the expense and pays first. Then, the company's plan pays the difference between what it would normally pay if it were Mary's only plan and what Mary's plan actually paid. If Mary's plan is a 70/30 coinsurance plan and John's plan is an 80/20 coinsurance plan, they had met the required deductibles under both plans, and the incurred expense was $100, the following displays how a claim is processed under the MOB process:

	Mary's Plan	John'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.

Plan Options

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

Participant Tiers

Participants will see three tiers within each plan. These tiers allow the retiree to select the coverage level appropriate to his or her circumstances. The tiers are:

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

Allowable Fee

The company's medical 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.

Coordination with Medicare

If you or your covered dependent are or become eligible for Medicare due to disability, Medicare will be primary and the company's plan secondary for you or your covered dependent's medical and pharmacy claims. This is important to consider when enrolling for coverage under the company's plan and Medicare. Additional information can be found in the Plan Document/Summary Plan Description (SPD) for the company's plan under the section entitled "Coordination with Medicare." To request a copy of the SPD, contact the Benefits department.

Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART	Premier $500 Plan	HSA-Qualified Plan (HSA Qualified)
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	$3,750/single $7,500/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
Preventive Care		
Well Child Care Routine immunizations up to 24 months of age	Deductible waived; subject to coinsurance	Deductible waived; subject to coinsurance
Adult Immunizations		
Influenza and Shingles	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
All other	Not covered	Not covered
Routine Physical Exam	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Preventive Mammogram Routine exam/lab charges	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
Preventive Pap Smear Routine exam/lab charges	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
Preventive Prostate Routine exam/lab charges	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
Preventive Colon Cancer		
Fecal Occult Blood Test	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Sigmoidoscopy	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Colonoscopy	Routine screening; subject to deductible & coinsurance	Routine screening; subject to deductible & coinsurance
Other Medical Care		
Chiropractic Benefits limited to 35 visits per year; $30 per treatment and $100 for x-rays per 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 (Retiree 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 year
Home Health Care	Subject to deductible & coinsurance	Subject to deductible & coinsurance

Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART (continued)				
	Premier $500 Plan			**HSA-Qualified Plan**
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
Prescription Drugs	**Retiree Co-Pay**			**Retiree Coinsurance**
Retail - 30 day supply	%	Min	Max	
Generic[4]	10%	$20	$200	Reimbursed at 80% after the Medical Deductible is met
Preferred Brand[5]	20%	$30	$200	
Non-Preferred Brand[6]	30%	$45	$200	
Retail - 90 day supply (maintenance drugs)				
Generic[4]	10%	$60	$600	Reimbursed at 80% after the Medical Deductible is met
Preferred Brand[5]	20%	$90	$600	
Non-Preferred Brand[6]	30%	$135	$600	
Mail Order - 90 day supply				
Generic	$30			Reimbursed at 80% after the Medical Deductible is met
Preferred Brand	$50			
Non-Preferred Brand	$80			
Rx Out-of-Pocket Max[7]	$750 per family member			Medical Out-of-Pocket Max

Notes and definitions:

1. **Deductible:** The amount of eligible expenses that a retiree 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 a retiree 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. **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.
5. **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 drug plan manager based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class.
6. **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 drug plan manager.
7. **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.

Dental Plan

Retiree Eligibility

A retiree is eligible to be covered under the plan as either a Participant or a Dependent.

Former employees whose employment terminated due solely to retirement are eligible to participate in the company's dental plan for early retirees, subject to the following eligibility requirements:

Montana Retirees

Termination Prior to January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 55 and 65; and
- Have completed at least 20 years of service with the company.

South Dakota/Nebraska Retirees

Termination Prior to November 1, 2009

Retirees who terminated employment prior to November 1, 2009 are not eligible to participate in the company's dental plan.

Termination on or after November 1, 2009 and before January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 55 and 65; and
- Have completed at least 20 years of service with the company.

Dependent Eligibility

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 for whom you have been appointed legal guardian by a court of competent jurisdiction prior to the child 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 nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

Dental Plan (continued)

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.

Coverage by More Than One Plan

When coverage is provided by more than one dental plan, the company will use the Maintenance of Benefits (MOB) method to determine which plan should pay first and how much each plan should pay.

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.

Plan Options

Eligible retirees have two options from which to choose. In addition, the benefits are provided through three coverage tiers:

- Single
- Two Party
- Family

Benefit Feature	Option I	Option II
Deductible[1]		
Per Person	$25	$25
Per Family	$75	$75
Coinsurance[2]	**Plan/Retiree**	**Plan/Retiree**
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 including oral exams, twice annual cleaning and X-rays, as well as topical fluoride once per year for those participants under age 19.
4. **Restorative:** Fillings for the treatment of decay.
5. **Other:** All other dental services such as periodontal treatment for diseases of the tissue surrounding the teeth, endodontic treatment of dental pulp and root canals, caps, crowns and prosthodontic for 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

Retiree Eligibility

A retiree is eligible to be covered under the plan as either a Participant or a Dependent.

