NorthWestern® Energy

Plan Document/Summary Plan Description

HEALTH BENEFIT PLAN

Retirees under Age 65
Medical and Dental

Effective May 1, 2020

BlueCross BlueShield of Montana

FOR CUSTOMER SERVICE
Medical - BCBSMT: (855) 258-3489
Pharmacy – Express Scripts: (866) 892-0071
Dental - Delta Dental: (800) 521-2651

FOR ELIGIBILITY
Medical - BCBSMT: (855) 258-3489
Pharmacy - Express Scripts: (866) 892-0071
Dental - Delta Dental: (800) 521-2651

FOR HOSPITAL ADMISSION CERTIFICATION AND PREAUTHORIZATION
(800) 447-7828
www.bcbsmt.com

- BCBSMT Provider Directory
- Customer Service
- Other Online Services and Information

BLUECARD® NATIONWIDE/WORLD WIDE COVERAGE PROGRAM
(800) 810-BLUE (2583) – http://provider.bcbs.com

FOR MEDICAL CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 7982
Helena, MT 59604-7982
Fax: (855) 831-3249

FOR MEDICAL APPEALS
Refer to “Medical and Prescription Drug Benefit Review and Appeal” section of this Plan.

FOR DENTAL CLAIMS, PROVIDER INFORMATION AND APPEALS
Delta Dental Insurance Company
PO Box 1809
Alpharetta, GA 30023
www.deltadentalins.com

FOR PRESCRIPTION DRUG REVIEW AND APPEALS
Refer to “Medical and Prescription Drug Benefit Review and Appeal” section of this Plan.

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager:	Express Scripts Phone: (866) 892-0071 www.express-scripts.com
Specialty Drug Pharmacy:	Accredo® Phone: (877) 222-7336 www.accredo.com
Mail Order Services:	Express Scripts Mail Pharmacy Service PO Box 66567 St. Louis, MO 63166-6567 Phone: (800) 698-3757 Fax: (800) 988-4106
Prior Authorization:	www.express-scripts.com/PA

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

COVER/SIGNATURE PAGE

Effective May 1, 2020, NorthWestern Corporation dba NorthWestern Energy restates its self-funded **HEALTH BENEFIT PLAN FOR RETIREES UNDER AGE 65 OF NORTHWESTERN CORPORATION DBA NORTHWESTERN ENERGY** ("Plan").

The purpose of this Plan is to provide reimbursement for Covered Medical Expenses, Covered Prescription Drug Products and Covered Dental Expenses of the Company's eligible Retirees and their eligible Dependents.

The Company has caused this instrument to be effective May 1, 2020 and executed as of the date of signature.

NORTHWESTERN CORPORATION DBA NORTHWESTERN ENERGY

BY: _____
Crystal Lail

TITLE: VP & CHIEF ACCOUNTING OFFICER

DATE: June 2, 2020

GRANDFATHERED PLAN UNDER AFFORDABLE CARE ACT

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

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

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INTRODUCTION

Effective May 1, 2020, NorthWestern Corporation dba NorthWestern Energy, hereinafter referred to as "NWE", the "Company" or "Employer", reinstates the benefits, rights and privileges which will pertain to participating Retirees and their eligible Dependents, as defined in the Plan. The Plan is a component of the NorthWestern Energy Flexible Compensation Plan. The Plan described in this summary (referred to herein as the "Plan Document") pertains to benefits in effect as of May 1, 2020.

Coverage provided under the Plan for Retirees and their Dependents will be in accordance with the Eligibility, Effective Date of Coverage, Qualified Medical Child Support Order, Termination, and other applicable provisions as stated in this Plan and the NorthWestern Energy Flexible Compensation Plan. Except as otherwise expressly set forth in this Plan Document, in the event of a conflict between the terms of the Plan and those of the NorthWestern Energy Flexible Compensation Plan, the terms of the NorthWestern Energy Flexible Compensation Plan, shall control.

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

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

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

The Claim Administrator for the medical benefits provided under the Plan is:

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

The Claim Administrator for dental benefits provided under the Plan is:

Delta Dental Insurance Company
PO Box 1809
Alpharetta, GA 30023
(800) 521-2651

The Pharmacy Benefit Manager for prescription drug benefits provided under the Plan is:

Express Scripts
1 Express Way
St. Louis, MO 63121
(866) 892-0071
Normal Business Hours: 8 a.m.-5 p.m. (Eastern), Monday through Friday, excluding holidays

After you have reviewed this document, if you have questions, please contact the NWE Benefits department at (888) 236-6656.

MEDICAL PLAN OPTIONS

The Company makes two self-funded medical plan options available to its Retirees who become Participants of this Plan. The chart below describes the plan options available and the cost sharing provisions for each plan option.

All options provide coverage for the same Covered Medical Expenses

THE BENEFIT PERIOD IS A CALENDAR YEAR

RETIREE UNDER 65 PLAN		
Cost Sharing Provision	**PREMIER PLAN**	**HSA-QUALIFIED PLAN**
Deductible per Benefit Period	$500 Per Covered Person $1,000 Per Family	$1,500 Single Coverage Deductible[2] $3,000 Family Coverage Deductible[3]
Benefit Percentage	80%	80%
Out-of-Pocket Maximum Per Benefit Period	$2,000 Per Covered Person[1] $4,000 Per Family[1]	$3,750 Single Coverage Out-of-Pocket Maximum[1] $7,500 Family Coverage Out-of-Pocket Maximum[1 & 4]
[1]The Out-of-Pocket Maximum includes the Deductible [2]Single Coverage applies when only the Retiree or the Retiree's Dependent is covered under the Plan. [3]Family Coverage applies when the Retiree and one or more Dependent(s) are covered under the Plan. The entire Family Coverage Deductible must be satisfied before Covered Medical Expenses are paid at 80% on any one Family member. [4]The entire Family Out-of-Pocket Maximum amount must be satisfied before Covered Medical Expenses are paid at 100% on any one Family member.		
Overall Lifetime Maximum Benefits	None. Limits apply to the amount that may be paid for certain non-essential items and services as described in this Plan Document, but there is no overall limit on the amount of benefits that may be paid under the Plan.	

SCHEDULE OF MEDICAL BENEFITS – PREMIER PLAN
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITATIONS AND THE ALLOWABLE FEE OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

GENERAL MEDICAL EXPENSES

The Deductible and Benefit Percentage apply according to the Medical Plan Option selected by the Participant, unless specifically stated otherwise.

Plan Option Benefit Percentage in excess of the Deductible
Before satisfaction of Out-of-Pocket Maximum ..... Applies
After satisfaction of Out-of-Pocket Maximum 100%

CHIROPRACTIC CARE
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies
Maximum Number of Treatments per Benefit Period 35
Maximum Benefit per treatment $30
Maximum Benefit for Diagnostic X-rays per Benefit Period $100

"Treatment" includes all services provided during a calendar day, except for X-rays

INPATIENT NEWBORN NURSERY/PHYSICIAN CARE
(Birth through 4 days old)
Plan Option Deductible ..... Waived
Plan Option Benefit Percentage 100%

INPATIENT NEWBORN NURSERY/PHYSICIAN CARE
(5 days old through 31 days old)
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

OUTPATIENT WELL-CHILD CARE (up through 24 months of age)
Plan Option Deductible ..... Waived
Plan Option Benefit Percentage ..... Applies

PREVENTIVE CARE (Influenza vaccine, shingles vaccine, routine gynecological, prostate and mammogram office visit and associated laboratory charges)
Plan Option Deductible..... Waived
Plan Option Benefit Percentage 100%

Other than stated above:

a. **Office visit charges for a routine examination and any associated routine laboratory or miscellaneous testing provided or ordered at the time of the routine examination are eligible under the Medical Benefits, subject to Deductible and Benefit Percentage.**

b. **Adult immunizations are not covered.**

SCREENING COLONOSCOPY
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

HEARING AIDS

Plan Option Deductible ..... Waived
Plan Option Benefit Percentage 50%
Maximum Benefit per 5 year Period for each ear $500

Coverage does not include maintenance or repairs or coverage for Dependents.

HEARING EXAM (Medically Necessary and ordered by a Physician)

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

Coverage does not include routine hearing examinations and tests.

FIRST SCREENING ULTRASOUND (Pregnancy)

Plan Option Deductible ..... Waived
Plan Option Benefit Percentage 100%
Maximum Benefit ..... One (1) per Pregnancy

The Plan Option Deductible and Benefit Percentage will apply to all other ultrasounds for pregnancy.

MENTAL ILLNESS, AND/OR SUBSTANCE USE DISORDER

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

INPATIENT/OUTPATIENT REHABILITATION THERAPY

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

HOME HEALTH CARE

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

INSULIN PUMP SUPPLIES

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

DIABETES SELF MANAGEMENT

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies
Maximum Per Benefit Period $250

TELEHEALTH

Effective beginning March 18, 2020 and ending on the last day of the public health emergency declared by the Department of Health and Human Services with respect to COVID-19.

Plan Option Deductible..... Applies
Plan Option Benefit Percentage..... Applies

Benefits for services provided by Telehealth when such services are Medically Necessary Covered Medical Expenses provided by a Covered Provider.

COVID-19 TESTING

Effective beginning March 18, 2020 and ending on the last day of the public health emergency declared by the Department of Health and Human Services with respect to COVID-19.

Plan Option Deductible..... Waived
Plan Option Benefit Percentage..... 100%

COVID-19 testing includes the diagnostic testing as well as all items and services furnished to a Participant during a health care provider office visit (which for this purpose includes in-person visits and Telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of the diagnostic testing, but only to the extent such items and services relate to the furnishing or administration of such testing or to the evaluation of such Participant for purposes of determining the need of such Participant for such testing.

COVID-19 TREATMENT

Effective beginning March 18, 2020 and ending on the last day of the public health emergency declared by the Department of Health and Human Services with respect to COVID-19.

Plan Option Deductible……Applies
Plan Option Benefit Percentage……..Applies

ORGAN AND TISSUE TRANSPLANT SERVICES

Center of Excellence Facility

Plan Option Deductible ..... Waived
Plan Option Benefit Percentage 100%

Facility other than a Center of Excellence

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

Maximum Benefit per Procedure, if performed at facility other than Center of Excellence:

Allogenic Stem Cell (related)	$250,000
Allogenic Stem Cell (unrelated)	$340,000
Autologous Stem Cell	$140,000
Stem Cell Other	$230,000
Heart	$275,000
Heart Lung	$345,000
Intestine	$485,000
Kidney	$95,000
Kidney Pancreas	$160,000
Liver	$220,000
Lung	$275,000
Pancreas	$140,000
Solid Other	$440,000
Other Eligible Transplant or Replacement Procedure	$75,000

Services subject to the maximums per procedure include, but are not limited to evaluation; pre-transplant, transplant and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. *Charges incurred after such 12-month period are eligible under the Medical Benefits of the Plan and do not accrue toward the maximums.*

Amounts exceeding the maximum case rate at contracted Centers of Excellence (also known as outliers) will be eligible for reimbursement under Medical benefits. Excess charges at non-contracted facilities will not be eligible for reimbursement.

NON-AMBULANCE TRAVEL BENEFIT

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

For the patient and one companion, **limited to travel to a contracted Center of Excellence,** if treatment at a contracted Center of Excellence is more cost effective than the same treatment if received from other providers. Benefits are payable up to $5,000 Maximum Lifetime Benefit, limited

to the following:

Coach airfare.
If driving, IRS standard medical mileage rate reimbursement.
Meals limited to $40 per day per person.
Lodging, not to exceed $125 per day.

SCHEDULE OF MEDICAL BENEFITS – HSA-QUALIFIED PLAN
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITATIONS AND THE ALLOWABLE FEE OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

GENERAL MEDICAL EXPENSES

The Deductible and Benefit Percentage apply according to the Medical Plan Option selected by the Participant, unless specifically stated otherwise.

Plan Option Benefit Percentage in excess of the Deductible
Before satisfaction of Out-of-Pocket Maximum ..... Applies
After satisfaction of Out-of-Pocket Maximum 100%

CHIROPRACTIC CARE
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies
Maximum Number of Treatments per Benefit Period 35
Maximum Benefit per treatment $30
Maximum Benefit for Diagnostic X-rays per Benefit Period $100

"Treatment" includes all services provided during a calendar day, except for X-rays

ROUTINE INPATIENT NEWBORN NURSERY/PHYSICIAN CARE
(Birth through 4 days old)
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

INPATIENT NEWBORN NURSERY/PHYSICIAN CARE
(5 days old through 31 days old)
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

OUTPATIENT WELL-CHILD CARE (up through 24 months of age)
Plan Option Deductible ..... Waived
Plan Option Benefit Percentage ..... Applies

PREVENTIVE CARE (Influenza vaccine, shingles vaccine, routine gynecological, prostate and mammogram office visit and associated laboratory charges)
Plan Option Deductible ..... Waived
Plan Option Benefit Percentage 100%

Other than stated above:

a. **Office visit charges for a routine examination and any associated routine laboratory or miscellaneous testing provided or ordered at the time of the routine examination are eligible under the Medical Benefits, subject to Deductible and Benefit Percentage.**

b. **Adult immunizations are not covered.**

SCREENING COLONOSCOPY
Plan Option Deductible ..... Applies
Plan Option Benefit Percentage ..... Applies

HEARING AIDS

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... 50%
Maximum Benefit per 5 year Period for each ear $500

Coverage does not include maintenance or repairs or coverage for Dependents.

HEARING EXAM (Medically Necessary and ordered by a Physician)

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... Applies

Coverage does not include routine hearing examinations and tests.

FIRST SCREENING ULTRASOUND (Pregnancy)

Plan Option Deductible ..... Waived
Plan Option Benefit Percentage..... 100%
Maximum Benefit..... One (1) per Pregnancy

The Plan Option Deductible and Benefit Percentage will apply to all other ultrasounds for pregnancy.

MENTAL ILLNESS AND/OR SUBSTANCE USE DISORDER

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... Applies

INPATIENT/OUTPATIENT REHABILITATION THERAPY

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... Applies

HOME HEALTH CARE

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... Applies

INSULIN PUMP SUPPLIES

Plan Option Deductible ..... Waived
Plan Option Benefit Percentage..... Applies

DIABETES SELF MANAGEMENT

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... Applies
Maximum Per Benefit Period $250

TELEHEALTH

Effective beginning March 18, 2020 and ending on the last day of the public health emergency declared by the Department of Health and Human Services with respect to COVID-19.

Plan Option Deductible……..……...Applies
Plan Option Benefit Percentage.....Applies

Benefits for services provided by Telehealth when such services are Medically Necessary Covered Medical Expenses provided by a Covered Provider.

COVID-19 TESTING

Effective beginning March 18, 2020 and ending on the last day of the public health emergency declared by the Department of Health and Human Services with respect to COVID-19.

Plan Option Deductible……..……Waived
Plan Option Benefit Percentage.....100%

COVID-19 testing includes the diagnostic testing as well as all items and services furnished to a Participant during a health care provider office visit (which for this purpose includes in-person visits and Telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of the diagnostic testing, but only to the extent such items and services relate to the furnishing or administration of such testing or to the evaluation of such Participant for purposes of determining the need of such Participant for such testing.

COVID-19 TREATMENT

Effective beginning March 18, 2020 and ending on the last day of the public health emergency declared by the Department of Health and Human Services with respect to COVID-19.

Plan Option Deductible……Applies
Plan Option Benefit Percentage……..Applies

ORGAN AND TISSUE TRANSPLANT SERVICES

Center of Excellence Facility

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... 100%

Facility other than a Center of Excellence

Plan Option Deductible ..... Applies
Plan Option Benefit Percentage..... Applies

Maximum Benefit per Procedure, if performed at facility other than Center of Excellence:

Allogenic Stem Cell (related) $250,000
Allogenic Stem Cell (unrelated) $340,000
Autologous Stem Cell $140,000
Stem Cell Other $230,000
Heart $275,000
Heart Lung $345,000
Intestine $485,000
Kidney $95,000
Kidney Pancreas..... $160,000
Liver $220,000
Lung $275,000
Pancreas..... $140,000
Solid Other..... $440,000
Other Eligible Transplant or Replacement Procedure $75,000

Services subject to the maximums per procedure include, but are not limited to evaluation; pre-transplant, transplant and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. *Charges incurred after such 12-month period are eligible under the Medical benefits of the Plan and do not accrue toward the maximums.*

Amounts exceeding the maximum case rate at contracted Centers of Excellence (also known as outliers) will be eligible for reimbursement under the Medical benefits. Excess charges at non-contracted facilities will not be eligible for reimbursement.

NON-AMBULANCE TRAVEL BENEFIT

Plan Option Deductible .....Applies
Plan Option Benefit Percentage.....Applies

For the patient and one companion, **limited to travel to a contracted Center of Excellence,** if treatment at a contracted Center of Excellence is more cost effective than the same treatment if

received from other providers. Benefits are payable up to $5,000 Maximum Lifetime Benefit, limited to the following:

Coach airfare.
If driving, IRS standard medical mileage rate reimbursement.
Meals limited to $40 per day per person.
Lodging not to exceed $125 per day

SCHEDULE OF DENTAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITATIONS OF THE PLAN AND THE CONTRACT ALLOWANCE OF THE PLAN.

Dental benefits are provided for the Company's Eligible Retirees and their Dependents. **South Dakota and Nebraska Retirees or their Dependents who retired prior to November 1, 2009 are not eligible for Dental benefits.** Dental benefits are administered by Delta Dental Insurance Company.

THE BENEFIT PERIOD IS A CALENDAR YEAR

The Deductible and Benefit Percentage apply according to the Plan Option selected by the Participant

FEATURE	**OPTION 1** Benefit Percentage	**OPTION 2** Benefit Percentage
Deductible Per Person Per Family	 $25 $75	 $25 $75
Yearly Maximum Per Person Applies to all Dental charges except Orthodontic Treatment and Implantology.	$2,000	$1,000
Preventive Oral Exam, including scaling and cleaning of teeth. Benefits limited to two (2) regular cleanings and four (4) periodontal cleanings per Benefit Period. Periodontal deep cleaning (CDT 4355) is limited to once every twenty four (24) months and does not apply to the limit of four (4) periodontal cleanings. Topical application of fluoride under age 19, but not more than once in any Benefit Period.	100%	100%
Diagnostic Dental x-rays, but not more than one full mouth x-ray or series in any three (3) Benefit Periods and not more than two (2) sets of supplementary bitewing x-rays in any Benefit Period. Does not include cephalometric x-rays for Orthodontic Treatment.	100%	100%
Sealants Plastic coating tooth sealants for Dependents under age 16 but not more than one treatment per permanent tooth per lifetime.	100%	100%
Space maintainers, not including orthodontics	100%	100%
Oral Surgery Removal of impacted teeth	80%	50%
Extractions, Removal of teeth	80%	50%

FEATURE	OPTION 1 Benefit Percentage	OPTION 2 Benefit Percentage
Anesthesia General Anesthesia, I.V. Sedation and Nitrous Oxide: When administered by a Dentist for covered oral surgery, implants or selected endodontic and periodontal surgical procedures.	80%	50%
Injection of Antibiotic drugs	80%	50%
Palliative Emergency Treatment or Care for Dental Pain	80%	50%
Crowns Includes gold, jackets, inlays and porcelain	80%	50%
Periodontics Prophylaxis and Treatment, including periodontal surgery, of diseases of tissues around the teeth	80%	50%
Endodontics Treatment of the dental pulp, including root canal therapy	80%	50%
Prosthodontics* *Includes the following services: Gold fillings, inlays, onlays or crowns, including precision attachments for dentures. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more extracted natural teeth. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more extracted natural teeth. Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures not more frequently than once in every two (2) Benefit Periods. Implantology for non-endentulous mouth limited to the amount the Plan would pay for a comparable Bridge. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture once every five (5) years. See the “Prosthesis Replacement Rule.” Replacement of an existing partial denture or fixed bridgework by new fixed bridgework, or the addition of teeth to an existing fixed bridgework once every five (5) years. See the “Prosthesis Replacement Rule.”	80%	50%

FEATURE	OPTION 1 Benefit Percentage	OPTION 2 Benefit Percentage
Implants (for Edentulous mouth only) Device surgically inserted into jawbone as support for a crown, or as an abutment for a fixed bridge. Predetermination is strongly recommended for implants for Edentulous Mouth. For purposes of this section, "Edentulous Mouth" means that the Covered Person either has no remaining teeth, and because of lack of bone structure, it is dentally not possible to use dentures, or that the tooth or teeth remaining are insufficient to use as attachments for prosthodontics (bridges, crowns, etc.)		
Lifetime Out-of-Pocket Maximum	$4,000	$4,000
Before satisfaction of Maximum Lifetime Out-of-Pocket Maximum	80%	50%
After satisfaction of Maximum Lifetime Out-of-Pocket Maximum up to Lifetime Maximum Benefit*	100%	100%
"Lifetime Out-of-Pocket Maximum" is the maximum dollar amount that any Covered Person will pay for Covered Dental Expenses for Implants while the Covered Person is covered under this Plan. The Lifetime Out-of-Pocket Maximum includes amounts in excess of the Benefit Percentage paid by the Plan.		
TMJ Non-surgical splint therapy for TMJ disorder. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.	80% up to the Lifetime Maximum Benefit*	50% up to the Lifetime Maximum Benefit*
Orthodontic Treatment Benefit Covered Dental Expense is the Benefit Percentage Shown of the allowable charge for Dentally Necessary services, supplies, and appliances for straightening irregularly spaced teeth.	60% up to the Lifetime Maximum Benefit*	50% up to the Lifetime Maximum Benefit*
***Lifetime Maximum Benefit (per person)**		
For implants (Edentulous mouth only)	$31,000	$31,000
For TMJ splint therapy	$1,000	$1,000
For Orthodontia	$2,000	$2,000

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program benefit is for Prescription Drug Products which are self-administered. This benefit does not include medications which are administered by a Covered Provider. If a medication is administered by a Covered Provider, the claim will process under the Participant's Medical benefits.

Subject to the terms, conditions, and limitations of this Plan Document, the Plan will pay for Prescription Drug Products, which:

1. Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;

2. Require a Physician's written prescription; and

3. Are dispensed under federal or state law pursuant to a prescription order or refill.

COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of purchase, as specifically stated below. Copayments are not payable by the Plan. Copayments made under the Premier plan **do not serve to satisfy** the Medical Benefits Deductible or the Out-of-Pocket Maximum. Copayments made under the HSA-Qualified Health Plan and the Standard Plan **do serve to satisfy** the Medical Benefits Deductible and the Out-of-Pocket Maximum.

COPAYMENT ASSISTANCE

The financial assistance received by a Covered Person from a prescription drug manufacturer and/or foundational program to assist the Covered Person with their Copayment costs for a Specialty Medication may not be applied to their medical or pharmacy benefit Deductible and Out-of-Pocket Maximum.

RETAIL AND MAIL ORDER PHARMACY OUT-OF-POCKET MAXIMUM

The Retail and Mail Order Pharmacy Out-of-Pocket Maximum applies to Retail and Mail Order Pharmacy and includes Retail and Mail Order Pharmacy Copayment amounts, which will accrue toward the Retail and Mail Order Pharmacy Out-of-Pocket Maximum. After satisfaction of the Retail and Mail Order Pharmacy Out-of-Pocket Maximum during any Benefit Period, the Copayment for eligible Retail and Mail Order Pharmacy charges will be waived and charges will be paid at 100% for the remainder of the Benefit Period.

EXTENDED SUPPLY NETWORK

The Extended Supply Network are retail Participating Pharmacies that provide the convenience of obtaining a 90 day supply of a prescribed maintenance medication. Information regarding Participating Pharmacies can be found on the Express Scripts website at www.express-scripts.com.

RETIREES UNDER AGE 65				
	PREMIER PLAN			HSA-QUALIFIED HEALTH PLAN
Retail Pharmacy				
(30 day supply)	**Copayment**	**Minimum**	**Maximum**	**Copayment**
Generic	10%	$20	$200	100% until Medical Benefits Deductible is met, then 20%
Preferred Brand	20%	$30	$200	
Non Preferred Brand	30%	$45	$200	
Extended Supply Network				
(90 day supply)	**Copayment**	**Minimum**	**Maximum**	**Copayment**
Generic	10%	$60	$600	100% until Medical Benefits Deductible is met, then 20%0%
Preferred Brand	20%	$90	$600	
Non-Preferred Brand	30%	$135	$600	
Mail Order				
(90 day supply)	**Copayment**			**Copayment**
Generic	$30			100% until Medical Benefits Deductible is met, then 20%0%
Preferred Brand	$50			
Non Preferred Brand	$80			
Retail and Mail Order Pharmacy Out-of-Pocket Maximum	$750 per person			Medical Benefits Out-of-Pocket Maximum

Diabetic insulin will have a Copayment of $25 and diabetic supplies will have a Copayment of $0 when filled at a **mail order pharmacy only.**

COVERED PRESCRIPTION DRUG PRODUCTS

The following Prescription Drugs Products, obtained from a Participating Pharmacy, either retail or mail order, or a retail nonparticipating pharmacy, are covered:

1. Legend drugs - drugs requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury.
2. Compounded medication of which at least one ingredient is a covered drug. The national drug code (NDC) number must be provided for reimbursement.
3. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration.
4. Insulin on prescription.
5. Disposable insulin needles/syringes.
6. Devices for self-monitoring of glucose levels (including those for the visually impaired).
7. Test strips.
8. Lancets.
9. Oral contraceptives, contraceptive devices or injections prescribed by a Physician.
10. Insulin pump supplies which include insulin administration supplies, insulin infusion pump supplies, IV sets/tubing and subcutaneous administration supplies billed by a participating provider with the Plan's Pharmacy Benefit Manager.
11. Vitamins.
12. Smoking deterrent drugs or aids.

The Schedule of Benefits lists the payment limitations for these Prescription Drug Products.

NON-COVERED PRESCRIPTION DRUG PRODUCTS

The Plan will not pay for:

1. Nonlegend drugs other than insulin.
2. Anabolic Steroids.
3. Any drug used for the purpose of weight loss.
4. Over-the-counter drugs that do not require a prescription.
5. Prescription Drug Products for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).
6. Prescription Drug Products used for erectile dysfunction. Certain drugs used for erectile dysfunction may be covered, if Medically Necessary and if the Participant receives Prior Authorization.
7. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section.
8. Insulin pumps. Insulin pumps are covered under the Durable Medical Equipment Benefit.
9. Drugs or items labeled "Caution - limited by federal law to investigational use," or Experimental drugs, even though the Participant is charged for the item.
10. Biological sera, blood, or blood plasma.
11. Prescription Drug Products which are to be taken by or administered to the Participant, in whole or in part, while the Participant is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge.
12. Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
13. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage.
14. Prescription products obtained from a pharmacy located outside the United States for consumption within the United States.
15. Prescription Drug Products provided by a mail-order pharmacy that is not approved by the Plan.
16. Prescribed (brand or generic) non-sedating antihistamine drug products used in the treatment of histamine-mediated allergic conditions.
17. Prescribed brand proton pump inhibitor drug products and select combinations used in the treatment of gastric acid-related conditions. However, for children less than age 12, brand name PPI's delivered in specialty formulations may be eligible for coverage under the non-preferred brand coverage tier. This may include sprinkles, solutabs and granules **with no generic equivalents.**

PURCHASE AND PAYMENT OF PRESCRIPTION DRUG PRODUCTS

Prescription Drug Products may be obtained using an Outpatient pharmacy, an Extended Supply pharmacy or a mail order pharmacy approved by the Plan. To use a mail-order pharmacy, the Participant must send an order form and the prescription to the address listed on the mail-order service form and pay the required Copayment. The address of the mail order pharmacy approved by the Plan is listed on the inside cover of this Plan Document.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an Extended Supply pharmacy or a mail order pharmacy approved by the Plan, and the Participant presents the Participant's ID card at the time of purchase, the Participant must pay the required Copayment.

If the Participant uses a Participating Pharmacy to fill a prescription, but elects to submit the claim directly to the Plan's Pharmacy Benefit Manager, instead of having the Participating Pharmacy submit the claim, the Participant will be reimbursed for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less the Participant's Copayment amount.

If drugs or Prescription Drug Products are purchased at a nonparticipating Outpatient pharmacy, the Participant must pay for the prescription at the time of dispensing and then file a prescription drug claim form with the Plan's Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed for the prescription drug based on the amount that would have been paid to a Participating Pharmacy, less the Participant's Copayment amount.

If the Participant chooses a Brand-Name Drug when a Generic Drug is available, the Participant must pay the Generic Drug Copayment amount plus the difference in cost between the Brand-Name Drug and the Generic Drug equivalent. The amount the Participant pays for the difference between a Brand-Name Drug and the Generic Drug equivalent does not apply to the Out-of-Pocket Maximum.

The Participant may not be required to pay the difference between the Brand-Name Drug and the Generic Drug equivalent if it is determined through the Plan's appeal process that there is a medical reason the Participant needs to take the Brand-Name Drug and certain criteria is met. The Brand-Name Copayment amount will still apply.