Former employees whose employment terminated due solely to retirement are eligible to participate in the company's vision plan for early retirees, subject to the following eligibility requirements:

Montana Retirees

Termination Prior to January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 55 and 65; and
- Have completed at least 20 years of service with the company.

South Dakota/Nebraska Retirees

Termination Prior to November 1, 2009

Retirees who terminated employment prior to November 1, 2009 are not eligible to participate in the company's vision plan.

Termination on or after November 1, 2009 and before January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 55 and 65; and
- Have completed at least 20 years of service with the company.

Dependent Eligibility

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 for whom you have been appointed legal guardian by a court of competent jurisdiction prior to the child 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 nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.

Vision Plan (continued)

Plan

Vision Service Plan (VSP) is the administrator for the company's vision plan. Benefits are provided under the VSP Signature Plan. Information for VSP can be found in the resource section of this guide. The benefits will be provided through three coverage tiers:

• Single • Two Party • Family

Benefit	Coverage	
	VSP Provider[1]	**Non-VSP Provider**[2]
WellVision Exam *Every 12 months*	$20 co-pay	Up to $40
Prescription Glasses[3]	$20 co-pay	
Lenses *Every 12 months*	• Single vision, lenticular, lined bifocal and lined trifocal lenses • Standard progressive lenses (additional co-pay for premium or custom progressive lenses) • Polycarbonate lenses for dependent children	Single vision lenses - Up to $48 Lined bifocal lenses - Up to $60 Lined trifocal lenses - Up to $75 Lenticular lenses - Up to $160
Frames *Every 24 months*	Retail - Up to $130 Wholesale - Up to $70	Retail - Up to $64 Wholesale - N/A
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 a 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
Extra Discounts and Savings		
Glasses and Sunglasses	• 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	
Routine Retinal Screening	• No more than a $39 co-pay on routine retinal screening as an enhancement to a WellVision Exam	
Contacts	• 15% off cost of contact lens exam (fitting and evaluation)	
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any Member Provider	

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. A member will pay the provider and file a claim for reimbursement by sending VSP a copy of an itemized invoice along with the member'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 member's responsibility. VSP provides a discount on these additional costs of 20 percent.

Life Insurance Plan

Retiree Eligibility

Former employees whose employment terminated due solely to retirement are eligible to participate in the company's life insurance plan for early retirees, subject to the following eligibility requirements:

Montana Retirees

Termination Prior to January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Were between the ages of 50 and 65; and
- Had completed at least 5 years of service with the company.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 60 and 65; and
- Have completed at least 20 years of service with the company.

South Dakota/Nebraska Retirees

Termination Prior to January 1, 2011

Retirees who terminated employment prior to January 1, 2011 are not eligible to participate in the company's life insurance plan.

Termination on or after January 1, 2011

You are eligible to participate in the plan if, on your termination date, you:

- Are between the ages of 60 and 65; and
- Have completed at least 20 years of service with the company.

Dependent Eligibility

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.

Life Insurance Plan (cont.)

Life Insurance

If you are eligible, you can elect to continue coverage for yourself and your Dependents under the company's life insurance plan. You can elect the same amount of coverage in effect prior to your termination date or you can elect to decrease your coverage. You cannot increase your coverage.

The Plan Options Available to You Include the Following:

Basic Life Insurance

For You - You can elect basic term life insurance coverage equal to 1x your annual base pay in effect prior to your termination date or you can elect to drop your coverage.

For Your Spouse – If your Spouse was enrolled for basic term life insurance coverage of $10,000 prior to your termination date, you can elect to continue or drop his or her coverage.

Additional Life Insurance

For You – If you were enrolled for additional term life insurance coverage prior to your termination date, you can elect to continue, decrease or drop your coverage.

For Your Spouse – If your Spouse was enrolled for additional term life insurance coverage prior to your termination date, you can elect to continue, decrease or drop his or her coverage.

Dependent Child Life Insurance

If you were enrolled for child term life insurance coverage prior to your termination date, you can elect to continue or drop coverage.

Notes:

1. A retiree cannot purchase Spouse life coverage if his or her spouse is also an employee or a retiree of the company.
2. If a retiree is married to another employee or a retiree of the company, only one of them can elect Dependent Child Life coverage.

COBRA

COBRA in General

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

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?

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

Who is Entitled to COBRA Continuation Coverage?

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

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

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

- The parent-retiree dies;
- The parent-retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the plan as a "dependent child"; or
- Bankruptcy.

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

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

Are There Other Coverage Options besides COBRA Continuation Coverage?

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

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information:

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

HIPAA & General Notices

Health Insurance Portability and Accountability Act (HIPAA)

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

The company's Privacy Notice covers the medical, dental and vision plans. The Privacy Notice also identifies the Privacy Officer who handles any privacy-related complaints.

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

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

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

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

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

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

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

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

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 retiring 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 your eligible dependents for coverage if they lose coverage under another health plan. 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 your eligible dependents for coverage if either: (a) coverage under Medicaid or the Children's Health Insurance Program (CHIP) is lost because they are no longer eligible, or (b) they 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:

- Reduce your coverage if you lose a dependent spouse or child as a result of, divorce, or death. 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 Retirees under Age 65 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.