See **"Medical and Prescription Drug Benefit Complaints and Grievances"** regarding the Plan's appeal process.

PRESCRIPTION DRUG PRODUCTS SUBJECT TO PRIOR AUTHORIZATION, STEP THERAPY OR QUANTITY LIMITS

1. Prescription Drug Products subject to Prior Authorization require prior approval from the Plan's Pharmacy Benefit Manager before they can qualify for coverage under the Plan. If the Participant does not obtain Prior Authorization before a Prescription Drug Product is dispensed, the Participant may pay for the prescription and then pursue authorization of the drug from the Plan's Pharmacy Benefit Manager. If the authorization is approved by the Plan's Pharmacy Benefit Manager, the Participant should then submit a claim for the prescription drug on a prescription claim form to the Plan's Pharmacy Benefit Manager for reimbursement.

2. Prior Authorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the prescription drug has been Prior Authorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date the drug is dispensed or the Participant's benefits may have changed as of the date the drug is dispensed.

3. A step therapy program is designed to help the Participant use the lowest cost product(s) within a drug class. Drugs subject to step therapy are widely considered equivalent to other products within the class by both physicians and pharmacists. In order to obtain a medication within a step therapy program, the Participant must fail a first line drug. In general, first line products are usually generic medications. In some cases, a pharmacy policy will allow the step therapy to be waived. The pharmacy policies are located on the Express Scripts website at www.express-scripts.com.

4. A quantity limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period. Quantity limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, appropriate utilization, and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a Prior Authorization before benefits are available.

5. Current information about Prescription Drug Products that are subject to Prior Authorization, step therapy, or quantity limits can be found on the Express Scripts website at www.express-scripts.com. The Participant or provider may also contact Express Scripts on their customer service number listed on the inside cover of this Plan Document to verify the most current list of Prescription Drug Products that are subject to Prior Authorization, step therapy, or quantity limits.

6. If the provider is prescribing a prescription drug subject to Prior Authorization, step therapy, or quantity limits, the Participant should ask the provider to submit a request electronically for an initial coverage review to the Plan's Pharmacy Benefit Manager. Information about electronic options can be found at www.express-scripts.com/PA

7. In making determinations of coverage, the Plan's Pharmacy Benefit Manager may rely upon pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in the United States, Pharmacy Benefit Manager evaluations, and Medical Necessity. The pharmacy policies can be found on the Express Scripts website at www.express-scripts.com.

SPECIALTY MEDICATIONS

1. Specialty Medications are generally prescribed for individuals with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These high cost medications also have one or more of the following characteristics:

   A. Injected or infused, but some may be taken by mouth

   B. Unique storage or shipment requirements

   C. Additional education and support required from a health care professional

   D. Usually not stocked at retail pharmacies

2. Specialty Medications must be acquired through the Plan's contracted Specialty Pharmacy listed on the inside cover of this Plan Document. Specialty Medications are limited to a 30 day supply and will have a 30 day Retail Copayment. A list of Specialty Medications can be found on the on the Plan's Specialty Pharmacy's website at www.accredo.com. Registration and other applicable forms are also located on the website.

PRESCRIPTION DRUGS AND CHANGES TO THE FORMULARY

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher Copayment. Collectively, these lists of drugs make up the Plan's Formulary. Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is (1) Medically Necessary and essential to the Covered Person's health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the Covered Person. If approved through that process, the applicable Formulary (Preferred Brand or Non-Preferred Brand) Copayment will apply. Without approval, the Covered Person will be required to pay the full cost of the excluded drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time. For example:

   A. A drug may be moved to a higher or lower cost-sharing Formulary tier.

   B. Additional drugs may be excluded from the Formulary.

C. A restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization).

D. A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

The Plan's Formulary is updated periodically and subject to change. A Covered Person should refer to the Formulary prior to purchasing a drug. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol of step therapy is followed first. As with all aspects of the Formulary, these requirements may also change from time to time. Details and information regarding the Formulary, drug exclusions, Prior Authorization and step therapy can found on the Express Scripts website at www.express-scripts.com.

MEDICAL PROVIDERS OF CARE FOR PARTICIPANTS

The participation or nonparticipation of providers from whom a Participant receives services, supplies, and medication impacts the amount the Plan will pay and the Participant's responsibility for payment.

PROFESSIONAL PROVIDERS AND FACILITY PROVIDERS

Professional providers and facility providers are either Participating Providers or nonparticipating providers.

Participating professional providers include, but are not limited to, Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, Advanced Practice Registered Nurses, physician assistants and physical therapists.

Participating facility providers include, but are not limited to, Hospitals, Rehabilitation Facilities, Home Health Agencies, Convalescent Homes, skilled nursing facilities, freestanding facilities for the treatment of Substance Use Disorder or Mental Illness, and freestanding surgical facilities (surgery center).

The Participant may obtain a list of Participating Providers from Blue Cross and Blue Shield of Montana free of charge by contacting the Plan at the number listed on the inside cover of this Plan Document.

HOW PROVIDERS ARE PAID BY THE CLAIM ADMINISTRATOR AND PARTICIPANT RESPONSIBILITY

Payment by the Claim Administrator for benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana network.

A **Participating Provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield of Montana for Covered Medical Expenses, together with any Deductible, Coinsurance and/or Copayments from the Participant, as payment in full. Generally, payment will be made directly to the Participating Provider. In any event, the Claim Administrator may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

Non-participating providers do not have to accept Blue Cross and Blue Shield of Montana payment as payment in full. Blue Cross and Blue Shield of Montana will reimburse a nonparticipating provider for Covered Medical Expenses according to the Allowable Fee. The nonparticipating provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible, Coinsurance and/or Copayments. The Participant will be responsible for the balance of the nonparticipating provider's charges after payment by Blue Cross and Blue Shield of Montana and payment of any Deductible, Coinsurance and/or Copayments.

The Plan will not pay for any services, supplies or medications which are not Covered Medical Expenses, or for which a benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Participant will be responsible for all charges for such services, supplies, or medications.

OUT-OF-AREA SERVICES – THE BLUECARD® PROGRAM

OUT-OF-AREA SERVICES

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Participant obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard® Program.

Typically, when accessing care outside the Blue Cross and Blue Shield of Montana service area, the Participant will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Participant may obtain care from non-participating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

1. **BlueCard® Program**

Under the BlueCard® Program, when a Participant incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

For inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the provider, and the Participant will be held harmless for the provider sanction.

Liability Calculation Method Per Claim

Whenever a Participant incurs Covered Medical Expenses outside the Blue Cross and Blue Shield of Montana service area and the claim is processed through the BlueCard® Program, the amount the Participant pays for Covered Medical Expenses is calculated based on the lower of:

1. The billed covered charges for the Participant's covered services; or
2. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Participant's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Participant's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation uses for the Participant's claim because they will not be applied retroactively to claims already paid.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal laws or laws in a small number of states may require the Host Blue to add a surcharge to the Participant's calculation. If any state law mandates other liability calculation methods, including

a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Participant's liability for any Covered Medical Expense according to applicable law.

Return of Overpayments

Recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will generally require correction on a claim-by-claim or prospective basis.

2. **Non-Participating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area**

a. Participant Liability Calculation

When a Participant incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by non-participating healthcare providers, the amount(s) the Participant pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payment for out-of-network emergency services.

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as (i) the provider's billed charges for Covered Medical Expenses, (ii) the payment Blue Cross and Blue Shield of Montana, would make if the Covered Medical Expenses had been received within the Blue Cross and Blue Shield of Montana service area, (iii) a special negotiated payment, or (iv) the lesser of any of the foregoing payment methods or the Allowable Fee determined for non-participating providers outside of Montana to pay for services provided by non-participating providers. In these situations, the Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

3. **Blue Cross Blue Shield Global Core**

If the Participant is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Participant may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Participant with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when the Participant receives care from providers outside the BlueCard service area, the Participant will typically have to pay the providers and submit the claims himself/herself to obtain reimbursement for these services. If the Participant needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Participant should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if the Participant contacts the service center for assistance, hospitals will not require the Participant to pay for covered Inpatient services, except for the cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit the Participant's claims to the service center to begin claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to receive reimbursement for Covered Medical Expenses.

  The Participant must contact Blue Cross and Blue Shield of Montana to obtain Preauthorization to verify that Inpatient services are for the treatment of a Medical Emergency.

- **Outpatient Services**

  Outpatient services are available for the treatment of a Medical Emergency. Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require the Participant to pay in full at the time of service. The Participant must submit a claim to obtain reimbursement for Covered Medical Expenses.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When the Participant pays for Covered Medical Expenses outside the BlueCard service area, the Participant must submit a claim to obtain reimbursement. For institutional and professional claims, the Participant should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Participant claim. The claim form is available from the Plan, service center or online at www.bcbsglobalcore.com. If the Participant needs assistance with the Participant claim submission, the Participant should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

MEDICAL BENEFITS

DEDUCTIBLE

1. **Premier Option:**

The Deductible applies to Covered Medical Expenses Incurred during each Benefit Period, unless specifically waived as stated in the Schedule of Medical Benefits, but it applies only once for each Covered Person within a Benefit Period. Also, if during a single Benefit Period members of a Family satisfy individual Deductible amounts that collectively equal the Family Deductible, no further Deductible will apply to any member of that Family during that Benefit Period. **A Covered Person cannot receive credit toward the Family Deductible for more than the individual annual Deductible amount, as stated in the Schedule of Medical Benefits.**

2. **HSA-Qualified Health Plan Option:**

The Single Coverage Deductible applies when only the Retiree or the Retiree's Dependent is covered under the Plan. The Family Coverage Deductible applies when the Retiree and one or more Dependents(s) are covered under the Plan.

The Single Coverage Deductible applies to Covered Medical Expenses Incurred during each Benefit Period. For single coverage, no further Deductible will apply to Covered Medical Expenses during that Benefit Period after the Single Coverage Deductible is satisfied.

The Family Coverage Deductible applies to Covered Medical Expenses Incurred during each Benefit Period for the members of a Family. After satisfaction of the Family Coverage Deductible, no further Deductible will apply to the Covered Medical Expenses for any member of that Family during that Benefit Period. No benefits will be payable to any Family member until satisfaction of the Family Coverage Deductible. **One or more Family members can individually or collectively satisfy the Family Coverage Deductible amount, as stated in the Schedule of Medical Benefits.**

BENEFIT PERCENTAGE

Covered Medical Expenses Incurred by a Covered Person will be paid by the Plan according to the applicable Benefit Percentage stated in the Schedule of Medical Benefits.

OUT-OF-POCKET MAXIMUM

1. **Premier Option:**

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts applied toward the Deductible and amounts in excess of the Benefit Percentage paid by the Plan. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, will be paid at 100% of the Maximum Covered Medical Expense for the remainder of the Benefit Period. **A Covered Person cannot receive credit toward the Family Out-of-Pocket Maximum amount for more than the individual annual Out-of-Pocket Maximum amount, as stated in the Schedule of Medical Benefits.**

2. **HSA-Qualified Health Plan Option:**

The Single Coverage Out-of-Pocket Maximum applies when only the Retiree or the Retiree's Dependent is covered under the Plan. The Family Coverage Out-of-Pocket Maximum applies when the Retiree and one or more Dependents(s) are covered under the Plan.

The Single Coverage Out-of-Pocket Maximum includes amounts applied toward the Deducible

and amounts in excess of the Benefit Percentage paid by the Plan. Expenses Incurred in a single Benefit Period after satisfaction of the Single Coverage Out-of-Pocket Maximum will be paid at 100% of the Maximum Covered Medical Expense for the remainder of the Benefit Period.

The Family Coverage Out-of-Pocket Maximum includes amounts applied toward the Deductible and amounts in excess of the Benefit Percentage paid by the Plan. After satisfaction of the Family Coverage Out-of-Pocket Maximum, expenses Incurred in a single Benefit Period for any member of that Family will be paid at 100% of the Maximum Covered Medical Expense for the remainder of the Benefit Period. **One or more members of a Family can individually or collectively satisfy the Family Coverage Out-of-Pocket Maximum amount, as stated in the Schedule of Medical Benefits.**

COVERED MEDICAL EXPENSES

Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

1. Covered under this Plan;
2. In accordance with Medical Policy; and
3. Provided to the Participant by and/or ordered by a Covered Provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

In order to be considered a Covered Medical Expense, the Participant must be charged for such services, supplies and medications.

Treatments, services or supplies excluded by this Plan may be reimbursable if the Plan Administrator approves such charges prior to beginning such treatment. Prior approval is limited to medically accepted treatments, services, or supplies, which, in the opinion of the Plan Administrator, (i) are not Experimental/Investigational/Unproven, (ii) are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and (iii) benefit the Covered Person.

MAXIMUM BENEFIT

The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

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

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan will become effective on the stated effective date of such change with regard to all Covered Persons to whom it applies, except a person who is on Family and Medical Leave Act leave (FMLA). The effective date of a change for a person on FMLA leave will be the day following the date he/she is no longer on FMLA leave, or the first day of the next Benefit Period following the change in coverage, whichever occurs first.

GENERAL COVERED SERVICES

Charges for services, treatments and supplies provided by a Covered Provider for the following are payable as stated in the Schedule of Medical Benefits, subject to all terms and conditions of this Plan:

1. Hospital:

   A. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit.

   B. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency or Medical Emergency only, Physical Therapy treatments, hemodialysis, and x-ray and linear therapy.

   C. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray and linear therapy, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent.

2. Charges made by an Ambulatory Surgical Center when treatment has been rendered.

   "Ambulatory Surgical Center" (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

   "Ambulatory Surgical Center" does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

3. Charges made by an Urgent Care Facility when treatment has been rendered.

   "Urgent Care Facility" means a freestanding facility that is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

4. Charges for services and supplies furnished by a Birthing Center.

5. Skilled Nursing Facility for the following services and supplies furnished by the facility during any one Convalescent Period. Only charges in connection with convalescence from the Illness or Injury for which the Covered Person was Hospital-confined will be eligible for benefits. These expenses include:

   A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

   B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.

   C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

6. Hospice services within any one Hospice Benefit Period for:

   A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

   B. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a public health nurse who is under the direct supervision of a Registered Nurse.

   C. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.

   D. Medical supplies, including drugs and self-administered injectables and the use of medical appliances.

   E. Physician's services.

   F. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

   G. Counseling and other support services provided to meet the physical, psychological, spiritual, and social needs of the terminally ill patient.

7. Services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

8. Drugs intended for use in a physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter, and which are not capable of self-administration by the covered person.

9. Pregnancy, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy. Coverage includes one (1) screening ultrasound per Pregnancy. Additional ultrasounds are subject to Medical Necessity.

10. Surgical Procedures.

    When two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

    A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Covered Medical Expense will be considered for the Major Procedure; and 50% of the Covered Medical Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.

    B. When an incidental procedure is performed through the same incision, only the Covered Medical Expense for the Major Procedure will be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

    When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 25% of the primary surgeon's Covered Medical Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services will be limited to 10% of the surgeon's Covered Medical Expense for the Surgical Procedure.

11. Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) for private duty nursing.

12. Charges for home infusion services ordered by a Physician and provided by a home infusion therapy organization licensed and approved within the state in which the services are provided. A home infusion therapy organization is a health care facility that provides home infusion therapy services and skilled nursing services. Home infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a home infusion therapy organization. Services also include education for the Covered Person, the Covered Person's caregiver, or a family member. Home infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a home infusion therapy organization.

    Skilled nursing services billed by a home health agency are covered under the Home Health Care Benefit.

13. Services of a licensed physical therapist. Physical Therapy must be ordered by a Physician and rendered by a licensed physical therapist.

14. Services of a licensed Occupational Therapist whose primary purpose is to provide medical care for an Illness or Injury. Occupational Therapy must be ordered by a Physician and rendered by a licensed occupational therapist.

15. Services of a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:

    A. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.

    B. Improvement would **not** normally be expected to occur without intervention.

    C. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.

    D. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all conditions are met.

    Speech therapy is not covered if:

    A. Treatment is rendered for stuttering; or

    B. Treatment is rendered for behavioral or learning disorders.

16. Ambulance Service to the nearest facility where Emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient's home when Medically Necessary.

17. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury.

    Conditions of coverage for Outpatient prescription drugs and supplies available through the Prescription Drug Program Benefit are as stated in the Prescription Drug Program Benefit section of the Plan. **Prescription drugs for self-administration by the Covered Person must be obtained through the Plan's Prescription Drug Program Benefit to be covered.**

18. X-rays, CAT scans, MRIs, microscopic tests, and laboratory tests.

19. Radiation therapy or treatment and chemotherapy.

20. Blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives.

21. Oxygen and other gases and their administration.

22. Electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

23. Charges for the cost and administration of an anesthetic.

24. Licensed Health Care Provider for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies, except for dental braces or corrective shoes, which are specifically excluded.

25. Adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies except only upon prior approval of the Plan. **Approval will be based on guidelines of cost effectiveness and Medically Necessary treatment of an Illness or Injury as determined by the Plan Administrator.**

26. Charges for the Durable Medical Equipment, Orthopedic Appliances, or Prosthetic Appliances as follows:

    A. Rental of, up to the purchase price of, a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. For Durable Medical Equipment for which purchase is not medically feasible, rental charges will be paid without limitation based upon purchase price.

    B. Insulin pumps for conditions such as diabetes. Insulin pump supplies, syringes and related supplies are also eligible under the Prescription Drug Program Benefit.

    C. Purchase of Orthopedic Appliances or Prosthetic Appliances, including but not limited to artificial limbs, eyes, and larynx.

    D. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances.

       Preauthorization of charges for Durable Medical Equipment, Orthopedic Appliances or Prosthetic Appliances that may exceed $1,000 is strongly recommended. If Preauthorization is not obtained, charges may be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted. The request for Preauthorization must include:

       1) The attending Physician's prescription; and

       2) A written explanation from the Physician as to why rental or purchase, repair or replacement is necessary; and

       3) An itemized rental or purchase, repair or replacement cost statement from the proposed provider of services.

27. Orthotics and impression casting when prescribed by a Physician.

28. Voluntary sterilization.

29. Treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism.

30. Contraceptive Management, regardless of Medical Necessity. “Contraceptive Management” means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation, placement of any contraceptive device, and prescription contraceptive drugs not available through the Prescription Drug Program Benefit. Coverage also includes removal of a contraceptive device, only when Medically Necessary. Also see Preventive Care for contraceptive benefits.

31. Organ or tissue transplant procedures that are not Experimental/Investigational/Unproven, subject to the following conditions:

    A. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

    B. If the donor is covered under this Plan, expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient’s plan.

    C. If the recipient is covered under this Plan, expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered Covered Medical Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the applicable benefit limits still available to the recipient.

    D. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.

    E. The Allowable Fee of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ will be considered a Covered Medical Expense.

    Charges from the Center of Excellence for transplant procedures will be payable at 100 percent of the Covered Medical Expenses. Under the Premier and Standard Plans, the Deductible is waived for transplant procedures at a Center of Excellence. Under the HSA-Qualified Health Plan, the Deductible applies. To obtain a list of Centers of Excellence, contact the Claim Administrator at (855) 258-3489.

32. Treatment required because of accidental bodily Injury to natural teeth. Such expenses must be Incurred within twenty-four (24) months of the date of accident. This does not include repair or replacement of a denture.

33. Producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.

34. Surgical treatment for temporomandibular joint dysfunction (TMJ) or any related diagnosis, including correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia.

35. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

"Certified Nurse Midwife" means an individual who has received advanced nursing training and is authorized to use the designation of "CNM" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

36. Charges for Mental Illness are payable as specifically stated in the Schedule of Medical Benefits. Coverage under this benefit includes the following services:

    A. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment.

    B. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

    C. In-patient and partial hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

    D. Medically Necessary treatment at a Psychiatric Facility.

    E. Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services at a Residential Treatment Center.

37. Charges for Substance Use Disorder are payable as specifically stated in the Schedule of Medical Benefits. Coverage under this benefit includes the following services:

    A. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment, including but not limited to group therapy.

    B. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

    C. In-patient and partial hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

    D. Medically Necessary treatment, including aftercare, at a Substance Use Disorder Treatment Facility.

    E. Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services at a Residential Treatment Center.

CHIROPRACTIC CARE

Charges for Chiropractic Services are payable as specifically stated and limited in the Schedule of Medical Benefits. Coverage does not include charges for chiropractic treatment that are not related to an actual Illness or Injury or which exceed the maximum benefit as stated in the Schedule of Medical Benefits.

DIABETES SELF-MANAGEMENT

Charges are payable as specifically stated and limited in the Schedule of Medical Benefits. Coverage includes charges for equipment, supplies and self-management training and education, including medical nutrition therapy, for treatment of persons diagnosed with diabetes.

HOME HEALTH CARE BENEFIT

Charges are payable as specifically stated in the Schedule of Medical Benefits. Coverage under this benefit includes charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan for the following services:

1. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides; or

3. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

"Home Health Care Agency" means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy, medical social services) on a visiting basis, in a place of residence used as the Covered Person's home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

"Home Health Care Plan" means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan.

2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

3. Services of any social worker.

4. Transportation services.

5. Housekeeping services.

6. Custodial Care.

INFERTILITY AND IN-VITRO FERTILIZATION BENEFIT

In-Vitro Fertilization Benefit is only eligible for coverage under the Premier Plan.

"Infertility" means the physical inability to conceive after 24 consecutive months of regular heterosexual sexual intercourse between a Participant and the Participant's legal spouse without use of contraception of any kind as evidenced by medical history. Voluntary sterilization shall not be considered to be infertility.

Preauthorization is strongly recommended for in-vitro fertilization. Failure to pre-authorize the charge could result in denial of the claim if the charge is not found to be Medically Necessary when the claim is submitted. Charges for testing and treatment of Infertility are eligible only under the Medical Benefits section of this Plan, subject to the following conditions and limitations:

1. Preauthorization shall consist of an independent medical review by the Plan of the proposed treatment regimen and medical history by a board-certified specialist in Infertility and Reproductive Medicine. Such independent medical review shall be based upon the current published, approved protocols of the American Society of Reproductive Medicine, and the American College of Obstetricians and Gynecologists.

2. Infertility testing is covered only for testing performed upon the person covered under this Plan, only if the testing is for the Participant or the Participant's covered spouse, and only if the persons who are the subject(s) of the testing are legally married to each other.

3. Coverage is limited to in-vitro fertilization.

4. In-vitro fertilization procedures, including but not limited to Gamete Intrafallopian Transfers, Intracytoplasmic Sperm Injections, Zygote Intrafallopian Transfers or any combination of these procedures are limited to a combined total of two (2) attempts per lifetime, per Participant or covered spouse, unless one of two attempts results in pregnancy. In the event that one of two attempts results in pregnancy, an additional two attempts will be eligible until a combined total of two consecutive attempts are unsuccessful. No additional attempts are eligible after a combined total of two consecutive unsuccessful attempts.

Unless otherwise specified and limited in the Schedule of Medical Benefits, charges for the treatment of Infertility are not covered under the following conditions:

1. If the treatments, including prescription fertility drugs, **in the opinion of an independent medical reviewer**, have a significant likelihood of producing multiple conception, multiple births, high-risk pregnancies or do not have a medically reasonable likelihood of achieving conception.

2. Artificial insemination procedures under any condition.

3. If testing and procedures are performed upon a person not covered under this Plan.

4. If the testing or treatment is for a person other than the Participant or the Participant's covered spouse.

5. If the persons who are the subject(s) of the treatment are not legally married to each other.

6. Use of surrogates for placement of the fertilized egg, fees for sperm donors other than a legal spouse who is covered under this Plan.

7. Harvesting an egg or eggs from a person not covered under this plan, from a person who is unmarried, or from a person who is not either the Participant or the Participant's legal spouse. Refer to "Exclusions and Limitations, Sexual Dysfunction and Infertility".

8. If the treatment is for reversal of voluntary sterilization.

9. If the testing or treatment is for covered Dependent children.

HEARING AIDS

For the Retiree only, charges for hearing aids are payable as specifically stated and limited in the Schedule of Medical Benefits. Coverage is not included for dependents. Coverage does not include charges for routine hearing examinations and tests, maintenance or repairs, tinnitus maskers or similar aid devices.

REHABILITATION THERAPY

Charges for Inpatient services for Rehabilitation Therapy are payable as specifically stated in the Schedule of Medical Benefits. Coverage includes services provided while the Covered Person is a registered bed patient of a Hospital or rehabilitation unit. A Multi-disciplinary Team under the direction of a physiatrist must provide therapy.

"Rehabilitation Therapy" is specialized treatment monitored/provided by a Multi-disciplinary Team providing multi-modality treatment in either an inpatient or outpatient basis for an injury or physical deficit, with the purpose of restoring or bringing body function to a condition of function as near as possible to what it was before the illness or loss of body part or body function. Rehabilitative services include, but are not limited to, physical therapy, occupational therapy, speech therapy and cardiac rehabilitation.

Care provided must be under the direction of a qualified physician and have a formal written treatment plan with a specific goal.

"Multi-disciplinary Team" in this context is a group of health service providers who must be either licensed or certified, or otherwise approved to practice their respective professions in the state where the services are provided.

NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits. Coverage includes Newborn Inpatient Nursery/Physician Care including the following services:

1. Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision and standby care provided by a pediatrician at a cesarean section birth.

2. Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.

OUTPATIENT WELL-CHILD CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits. Coverage includes charges for the following outpatient routine services:

Routine Outpatient Well-Child Care for Dependent children through age 24 months for the following routine services:

1. Well-child examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider.

2. Lab tests recommended by a Physician or Licensed Health Care Provider.

3. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.

PREVENTIVE CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits for “Preventive Care”. “Preventive Care” means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes charges incurred for physical examinations, Mammograms, pap smears, x-rays, PSA’s, routine or miscellaneous laboratory testing provided or ordered at the time of a routine examination.

Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan.

Charges for treatment of an active Illness or Injury are subject to the Deductible and Benefit Percentage and other plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

Screening Colonoscopies are covered subject to the limitations stated in the Schedule of Benefits.

Adult immunizations are covered subject to the limitations stated in the Schedule of Benefits.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage includes charges for reconstructive breast surgery subsequent to any mastectomy. Covered Medical Expenses are limited to charges for the following:

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;

2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;

3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;

2. Breast augmentation procedures unrelated to producing a symmetrical appearance;

3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;

4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

MEDICAL EXPENSE SELF-AUDIT BONUS

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person should review all charges and verify that each itemized goods or service has been received and that the bill does not represent either an overcharge or a charge for goods or services never received. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

In the event a self-audit results in elimination or reduction of charges, fifty percent (50%) of the amount eliminated or reduced will be paid directly to the Covered Person as a bonus, provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Plan (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus shall only apply to erroneous charges that have been submitted to and paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus. Rewards are subject to the following:

- A minimum reward of $25 (on overcharge of $50)
- A maximum reward of $1,000 (on overcharge of $2,000 or more).

This self-audit is a bonus in addition to the benefits of this Plan. The Covered Person must indicate on the corrected billing statement ”This is a claim for the Medical Expense Self-Audit Bonus” and submit to the Claim Administrator at the following address a copy of the incorrect bill and a copy of the corrected billing in order to receive the bonus:

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

PREAUTHORIZATION

Preauthorization is required for certain services and supplies as described below to alert the Participant in advance as to whether a service may be covered under the Plan.

Services and supplies are not covered under the Plan if they are not Medically Necessary, if they are Experimental/Investigational/Unproven, if they are not performed in the appropriate treatment setting, or if they do not otherwise meet the terms and conditions of this Plan Document. The Preauthorization process allows Blue Cross Blue Shield of Montana to determine whether these conditions are met and alerts Participants – before they commit to the service or supply – if the service or supply will not be covered for one of these reasons. However, Preauthorization does not guarantee coverage under the Plan.

The Participant is responsible for satisfying the requirements for Preauthorization. This means that the Participant must request Preauthorization or assure that the Participant's Physician, provider of services, the Participant's authorized representative, or a Family member complies with the requirements below. If the Participant utilizes a Participating Provider for covered services, that provider may request Preauthorization for the services. However, it is the Participant's responsibility to assure that the services are Preauthorized before receiving care.

To request Preauthorization, the Participant, his/her Physician or other appropriate party, as identified above, must call the Preauthorization number shown on the inside cover of this Plan Document, or the Participant's identification card, before receiving treatment. The Claim Administrator will assist in coordination of the Participant's care so that his/her treatment is received in the most appropriate setting for his/her condition and that the Participant receives the highest level of Benefits under this Plan Document.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits under this Plan Document. In addition, a nonparticipating provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible, Coinsurance and/or Copayment even if the service is an Emergency Service or the if the service has been Preauthorized.

Preauthorization Process for Inpatient Services

For an Inpatient facility stay, the Participant or other appropriate party, as identified above, must request Preauthorization from the Claim Administrator before the Participant's scheduled admission. The Claim Administrator will consult with the Participant's Physician, Hospital, or other facility to determine if Inpatient level of care is required for the Participant's illness or injury. The Claim Administrator may decide that the treatment the Participant needs could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office).