Medicare Creditable Coverage Notice (continued)

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**.

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 company's plan changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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 or Local: (406) 437-7043 Fax (claims): (855) 831-3249	www.bcbsmt.com
Delta Dental	Dental	(800) 521-2651	www.deltadentalins.com
Vision Service Plan	Vision	(800) 877-7195	www.vsp.com
Express Scripts, Inc.	Prescription Drug Program	(866) 892-0071	www.express-scripts.com
Benefits Department	General Benefits	**(888) 236-6656**	benefits@northwestern.com
Retiree website	General Benefits		http://retirees.northwesternenergy.com
Lincoln Financial Group	Life Insurance	(888) 787-2129	GroupLifeClaims@lfg.com

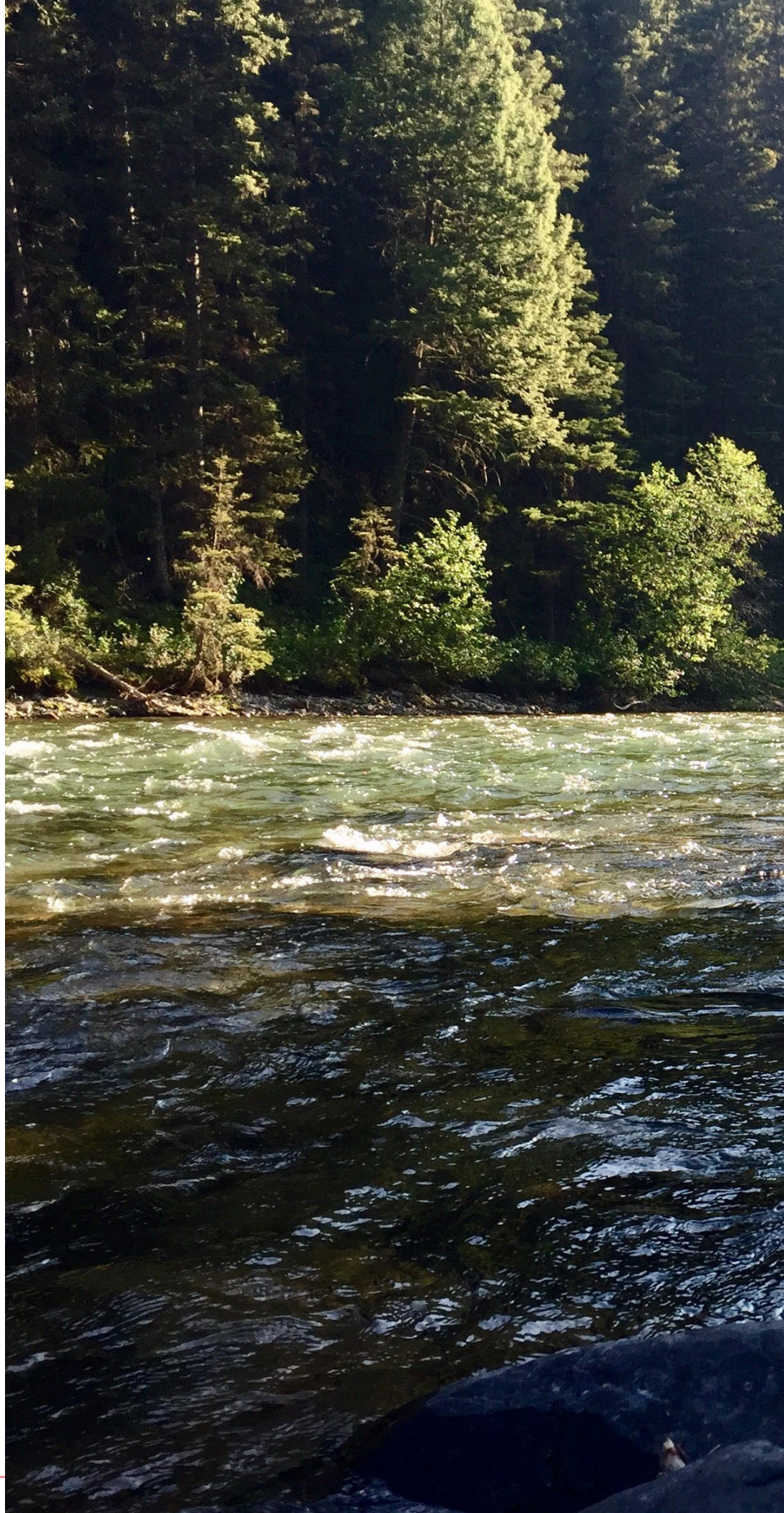
Resource	Phone Number	Web Address/E-mail
Centers for Disease Control and Prevention	(800) 232-4636	www.cdc.gov
American Heart Association	(800) 242-8721	www.heart.org
American Cancer Society	(800) 227-2345	www.cancer.org
Diabetes Association	(800) 342-2383	www.diabetes.org
General Medical Topics		www.webmd.com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

This booklet is intended to help retirees 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

Additional Notes



NorthWestern® Energy

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