For Inpatient Hospital facility services, the Participant's Participating Provider is required to obtain Preauthorization. If Preauthorization is not obtained, the Participating Provider may be sanctioned based on Blue Cross and Blue Shield's contractual agreement with the provider and the Participant will be held harmless for any provider sanction. For additional information about Preauthorization for services outside of the Blue Cross and Blue Shield of Montana service area, see the section entitled, Out-of-Area Services – The BlueCard Program.

If the Claim Administrator determines that the Participant's treatment does not require Inpatient level of care, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with an Inpatient stay without the Claim Administrator's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically

Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of this Plan Document, the Participant may be responsible for the full cost of the services.

Unscheduled Inpatient admissions, such as admissions for Medical Emergency, should be Preauthorized within two days after admission. For maternity care, Preauthorization should be obtained for stays exceeding more than 48 hours for a vaginal delivery and 96 hours for a Caesarean-section delivery.

Preauthorization Process for Mental Illness and Substance Use Disorder Services

All Inpatient and partial hospitalization services related to treatment of Mental Illness and Substance Use Disorder must be Preauthorized by the Claim Administrator.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform covered services under this Plan Document. However, all services are subject to the provisions in the section entitled Concurrent Review.

If the Claim Administrator determines that the Participant's treatment does not require Inpatient or partial hospital level of care, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with an Inpatient stay or partial hospital level of care, without the Claim Administrator's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of this Plan Document, the Participant may be responsible for the full cost of the services.

Preauthorization Process for Other Outpatient Procedures/Services

In addition to the Preauthorization requirements outlined above, the Plan also requires Preauthorization for certain Outpatient services, including Home Health Care, Hospice Services and Home Infusion Therapy. For additional information on Preauthorization, the Participant or the Provider may call the Claim Administrator's customer service number on the Participant's identification card.

For specific details about the Preauthorization requirement for the above referenced Outpatient services, please call the Claim Administrator's customer service number listed on the inside cover of this Plan Document, or on the back of the Participant's identification card. The Plan reserves the right to no longer require Preauthorization during the Benefit Period. Updates to the list of services requiring Preauthorization may be confirmed by calling the Claim Administrator's customer service number.

It is NOT necessary to Preauthorize standard x-ray and lab services or Routine office visits.

If the Claim Administrator does not approve the Outpatient Service, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with the services without the Claim Administrator's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of this Plan Document, the Participant may be responsible for the full cost of the services.

Preauthorization Request Involving Non-Urgent Care

Except in the case of a Preauthorization Request Involving Urgent Care (see below), the Claim Administrator will provide a written response to the Participant's Preauthorization request no later than 15

days following the date the Claim Administrator receives the Participant's request. This period may be extended one time for up to 15 additional days, if the Claim Administrator determines that additional time is necessary due to matters beyond the Claim Administrator's control.

If the Claim Administrator determines that additional time is necessary, the Claim Administrator will notify the Participant in writing, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to make the determination.

If an extension of time is necessary due to the need for additional information, the Claim Administrator will notify the Participant of the specific information needed, and the Participant will have 45 days from receipt of the notice to provide the additional information.

The Claim Administrator will provide a written response to the Participant's request for Preauthorization within 15 days following receipt of the additional information. The procedure for appealing an adverse Preauthorization determination is set forth in the section entitled Medical and Prescription Drug Benefit Complaints and Grievances.

Preauthorization Request Involving Urgent Care

A Preauthorization Request Involving Urgent Care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request.

In case of a Preauthorization Request Involving Urgent Care, the Claim Administrator will respond to the Participant as soon as possible (taking into account medical exigencies) but no later than 72 hours after receipt of the request, unless the Participant fails to provide sufficient information, in which case, the Participant will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. If such information is not received during that time period, a Benefit determination will be made within 48 hours after the deadline for providing the information. Otherwise, a Benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 48 hours after the missing information is timely received.

NOTE: The Claim Administrator's response to the Participant's Preauthorization Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Preauthorization Request Involving Emergency Care

If the Participant is admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, the Participant's Provider must notify the Claim Administrator within two working days following the Participant's emergency admission.

Preauthorization Required For Certain Drug Products and Other Medications

Prescription Drug Products that are self-administered process under the Prescription Drugs section of this Plan Document. There are other medications that are administered by a Covered Provider which process under the medical Benefits.

Other Medications – Covered Under Medical Benefits

Medications that are administered by a Covered Provider will process under the medical Benefits of this Plan Document. Certain medications administered by a Covered Provider require Preauthorization. The medications that require Preauthorization are subject to change by the Claim Administrator.

For any medication that is subject to Preauthorization, the Participant or provider should fax the request for Preauthorization to the Blue Cross and Blue Shield of Montana Medical Review Preauthorization Department at 1-866-589-8256. The Participant or provider may also submit a written request for Preauthorization. Preauthorization forms are located on the Claim Administrator's website at www.bcbsmt.com, and may be printed directly from the website. The Claim Administrator will notify the Participant and provider of the Preauthorization determination.

In making determinations of coverage, the Claim Administrator may rely upon pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Medical Necessity, and Medical Policies. The pharmacy policies and Medical Policies are located on the Claim Administrator's website at www.bcbsmt.com.

To determine which medications are subject to Preauthorization, the Participant or provider should refer to the list of medications which apply to this Plan Document on the Claim Administrator's website at www.bcbsmt.com or call the Claim Administrator's customer service toll-free number identified on the Participant's identification card or the Claim Administrator's website at www.bcbsmt.com

General Provisions Applicable to All Required Preauthorizations

1. **No Guarantee of Payment**

Preauthorization does not guarantee payment of Benefits by the Claim Administrator. Even if the Benefit has been Preauthorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date of service or the Participant's Benefits may have changed as of the date the service.

2. **Request for Additional Information**

The Preauthorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Preauthorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Claim Administrator to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

3. **Failure to Obtain Preauthorization**

If the Participant does not obtain Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Any treatment the Participant receives which is not a covered service under this Plan Document, or is not determined to be Medically Necessary, or is not performed in the appropriate setting will be excluded from the Participant's Benefits. This applies even if Preauthorization approval was requested or received.

4. **Concurrent Review**

Whenever it is determined by the Plan that Inpatient care or an ongoing course of treatment may no longer meet Medical Necessity criteria or is considered Experimental/Investigational/Unproven, the Participant, the Participant's provider or the Participant's authorized representative may submit a request to the Plan for continued services. If the Participant, the Participant's provider or the Participant's authorized representative requests

to extend care beyond the approved time limit and it is a Request Involving Urgent Care, the Claim Administrator will respond to the Participant, the Participant's provider or the Participant's authorized representative as soon as possible (taking into account medical exigencies), but no later than 72 hours after receipt of the request, unless such individual fails to provide sufficient information, in which case, the individual will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. If such information is not received during that time period, a Benefit determination will be made within 48 hours after the deadline for providing the information. Otherwise, a Benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 48 hours after the missing information is timely received.

CARE MANAGEMENT

The goal of Care Management is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic Illness, the Participant or their designee should contact the Plan. If appropriate, a care manager will be assigned to work with the Participant and the Participant's providers to facilitate a treatment plan. Care Management is a voluntary program that includes Participant education, referral coordination, utilization review, and individual care planning. Involvement in Care Management does not guarantee payment by the Plan.

PRE-EXISTING CONDITION EXCLUSIONS

Covered Medical Expenses resulting from treatment of Pre-Existing Conditions are excluded from coverage under the Plan as specified below:

1. For a period of twelve (12) consecutive months from the Enrollment Date.

2. In the case of a Late Enrollee only, for a period of eighteen (18) consecutive months from the Enrollment Date.

All Pre-Existing Condition exclusionary periods will commence on the Enrollment Date.

All Pre-Existing Condition exclusionary periods set out in this Plan will be reduced on a day for day basis for any period(s) of Creditable Coverage that occurred prior to a Covered Person's Enrollment Date, provided there has been no break in the Creditable Coverage exceeding sixty-three (63) consecutive days prior to the Covered Person's Enrollment Date. The Waiting Period imposed by this Plan will not be considered to be a break in Creditable Coverage.

Pre-Existing Condition Exclusions will not apply to any of the following:

1. Pregnancy related expenses.

2. A Covered Person who is less than nineteen (19) years of age.

3. A genetic predisposition to a disease or condition without a diagnosis of a condition related to the genetic information.

MEDICAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits in addition to charges for the following Medical Benefit Exclusions:

1. Routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed as a covered benefit.

2. Cosmetic services or complications resulting therefrom, except when provided to correct a condition resulting from an Accidental Injury or to treat congenital anomaly, as applicable in Medical Policy.

3. Services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental/Investigational/Unproven, except as specifically stated as a covered benefit of this Plan.

4. Elective abortions.

5. Hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.

6. Physicians' fees for any treatment that is not rendered by or in the physical presence of a Physician.

7. Licensed Health Care Providers' fees for any treatment that is not rendered by or in the physical presence of a Licensed Health Care Provider.

8. Special duty nursing services are excluded:

   A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or

   B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.

9. Eye refractions, the purchase or fitting of eyeglasses or contact lenses. **This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.**

10. Hearing aids or such similar aid devices, except as specifically listed as an Covered Medical Expense.

11. Dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes, except as specifically listed under Medical Benefits.

12. Fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique, except as specifically listed as an Covered Medical Expense.

13. Marital counseling, family counseling, recreational counseling or milieu therapy.

14. Reversal of a sterilization procedure.

15. Services or supplies provided for the treatment of obesity and weight reduction, including bariatric surgery or any other related bariatric procedures.

16. Acupuncture, naturopathy, holistic medical procedures or rolfing.

17. Hair transplant procedures, wigs and artificial hairpieces, or drugs that are prescribed to promote hair growth.

18. Services, care or treatment for sexual dysfunction, trans-sexualism, gender dysphoria or sexual reassignment including related drugs, medications, surgery, medical or Psychiatric Care or treatment.

19. Surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.

20. Custodial Care.

21. Artificial organ implant procedures.

22. Incidental supplies or common first-aid supplies, such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a covered benefit.

23. Dental braces or corrective shoes.

24. Charges in connection with any non-surgical treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

25. Charges for non-prescription contraceptives supplies or devices, or the removal of contraceptive devices, unless Medically Necessary.

26. Complications that directly result from acting against medical advice, non-compliance with specific physician's orders or leaving an inpatient facility against medical advice.

27. Breast pumps.

28. Equipment, including, but not limited to, motorized wheelchairs or beds, that exceeds the patient's needs for everyday living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review and not primarily for personal convenience.

29. Specialized computer equipment, including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary by independent review, and not primarily for personal convenience.

30. Routine hearing examinations and tests, maintenance or repairs, supplies or tinnitus maskers.

31. Detoxification services or outpatient therapy under court order or as condition of parole.

32. Nutrition -based therapy for Substance Use Disorder.

33. Health care services to treat Substance Use Disorder co-dependency.

34. Immunizations, medications and other preventive treatments that are recommended because of increased risk due to your type of employer or travel, including, but not limited to, immunizations, medications and/or other preventive treatments for malaria and yellow fever.

35. Examinations for employment, licensing, insurance, school camp, sports or adoption purposes.

36. Court-ordered examinations or treatment

37. Expenses for examinations and treatment conducted for the purpose of medical research.

38. FAA and DOT Physicals

39. Charges for the following (known as a “Never Event” when the condition is a result of patient confinement or surgery:

    A. Removal of an object left in the body during surgery;

    B. Catheter-associated urinary tract infection;

    C. Pressure ulcers;

    D. Vascular catheter-associated infection;

    E. Infection inside the chest after coronary artery bypass graft surgery;

    F. Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns;

    G. Treatment, amputation or removal of the wrong body part or organ.

40. Charges for services of a direct-entry midwife or lay midwife or the practice of direct-entry midwifery. A Direct-entry midwife is one practicing midwifery and licensed pursuant to M.C.A. 37-27-101 et seq.

    “Direct-entry midwife” means a person who advises, attends, or assists a woman during pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.

41. In connection with services and supplies that are in excess of the Allowable Fee.

42. Services, supplies, drugs and devices which are not listed as a covered benefit of this Plan.

43. Over-the-counter food supplements, formulas and/or Medical Foods regardless of how administered, except when used for inborn errors of metabolism. Medical Foods means nutritional substances in any form that are:

    A. Formulated to be consumed or administered enterally under supervision of a Physician;

    B. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;

    C. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

    D. Essential to optimize growth, health, and metabolic homeostasis.

    Treatment under the supervision of a Physician of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Benefits include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

44. Foot care including but not limited to:

    A. Routine foot care, treatment or removal of corns or callosities, hypertrophy, hyperplasia of

the skin or subcutaneous tissues and cutting or trimming of nails, except for foot care provided to a Covered Person with diabetes.

B. Any treatment of congenital flat foot.

C. Injections and nonsurgical treatment of acquired flat foot, fallen arches, or chronic foot strain.

D. Any treatment of flat foot purely for the purpose of altering the foot's contour where no medical or functional impairment exists.

45. Routine foot care for a Covered Person without comorbidities, except routine foot care is covered if a Covered Person has comorbidities such as diabetes.

46. Applied Behavioral Analysis (ABA) and Early Intensive Behavioral Intervention (EIBI) services for autism.

PROCEDURES FOR CLAIMING MEDICAL BENEFITS

HOW TO OBTAIN BENEFITS FOR COVERED MEDICAL EXPENSES

When a Covered Person obtains services from a covered health care provider, the Covered Person must present the Covered Person's identification card to the provider of care. Billing and payments for Physician, Hospital, and other providers usually will be handled directly by the provider's office. Normally, there are no claim forms for the Covered Person to file. A Participating Professional or Facility Provider will always file claims directly with the Claim Administrator.

HOW TO FILE A CLAIM

If it is necessary for the Covered Person to file a claim, the Covered Person should complete a Blue Cross and Blue Shield of Montana claim form and send the claim form with the provider's itemized bill(s) to the address on the form. To obtain a claim form, contact Blue Cross and Blue Shield of Montana on their customer service number listed on the inside cover of this Plan Document or at www.bcbsmt.com.

In certain instances, the Claim Administrator may require that additional documents or information be submitted, including, but not limited to, accident reports and medical records. This information must be submitted within the time frame requested when the additional documentation is requested, before payment can be made for the services.

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

OUT-OF-STATE SERVICES – CLAIMS FOR FAMILY MEMBERS WHO LIVE OUT-OF-STATE AND ALL OTHER CLAIMS FOR OUT-OF-STATE SERVICES

Family members who live out of state or Covered Persons who have health care services out of state should use Participating Blue Cross and Blue Shield Providers in that state. In most cases providers will file claims directly with the Claim Administrator. Please refer to the BlueCard® Program section. If the provider does not file the claim, the Covered Person should use the same procedures outlined in the section entitled, "How to File a Claim".

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

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

MEDICAL AND PRESCRIPTION DRUG BENEFIT COMPLAINTS AND GRIEVANCES

The Claim Administrator has established benefit review and appeal procedures that are outlined in this section. In the event of a conflict between the terms of this section and the terms of the NorthWestern Energy Flexible Compensation Plan document or summary plan description, the provisions of this section shall control.

Most issues can be handled by calling the Claims Administrator's customer service number appearing on the inside cover of this Plan Document. The Participant may also submit a request in writing to the Claim Administrator for review of a benefit claim or appeal of an adverse benefit determination. For urgent care claims, the Participant's request may also be submitted by phone. Information regarding filing a claim for review or appeal is provided below.

TYPES OF CLAIMS

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

1. **Pre-Service Claims**

   A pre-service claim is any claim for a benefit that, under the terms of this Plan, requires authorization or approval from the Claim Administrator or the Claim Administrator's subcontracted administrator prior to receiving the benefit. For example, certain Prescription Drug Products require prior authorization under the terms of this Plan and are considered pre-service claims.

2. **Urgent Care Claims**

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

3. **Post-Service Claims**

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

4. **Rescission Claims**

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

5. **Concurrent Care Claim**

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

PRESCRIPTION DRUG BENEFIT INITIAL COVERAGE REVIEW

There are two types of initial coverage reviews that are conducted by the Claim Administrator:

1. Clinical coverage review – a request for coverage of a medication that is based on clinical conditions of coverage established under the Plan, such as medications that require prior authorization.

   To request an initial clinical coverage review, also called prior authorization, the Participant's attending provider must submit the request electronically to the Claim Administrator. Information about electronic options can be found at www.express-scripts.com/PA.

2. Administrative coverage review – a request for coverage of a medication that is based on the Plan's benefit design.

   To request an initial administrative coverage review, the Participant or his or her representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, can be obtained by calling the Claim Administrator's Customer Service number appearing on the inside cover of this Plan Document. The form must be submitted by mail or fax to:

   Express Scripts, Inc.
   Attn: Benefit Coverage Review Department
   PO Box 66587
   St. Louis, MO 63166-6587
   Fax: (877) 328-9660

An urgent care claim review must be requested by phone at (800) 753-2851.

INITIAL CLAIM DETERMINATION BY TYPE OF CLAIM

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

   a. Notice of Determination

      Upon receipt of a pre-service claim, the Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim. For a pre-service prescription drug benefit claim, the Claim Administrator will provide notice of the initial claim determination no later than 5 days after receiving a mail order pharmacy claim or no later than 15 days after receiving a retail pharmacy claim.

   b. Notice of Extension

      1. For reasons beyond the control of the Claim Administrator

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

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

         If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Participant will be given 45 days from receipt of the

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

c. Notice of Improperly Submitted Claim

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

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

a. Designation of Claim

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

b. Notice of Determination

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

c. Notice of Incomplete or Improperly Submitted Claim

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

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

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

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

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

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

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

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

1. In response to the Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves urgent care, the Claim Administrator will review the claim and notify the Participant of its determination no later than 24 hours from the date the Claim Administrator received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.
2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant's claim will be treated as and decided within the timeframes for an urgent care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."
3. If the Participant's claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

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

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

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

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

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

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

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

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

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

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

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

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

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

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

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

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

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

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

HOW TO FILE AN INTERNAL APPEAL OF AN ADVERSE BENEFIT DETERMINATION

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

Medical Benefit Claim Appeals

If the Participant disagrees with an adverse benefit determination (including a rescission), the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of urgent care claims, The Participant's appeal must be made in writing, should list the reasons why the Participant does not agree with the adverse benefit determination, and must be submitted by mail or fax to:

Blue Cross and Blue Shield of Montana
PO Box 7982
Helena, MT 59604-7982
Fax: (406) 437-7875

An urgent care claim appeal may be submitted by phone at (800) 447-7828.

Prescription Drug Benefit Claim Appeals

Level 1 Appeal

If the Participant disagrees with an adverse benefit determination, the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of urgent care claims, the Participant's appeal must be made in writing and include the following information:

- Participant name
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

A non-urgent clinical appeal must be submitted by mail or fax to:

Express Scripts
Attn: Clinical Appeal Department
PO Box 66588
St. Louis, MO 63166-6588
Fax: (877) 852-4070

A non-urgent administrative appeal must be submitted by mail or fax to:

Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St. Louis, MO 63166-6587
Fax: (877) 328-9660

An urgent care claim appeal must be submitted by phone at (800) 753-2851 or fax at (877) 852-4070.

Level 2 Appeal

For urgent care claims, there is only one level of appeal prior to an external review.

For all other claims, when a level 1 appeal is denied (adverse benefit determination), the Participant may appeal the determination within 90 days from receipt of the notice of the level 1 appeal adverse benefit determination. The Participant's appeal must be made in writing and include the same information outlined above for a level 1 appeal.

A non-urgent clinical appeal must be submitted by mail or fax to:

Express Scripts
Attn: Clinical Appeal Department
PO Box 66588
St. Louis, MO 63166-6588
Fax: (877) 852-4070

A non-urgent administrative appeal must be submitted by mail or fax to:

Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St. Louis, MO 63166-6587
Fax: (877) 328-9660

2. **Authorized Representative**

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

3. **Access to Plan Documents**

The Participant may at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at the Claim Administrator's office at the address and during the normal business hours listed in the Introduction section of this Plan Document.

4. **Submission of Information and Documents**

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

5. **Consideration of Comments**

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

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

6. **Scope of Review**

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

7. **Consultation with Medical Professionals**

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine

involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination (nor have been a subordinate of any person previously consulted). The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant's claim.

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

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

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

Content of Notice of Final Internal Adverse Benefit Determination

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

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

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

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

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

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

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

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

8. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a Medical Necessity or an

Experimental/Investigational/Unproven treatment or similar exclusion or limitation as applied to the Participant's medical circumstances;

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

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

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

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

DENTAL PROVIDERS

CHOICE OF A DENTIST

Covered Persons may choose a Dentist from the Claim Administrator's panel of Delta Dental PPO℠ Dentists ("PPO Dentists") and Delta Dental Premier Dentists® ("Premier Dentists") or Covered Persons may choose a Non-Delta Dental Dentist. A list of PPO Dentists and Premier Dentists can be obtained by accessing the Delta Dental National Dentist Directory at www.deltadentalins.com. Covered Persons are responsible for verifying whether the selected Dentist is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, Covered Persons should always confirm with the Dentist's office that a listed Dentist is still a participating PPO Dentist or Premier Dentist.

PPO DENTIST

The PPO program potentially allows the greatest reduction in Covered Persons' out-of-pocket expenses, since this select group of Dentists will provide dental benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

PREMIER DENTIST

The Premier Dentist, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

NON-DELTA DENTAL DENTIST

If a Dentist is a Non-Delta Dental Dentist, the amount charged to Covered Persons may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the MPA and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the Dentist's submitted charge.

ADDITIONAL ADVANTAGES OF USING A PPO DENTIST OR PREMIER DENTIST

1. The PPO Dentist and Premier Dentist must accept assignment of benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the Deductible and Coinsurance, and the Covered Person does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.

2. The PPO Dentist and Premier Dentist will complete the dental Claim Form and submit it to Delta Dental for reimbursement.

DENTAL BENEFITS

COVERED DENTAL EXPENSES

All dental expenses must meet these conditions to be Covered Dental Expenses. Services, treatments or supplies are an eligible dental expense if they meet all of the following requirements:

1. They are administered or ordered by a Dentist, Denturist, Dental Hygienist or other Licensed Health Care Provider covered by the Plan; and

2. They are Dentally Necessary for the diagnosis and treatment of a dental condition or dental disease unless otherwise specifically included as an Covered Dental Expense; and

3. Charges therefore do not exceed the Contract Allowance of the Plan. If two or more procedures are separately suitable for the correction of a specific condition, the Covered Dental Expense will be based upon the least expensive procedure; and

4. They are not excluded under any provision or section of this Plan.

DEDUCTIBLE AND BENEFIT PERCENTAGE

The Dental Plan Options include a Calendar Year Deductible. Covered Dental Expenses Incurred by a Covered Person will be paid by the Plan subject to the applicable Deductible, and according to the applicable Benefit Percentage stated in the Schedule of Dental Benefits for the Plan Option elected. The Plan will pay the percentage of the Covered Dental Expense indicated as the Benefit Percentage, up to any applicable Benefit Period Maximum or Lifetime Maximum.

ORDER OF BENEFIT PAYMENT

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

MAXIMUM BENEFIT PAYABLE

The Maximum Benefit per Benefit Period as specified in the Schedule of Dental Benefits is the maximum amount that may be paid by the Plan for Covered Dental Expenses Incurred by each individual Covered Person in each Benefit Period as indicated in the Schedule of Dental Benefits. The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Dental Benefits, for any reason.

The Plan will not pay more than the amount which would have been paid to one Dental Provider providing the same service:

1. If the Participant transfers from the care of one Dental Provider to that of another during a course of treatment.

2. If more than one Dentist provides care to the Participant in the course of a single procedure.

EXPENSES INCURRED

For a dental appliance, or modification of a dental appliance, an expense is considered Incurred at the time the impression is made. For a crown, bridge or gold restoration an expense is considered Incurred at the time the tooth or teeth are prepared. For root canal therapy an expense is considered Incurred at the time the pulp chamber is opened. All other expenses are considered Incurred at the time a service is rendered or a supply furnished.

ORTHODONTIC TREATMENT BENEFIT

Orthodontic Treatment Benefits are separate from, and not subject to, the Maximum Benefit per Benefit Period. The following expenses will be considered "Orthodontic Treatment" for reimbursement purposes and will be payable as stated in the Schedule of Dental Benefits and subject to the separate Maximum Lifetime Benefit applicable to Orthodontic Treatment:

1. Treatment for a diagnosed malocclusion.

2. Cephalometric X-ray once in any twenty-four (24) consecutive month period.

3. One set of study models per Covered Person.

4. Initial placement of braces or appliances, ongoing treatment adjustment, removal and follow-up related to said initial placement.

If Orthodontic Treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

PROSTHESIS REPLACEMENT RULE

Replacement of or additions to existing dentures or bridgework as described in the Schedule of Dental Benefits will be covered only if evidence satisfactory to the Claim Administrator is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.

3. The existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

PRE-TREATMENT ESTIMATE

A Dentist may file a Claim Form before treatment, showing the services to be provided to a Participant. The Claim Administrator will estimate the amount of benefits payable under this Plan for the listed services. Benefits will be processed according to the terms of this Plan when the treatment is performed. A Pre-Treatment Estimate is valid for 60 days, or until an earlier occurrence of any one of the following events:

1. The date this Plan terminates;

2. The date the Participant's coverage ends; or

3. The date the Premier Dentist's or PPO Dentist's agreement with the Claim Administrator ends.

PREDETERMINATION OF BENEFITS FOR IMPLANTS FOR EDENTULOUS MOUTH

The Plan strongly recommends that charges for implants for an Edentulous Mouth be predetermined by having the Dentist complete the Predetermination of Benefits portion of the claim form and listing the procedures he/she is recommending, including an estimate of charges for the procedures and submit the claim form to Delta Dental Insurance Company for Predetermination of Benefits payable.

Upon the Plan's receipt of the Predetermination of Benefits request, the Claim Administrator will determine the eligibility of the Participant and determine the coverage available under the Plan for the recommended

dental procedures. After determining the Benefits payable under the Plan, the Claim Administrator will return the claim form to the Dentist. A copy of the predetermination of benefits will also be mailed to the Participant if over the age of 18 or to the Retiree if the Participant is under the age of 18, informing him or her of the amount of benefits estimated to be covered by the Plan for the recommended dental procedures.

A PREDETERMINATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME SERVICES ARE PERFORMED OR CHARGES ARE INCURRED.

DENTAL EXPENSE SELF-AUDIT BONUS

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of dental bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person should review all charges and verify that each itemized goods or service has been received and that the bill does not represent either an overcharge or a charge for services never received. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

In the event a self-audit results in elimination or reduction of charges, fifty percent (50%) of the amount eliminated or reduced will be paid directly to the Covered Person as a bonus, provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Plan (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus shall only apply to erroneous charges that have been submitted to and paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus. Rewards are subject to the following:

- A minimum reward of $25 (on overcharge of $50)
- A maximum reward of $1,000 (on overcharge of $2,000 or more)

This self-audit is a bonus in addition to the benefits of this Plan. The Covered Person must indicate on the corrected billing statement “This is a claim for the Dental Expense Self-Audit Bonus” and submit to the Claim Administrator at the following address a copy of the incorrect bill and a copy of the corrected billing in order to receive the bonus:

Delta Dental Insurance Company
Claim Administrator
PO Box 1809
Alpharetta, GA 30023-1809

DENTAL BENEFIT LIMITATIONS

The following examples describe limitations in coverage under the Plan.

1. Restorative:

   A. Gold, baked porcelain restorations, crowns, jackets: If a tooth can be restored with a material such as amalgam, and the Covered Person and dental service provider select another type of restoration, the Covered Dental Expense for the dental procedure actually performed will be limited to the Contract Allowance appropriate to the procedure using amalgam or a similar material.

   B. Reconstruction. Covered Dental Expenses will include only the appropriate Contract Allowance for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are eligible only under the Orthodontic Treatment Benefit, if provided by this Plan.

2. Prosthodontics:

   A. Partial Dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, and the Covered Person and the dental service provider elect a more elaborate appliance, Covered Dental Expenses for the Covered Dental Service performed will be limited to the Contract Allowance appropriate to the cast chrome or acrylic denture.

   B. Complete Dentures. If the Covered Person and the dental service provider decide on personalized or specialized techniques as opposed to standard procedures, the Covered Dentall Expense for the dental procedure actually performed will be limited to the Contract Allowance appropriate to the standard procedure.

   C. Replacement of existing dentures or removable or fixed bridgework. Charges for the replacement of existing dentures or removable or fixed bridgework will be considered a Covered Dental Expense only if the existing appliance is not serviceable and cannot be repaired. Otherwise, the Covered Dental Expense for the procedure performed will be limited to the Contract Allowance appropriate for those services that would be necessary to render such appliances serviceable.

The Schedule of Dental Benefits describes payment limitations for these services.

DENTAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Dental benefits in addition to all charges for the following Dental Benefit Exclusions:

1. Treatment that is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist.

2. Except for the Orthodontia Benefits specifically described in this Plan, dentures, crowns, inlays, onlays, bridgework or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures. Charges for veneers, composite, plastic, silicate or similar restorations placed on or replacing any teeth other than the ten (10) upper and lower anterior teeth are considered optional services and not Dentally Necessary. Covered Dental Expenses will include only the charge for a corresponding amalgam restoration.

3. Facility, Ambulatory Surgery Center and Hospital charges, if there is no satisfactory, documented and Dentally Necessary reason, at the Plan Administrator's sole discretion, the treatment or surgery cannot be performed in the dental service provider's office.

4. Local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.

5. Replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance or any appliance damaged when not in the mouth.

6. Services or supplies which are for Orthodontic Treatment, except as specifically provided for by the Plan.

7. Oral hygiene and dietary instructions.

8. Root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.

9. Temporary dentures.

10. Implants and any related services, except as specifically provided in the Plan.

11. In connection with any operation or treatment other than splint therapy for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including but not limited to correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia.

12. Services, supplies or appliances that are not specifically listed as a covered benefit of this Plan.

13. Hypnosis, prescribed drugs, premedications or any euphoric drugs, with the exception of nitrous oxide.

14. Biopsies or oral pathology, except as specifically provided for under Covered Dental Services.

15. Services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Dentally Necessary for the diagnosis and/or treatment of an active Dental condition or dental disease, or which are Experimental/Investigational/Unproven, except as specifically stated as a covered benefit of this Plan.

16. In connection with services and supplies that are in excess of the Contract Allowance.

PROCEDURES FOR CLAIMING DENTAL BENEFITS

HOW TO OBTAIN BENEFITS FOR COVERED DENTAL EXPENSES

When a Covered Person obtains dental services, the Covered Person must present their identification card to the provider of care. Billing and payments for dental services usually will be handled directly by the provider's office. Normally, there are no claim forms for the Covered Person to file. A Participating PPO or Premier Plan Dentist will always file claims directly with the Claim Administrator.

Claims must be submitted to the Plan within twelve (12) months after the date services or treatment are received or completed.

A claim will not, under any circumstances, be considered for payment of benefits if it is initially submitted to the Plan more than twelve (12) months from the date that such claim was incurred.

Upon termination of the Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED TO BE SUBMITTED UNTIL RECEIVED BY THE PLAN SUPERVISOR.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to be examined by a dental consultant retained by the Claim Administrator in or near his/her community or residence and to require the claimant to submit, or cause to be submitted, any and all dental l and other relevant records it deems necessary to properly adjudicate the claim.

NOTICE OF CLAIM FORMS

The Claim Administrator will furnish to any Dentist or Participant, on request, a standard Claim Form to make a claim for payment of benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Participant (or the parent or guardian of a minor) and submitted to the Claim Administrator at the address shown on the Claim Form. Participants may download a Claim Form from the Claim Administrator's web site at www.deltadentalins.com.

HOW TO FILE A CLAIM

If it is necessary for the Covered Person to file a claim, the Covered Person should obtain an itemized bill from the provider which includes all information about the services so the Claim Administrator can determine whether or not they are Covered Dental Expenses. The itemized bill must contain the following information:

- Retiree's name
- Plan Identification Number from the ID card
- Name of patient
- Patient's date of birth
- Retiree's address
- Provider name, address, telephone number
- Provider number
- Type of service
- Procedure code for each service
- Date of each service
- Diagnosis
- Charge for each service

Send this itemized bill to:

Delta Dental Insurance Company
PO Box 1809
Alpharetta, GA 30023-1809

BENEFIT PAYMENTS

Payment for services provided by a PPO Dentist or Premier Dentist will be made directly to the Dentist. Any other payments provided by this Plan Document will be made to the Covered Person, unless the Covered Person requests when filing a Claim Form that the payment be made directly to the Dentist providing the services. All benefits not paid to the Dentist will be payable to the Covered Person, or to his/her estate, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

DENTAL BENEFIT COMPLAINTS AND GRIEVANCES

CLAIM APPEAL

The Claim Administrator will notify the Covered Person and his/her Dentist if benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial.

If a Covered Person does not agree with the Claim Administrator's decision on a denied claim, the Covered Person has the right to appeal that decision.

The Covered Person or his/her Dentist has 180 days after receiving a notice of denial to appeal it by writing to the Claim Administrator giving reasons why he/she believes the denial was wrong. The Covered Person and his/her Dentist may ask for copies, at no cost, of any pertinent documents that are relevant to the claim.

The Covered Person or his/her Dentist may also ask the Claim Administrator to examine any additional information he/she includes that may support his/her appeal.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Claim Administrator in writing to:

Delta Dental Insurance Company
PO Box 1809
Alpharetta, GA 30023

PROCEDURES FOR APPEAL PROCESS

The Claim Administrator will make a full and fair review within 60 days after the Claim Administrator receives the request for appeal. The Claim Administrator may ask for more documents if needed. In no event will the decision take longer than 60 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Plan Document, the Claim Administrator shall consult with a Dentist who has appropriate training and experience. The review will be conducted for the Claim Administrator by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the Covered Person believes he/she needs further review of said claim, he/she may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

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

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all charges and expenses Incurred under this Plan:

1. Services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.

   For Dental benefits, this includes charges for dentures, crowns, inlays, onlays, bridgework or other appliances or services that were not ordered while the individual was a Covered Person. The date a prosthetic dental appliance is placed in the mouth is considered the date of service.

2. Caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression or caused during service in the armed forces of any country.

3. Services or supplies that are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body.

4. Charges by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:

   A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;

   B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;

   C. The Covered Person waived his/her rights to such coverage or benefits;

   D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;

   E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits; or

   F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective.

   G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or employer, or employment of a dependent member of an employer's family for whom an exemption may be claimed by the employer under the Internal Revenue Code.

5. The Covered Person is not, in the absence of this coverage, legally obligated to pay, or would not ordinarily be made in the absence of this coverage, as for example, when a Family member provides services to a spouse or dependent child.

6. Services or supplies used primarily for cosmetic, personal comfort, convenience, beautification items, television or telephone use that are not related to treatment of a medical condition.

7. Non-medical or non-dental expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician or a dental service provider.

8. Professional services on an Outpatient basis in connection with disorders of any type or cause that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.

9. Services, treatment or supplies not considered legal in the United States.

10. Incurred outside of the United States if the Covered Person traveled to such a location for the purpose of obtaining treatment, services, drugs, or supplies.

11. Travel Expenses Incurred by any person for any reason, except as specifically listed as a covered benefit.

12. Services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.

13. Preparation of reports or itemized bills in connection with Covered Dental Expenses, unless specifically requested and approved by the Plan.

14. Treatments, services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant's employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.

15. Broken or missed appointments.

16. Infection control (OSHA) fees or claim filing.

17. Facility Miscellaneous Charges as defined in the Plan.

18. Charges for the following treatments, services or supplies:

    A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.

    B. Charges that are the result of any medical complication resulting from a treatment, service or supply which are, or were at the time the charge was incurred, excluded from coverage under this Plan.

19. Treatment, services or supplies not actually rendered to or received and used by the Covered Person.

20. Charges to the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.

21. In connection with treatment, services or supplies provided for complications resulting from treatment, services or supplies that are excluded from the Plan.

COORDINATION (MAINTENANCE) OF BENEFITS

The Maintenance of Benefits provision, also known as Coordination of Benefits, prevents the total combined payment of benefits from exceeding the amount this Plan would pay in absence of other coverage. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan or plans.

If this Plan is determined to be primary, benefits will be paid without regard to other coverage and in accordance with the terms and conditions of the Plan.

If this Plan is determined to be secondary, benefits will be paid only if the amount paid by the primary coverage is less than the amount this Plan would pay if it were primary. In that event, the Plan will pay only the difference between the amount paid by the primary coverage and the amount this Plan would have paid if it were primary. The secondary payment by this Plan will not exceed the amount of patient responsibility remaining based upon the primary coverage's calculation. Only the amount paid by this Plan will be charged against the Plan maximums.

In the event of a motor vehicle or premises accident, this Plan is not the primary coverage including, but not limited to, auto medical, no fault or homeowners, liability insurance and medical payment insurance.

The Maintenance of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits provided under this Plan are subject to this provision.

DEFINITIONS

"Allowable Expenses" means any necessary item of expense, based on the Allowable Fee, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

"Plan" as used herein means any plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:

    A. Hospital indemnity benefits; and

    B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or

4. A licensed Health Maintenance Organization (H.M.O.); or

5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a Governmental program, and any coverage required or provided by any statute; or

7. Automobile insurance; or

8. Individual automobile insurance coverage on an automobile leased or owned by the Company or any responsible third-party tortfeasor; or

9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage;

10. Homeowner or premise liability insurance, individual or commercial.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent**

The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Child Covered Under More Than One Plan**

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

2) The parents are not separated (whether or not they have ever been married), or

3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

C. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility does not have coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.

D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

1) The plan of the custodial parent

2) The plan of the spouse of the custodial parent

3) The plan of the non-custodial parent

4) The plan of the spouse of the non-custodial parent

3. **Active or Inactive Employee**

The plan that covers a person as an employee who is neither laid-off nor retired (or as that

employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

4. **Longer or Shorter Length of Coverage**

If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.

B. The start of a new plan does not include:

1) A change in the amount or scope of a plan's benefits

2) A change in the entity that pays, provides, or administers the plan's benefits; or

3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).

C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. **No Rules Apply**

If none of these preceding rules determines the primary plan, the Allowable Expenses will be determined equally between the plans.

COORDINATION WITH MEDICARE

Medicare Part A, Part B and Part D will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare benefits.* This means that the Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B or Part D when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B or Part D.

Notwithstanding this provision and the language in subsection 2 below, a Participant eligible for Medicare by reason of disability who is not enrolled in Medicare Part D as of January 1, 2018 and who is not eligible to enroll in Medicare Part D until the next Medicare Part D open enrollment period, will not be deemed to have Medicare as primary coverage with respect to pharmacy claims incurred between January 1, 2018 and December 31, 2018. Effective January 1, 2019, the provisions outlined in subsection 2 below that govern coordination of benefits with Medicare shall also apply to such individuals.

1. **For Medicare Eligible Retired Persons**

   Retirees and Dependent spouses, who are eligible for Medicare as a result of age, are not eligible for coverage under this Plan.

2. **For Covered Persons who are Disabled**

   This Plan is secondary and Medicare will be primary for the covered Retiree or any covered Dependent who is eligible for Medicare by reason of disability.

3 **For Covered Persons with End Stage Renal Disease**

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

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

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

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

COORDINATION WITH MEDICAID

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

COORDINATION WITH TRICARE/CHAMPVA

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

ELIGIBILITY PROVISIONS

Coverage under this Plan is offered as alternative coverage. Upon termination of employment, an eligible Retiree and his or her eligible Dependents may elect either COBRA Continuation Coverage under the Company's health benefit plan for active employees or coverage under this Plan. By electing coverage under this Plan, an eligible Retiree and his or her eligible Dependents will waive their rights to COBRA Continuation Coverage under the Company's health benefit plan for active employees. The waiver of COBRA election rights will not be fully effective until the COBRA election period expires under the Company's health benefit plan for active employees. By waiving COBRA Continuation Coverage under the Company's health benefit plan for active employees, a Retiree and/or his or her Dependents are not waiving rights to COBRA Continuation Coverage that arise for qualifying events under this Plan.

If a Retiree and/or his or her Dependents elect COBRA Continuation Coverage under the Company's health benefit plan for active employees instead of coverage under this Plan, coverage under this Plan may not be elected at another time (i.e. when such COBRA Continuation Coverage has been exhausted). Further, as stated in the "Plan Amendments/Modification/Termination" section of this Plan, coverage under this Plan may be amended or terminated at any time. In such event, a Retiree and/or his or her Dependents will not be entitled to elect COBRA Continuation Coverage under the Company's health benefit plan if such coverage was waived to participate in this Plan.

RETIREE ELIGIBILITY

A Retiree is eligible to participate in this Plan provided that he or she was participating in the Company's health benefit plan for active employees on the last day of Active Service prior to retirement and he or she meets the following conditions, as applicable:

1. If the Retiree terminated employment on or before December 31, 2010:

   A. Is at least fifty (50) years of age, but less than sixty-five (65) years of age; and

   B. Completed at least five (5) years of service with the Company.

2. Unless otherwise specified under this provision, if the Retiree terminated employment after December 31, 2010:

   A. Is at least fifty-five (55) years of age, but less than sixty-five (65) years of age; and

   B. Completed at least twenty (20) years of service with the Company.

3. If the Retiree was employed by the Company under the terms of the September 26, 2013 Purchase and Sale Agreement between the Company and PPL Montana, LLC and has an adjusted service date, per the Company's records, prior to July 1, 2013 and is represented under a collective bargaining agreement between the Company and the IBEW Local 44 of the International Brotherhood of Electrical Workers, AFL-CIO:

   A. Terminated employment on or before April 30, 2017; and

   B. Is at least fifty-five (55) years of age, but less than sixty-five (65) years of age; and

   C. Completed at least fifteen (15) years of service with the Company.

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

An eligible Retiree who is married to another eligible Retiree may elect coverage under the Plan as a Retiree or as a Dependent, provided that he or she meets the Dependent eligibility requirements as defined below.

DEPENDENT ELIGIBILITY

FOR MEDICAL AND PRESCRIPTION DRUG BENEFIT COVERAGE

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

1. The Retiree's legal spouse of the opposite sex or the same sex who is less than age sixty-five (65) and to whom the Retiree is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

   An eligible Dependent does not include a spouse who is divorced from the Retiree and has a court order or decree stating such from a court of competent jurisdiction. **See "Termination of Coverage."**

2. The Retiree's Dependent who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child who has been placed with the Retiree for adoption and for whom as part of such placement the Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Retiree has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

   B. Is less than twenty-six (26) years of age. This requirement is waived if the Retiree's child is mentally handicapped/challenged or physically handicapped/challenged provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Retiree for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time; and

   C. Is not eligible to enroll in an employer-sponsored health plan of the Dependent's employer.

An eligible Dependent does not include (1) a Nonresident Alien (as defined in the Company's Flexible Compensation Plan); (2) a spouse of the Dependent child; (3) a child of the Dependent child; or (4) a dependent on active military duty for more than thirty-one (31) consecutive days.

A child born to or adopted by the Retiree or Retiree's spouse will be eligible for benefits from the moment of birth or adoption for a period of thirty-one (31) days whether the child is enrolled or not, provided the mother was covered for pregnancy. The child must be enrolled in accordance with the terms of the applicable Special Enrollment provisions of this Plan for coverage to continue beyond thirty-one (31) days.

FOR DENTAL BENEFIT COVERAGE

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

1. The Retiree's legal spouse of the opposite sex or the same sex who is less than age sixty-five (65) and to whom the Retiree is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

   An eligible Dependent does not include a spouse who is divorced from the Retiree and has a court order or decree stating such from a court of competent jurisdiction. **See "Termination of Coverage."**

2. The Retiree's Dependent who meets all of the following "Required Eligibility Conditions":

A. Is unmarried; and

B. Is a natural child; step-child; legally adopted child; a child who has been placed with the Retiree for adoption and for whom as part of such placement the Retiree has been granted full legal custody by a court of competent jurisdiction; a person for whom the Retiree has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

C. Is less than twenty-four (24) years of age. This requirement is waived if the Retiree's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Retiree for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time.

An eligible Dependent does not include (1) a Nonresident Alien (as defined in the Company's Flexible Compensation Plan); or (2) a dependent on active military duty for more than thirty-one (31) consecutive days.

If Eligible Retirees are married and both are eligible for Dependent Coverage, then either one or both of them may elect coverage under the Plan for children who meet the Dependent eligibility requirements as defined above.

ELIGIBILITY FOR DEPENDENT COVERAGE

A Retiree will become eligible for Dependent Coverage on the latest of: 1) the date the Retiree becomes eligible for coverage; or 2) the date on which the Retiree first acquires a Dependent. Except for COBRA Continuation Coverage, if both the Retiree and the Retiree's spouse are no longer covered under this Plan, Dependent children are ineligible for coverage.

WAIVE OR DECLINE COVERAGE

1. An eligible Retiree of the Company's South Dakota or Nebraska operations who terminated employment prior to November 1, 2009 and initially declined or waived coverage **is not** eligible to enroll for coverage under the Plan at a later date.

2. An eligible Retiree of the Company's South Dakota or Nebraska operations who terminated employment on or after November 1, 2009 but prior to January 1, 2011 and initially declined or waived coverage **is** eligible to enroll for coverage under the Plan at a later date.

3. An eligible Retiree of the Company's Montana operations who terminated employment prior to January 1, 2011 and initially declined or waived coverage **is** eligible to enroll for coverage under the Plan at a later date.

4. An eligible Retiree of the Company's Montana, South Dakota or Nebraska operations who terminates employment on or after January 1, 2011 and initially declines or waives coverage **is not** eligible to enroll for coverage under the Plan at a later date.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

RETIREE COVERAGE

Retiree coverage under the Plan will become effective on the Retiree's retirement date, provided that the Retiree meets the applicable eligibility requirements and application for such coverage is made on the Plan's enrollment form within thirty-one (31) days following the date of retirement.

DEPENDENT COVERAGE

For Dependents, coverage will become effective as follows:

1. On the Retiree's effective date of coverage, provided the Dependent was eligible on that date and the Retiree applies for Dependent Coverage on the Plan's enrollment form within thirty-one (31) days following his or her effective date of coverage. Enrollment under this subsection will not be considered Late Enrollment.

2. In the event a Dependent is acquired after the Retiree's effective date of coverage as a result of a legal guardianship or in the event that a Retiree is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following receipt of the Plan's enrollment form and copy of the court order, if applicable. Enrollment under this subsection will not be considered Late Enrollment.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be a period established by the Plan Administrator between October 1st and November 30th of each year, or such other times as determined by the Plan Administrator. The following may occur during an Open Enrollment Period:

1. A Retiree described under the Eligibility Provisions of this Plan who waived or declined coverage during the Initial Enrollment Period and is eligible to enroll for coverage at a later date may apply for Retiree and Dependent coverage during the Open Enrollment Period. Coverage must be requested on the Plan's enrollment form. A person who makes application for Retiree or Dependent coverage under this Plan other than during the Initial Enrollment Period or Special Enrollment Period will be considered a Late Enrollee, and subject to a maximum eighteen (18) month Pre-Existing Condition exclusionary period. Coverage requested under this provision during the Open Enrollment Period will become effective on the first day of the Calendar Year immediately following the Open Enrollment Period.

2. This Plan offers multiple options. During the Open Enrollment Period, a Retiree or the Retiree's eligible Dependents enrolled for coverage under the Plan at that time may elect to change plan options. Such change must be requested on a Plan's enrollment form. A change in a plan option will become effective on the first day of the Calendar Year immediately following the Open Enrollment Period. If no election or change is made during the Open Enrollment Period, coverage will be deemed to continue under the existing plan options.

   A person who changes their plan options during an Open Enrollment Period will not be considered a Late Enrollee.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment time allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below.

A "Special Enrollment Period" means a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period, during which an eligible person can request coverage under this Plan as a result of certain events that create special enrollment rights.

A. Special Enrollment for Birth

1. Eligible Individuals. When the following event occurs, a Retiree who is covered under the Plan at the time of the event, may enroll his or her eligible Dependents who are acquired through the event for coverage under the Plan:

    a. Birth of the Retiree's child.

2. Enrollment Period and Effective Date of Coverage. The Special Enrollment Period for eligible persons under this provision is for a period of ninety (90) days from the date of the event. Coverage will become effective on the date of the event provided that an application for such coverage on the Plan's enrollment form is submitted within ninety (90) days of special enrollment event.

B. Special Enrollment for Marriage, Adoption, or Placement for Adoption

1. Eligible Individuals. When the following events occur, a Retiree who is covered under the Plan at the time of the event, and may enroll his or her eligible Dependents who are acquired through the event for coverage under the Plan:

    a. Marriage to the Retiree; or

    b. Adoption of a child by the Retiree, provided the child is under the age of 19; or

    c. Placement for adoption with the Retiree provided such Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

2. Enrollment Period and Effective Date of Coverage. The Special Enrollment Period for eligible persons under this provision is for a period of sixty (60) days from the date of the event. Coverage will become effective on the date of the event provided that an application for such coverage on the Plan's enrollment form is submitted within sixty (60) days of the special enrollment event.

C. Special Enrollment for Loss of Coverage under Other Health Plan

1. Eligible Individuals. When coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), a Retiree who is covered at the time of the event may enroll his or her eligible Dependents who previously declined enrollment because of the other coverage.

    Loss of Coverage means only one of the following:

    a. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or

    b. Group or insurance health coverage that has been terminated as a result of termination of employer contributions** towards that other coverage; or

c. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:

1) Cessation of dependent status under other plan;

2) Death of the eligible Retiree's spouse;

3) Termination of employment of the eligible Dependent;

4) Reduction in the number of hours of employment of the eligible Dependent;

5) Termination of the eligible Dependent's employer's plan; or

6) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or

7) Any loss of eligibility for individual or group coverage because the eligible Dependent no longer resides, lives or works in the service area of the HMO or other such plan; or

8) Any loss of eligibility for coverage because the eligible Dependent incurs a claim for benefits that would meet or exceed the lifetime maximum of benefits for all causes.

**Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the eligible Dependent to pay premiums on a timely basis or coverage was terminated for cause.

2. Enrollment Period and Effective Date of Coverage. The Special Enrollment Period for eligible persons under this provision is for a period of sixty (60) days from the date of the event. Coverage will become effective on the date of the event provided that an application for such coverage on the Plan's enrollment form is submitted within sixty (60) days of the special enrollment event.

C. Special Enrollment for Loss of Eligibility or Entitlement to Financial Assistance under Children's Health Insurance Program or Medicaid Program

The Special Enrollment Period for eligible persons under this provision is for a period of sixty (60) days from the date coverage is terminated due to loss of eligibility or the date of entitlement to a Premium Assistance Subsidy. Coverage will become effective on the date of the event provided that an application for such coverage on the Plan's enrollment form is submitted within sixty (60) days of the special enrollment event.

1. Eligible Individuals. When coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) is terminated due to loss of eligibility or when entitlement to a Premium a Premium Assistance Subsidy is authorized under Medicaid or CHIP, a Retiree who is covered at the time of the event may enroll his or her eligible Dependents who lost coverage or became entitled to financial assistance under Medicaid or CHIP.

2. Enrollment Period and Effective Date of Coverage. The Special Enrollment Period for eligible persons under this provision is for a period of sixty (60) days from the date of the event. Coverage will become effective on the date of the event provided that an application for such coverage on the Plan's enrollment form is submitted within sixty (60) days of the special enrollment event. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (Medicaid or CHIP).

CHANGE IN STATUS EVENTS

In addition to the Special Enrollment rights described, above, which govern when a Retiree may enroll eligible persons outside of the Initial or Open Enrollment Periods, a Retiree is permitted to change or revoke their elections under this Plan outside of the Open Enrollment Period in the event of any of the following:

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

2. A change in the number of the Retiree's Dependents, including birth, death, adoption or placement for adoption;

3. A change in the employment status of the Retiree or his or her Dependent including a termination or commencement of employment, a strike or lockout, or a change in worksite. In addition, if eligibility conditions of this Plan, or the employer benefit plan of the Retiree's Dependent, depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment status;

4. Events that cause the Retiree's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance;

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

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

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

Any change or revocation of an election under this Plan as a result of one of the above events must be consistent with the event. For example, if, as a result of marriage, the Retiree gains eligibility for coverage under his or her Spouse's employer benefit plan, revocation by the Retiree of his or her coverage under this Plan would be consistent with that Change in Status Event (marriage).

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

CHANGE IN EMPLOYMENT STATUS WITH THE COMPANY

If a Covered Dependent under this Plan becomes an eligible Employee of the Company, he/she may continue his/her coverage as a Dependent or elect to be covered as a Participant under the Company's plan for active employees.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.

2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:

   A. Provides for child support for a child of a Participant under this Plan, or;

   B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and

   C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

3. "Plan" means this self-funded Retiree Health Benefit Plan, including all supplements and amendments in effect.

4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and

2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether Medical Child Support Orders are qualified orders; and

2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

ERISA REPORTING AND DISCLOSURE REQUIREMENTS

The Plan Administrator will ensure that the Alternate Recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the Alternate Recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan amendment.

NATIONAL MEDICAL SUPPORT NOTICE

If the Plan Administrator of a group health plan which is maintained by the Employer of a noncustodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

TERMINATION OF COVERAGE

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

1. An event that creates a special enrollment right as described in the "Special Enrollment Period" provisions of this Plan.

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

3. An event described in the "Retiree Termination" and "Dependent Termination" provisions of this Plan.

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

RETIREE TERMINATION

Retiree coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month immediately preceding the month in which the Retiree attains age sixty-five (65); or

2. On the last day of the month in which the Retiree ceases to be eligible for coverage; or

3. The date the Plan is terminated; or

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

5. The date the Retiree dies; or

6. The date the Retiree enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days.

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

DEPENDENT TERMINATION\

Each Covered Person, whether Retiree or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage after Termination.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Retiree ceases to be eligible for coverage, provided that:

   A. If the Retiree ceases to be eligible for coverage because he or she has attained age sixty-five

(65) but his or her Dependent spouse has not, then such Dependent spouse and Dependent children may remain covered under the terms of this Plan provided that the Retiree was enrolled for coverage under the Plan immediately prior to attaining age sixty-five (65);

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

3. The date the Plan is terminated; or

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

5. On the last day of the month in which the Retiree dies; or **See "Surviving Spouse Continuation Coverage."**

6. The date the Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty-one (31) days.

CONTINUATION COVERAGE AFTER TERMINATION

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

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

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

1. Qualifying Events for Dependents who are Qualified Beneficiaries, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

   A. Death of the Retiree.

   B. The divorce or legal separation of the Retiree from his or her spouse.

   C. A covered Dependent child ceases to be a Dependent as defined by the Plan.

2. Qualifying Events for covered Retirees, for purposes of this section are:

   A. Bankruptcy, if the covered Retiree retired on or before the date of any substantial elimination of group health coverage due to bankruptcy.

3. Qualifying Events for the Dependents of Covered Retirees, for purposes of this section are:

   A Bankruptcy, if the Dependent was a Qualified Beneficiary of a covered Retiree on or before the day before the bankruptcy-qualifying event.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Plan Administrator in writing within sixty (60) days after the date of any of the following Qualifying Events.

1. Death of the Retiree.

2. The divorce or legal separation of the Retiree from his or her spouse.

3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

ELECTION OF COVERAGE

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

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

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA participant plus an additional administrative expense of up to a maximum of two percent (2%).

2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA participant.

3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:

    A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce, legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.

    B. If the second Qualifying Event occurs during the nineteenth (19^{th}) through the twenty-ninth (29^{th}) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Plan Administrator of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Plan Administrator.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: NorthWestern Corporation dba NorthWestern Energy, 11 E Park St, Butte, Montana 59701-1711.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and dependent children of the Retiree can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the Retiree dies or becomes divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: NorthWestern Corporation dba NorthWestern Energy, 11 E Park St, Butte, Montana 59701-1711. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The dependents of a Retiree are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the Retiree's enrollment in Part A, Part B or Part D of Medicare, whichever occurs earlier.

When the Retiree enrolls in Medicare after the Qualifying Event of termination of employment, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

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

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

   This exception applies to all Qualified Beneficiaries.

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

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

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

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

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

   A. Thirty-six (36) months for Qualified Beneficiaries due to divorce or legal separation of the Retiree from his or her spouse; loss of Dependent child eligibility; or the death of the Retiree.

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

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

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to NorthWestern Corporation dba NorthWestern Energy, 11 E Park St, Butte, Montana 59701-1711, or contact the nearest Regional or District

Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

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

SURVIVING SPOUSE AND DEPENDENT CONTINUATION COVERAGE

For Retirees who were deceased prior to January 1, 2010, a surviving spouse of a Retiree who was covered under this Plan on the date of the Retiree's death may elect to continue coverage under this Plan without electing COBRA Continuation Coverage until he or she reaches age 65, remarries or becomes eligible under another plan, whichever occurs first. Dependent children can continue coverage under this provision, as long as the surviving spouse is covered under this provision and they remain eligible Dependents. In the event there was no surviving spouse, Dependent children who were covered under this Plan on the date of the Retiree's death can continue coverage without electing COBRA Continuation Coverage until the earliest of the following events:

1. They cease to be eligible Dependents; or

2. They become eligible for another group plan; or

3. Another person/agency obtains legal guardianship.

In the event that a Retiree becomes deceased on or after January 1, 2010, a surviving spouse of a Retiree who is covered under this Plan on the date of the Retiree's death may elect to continue coverage under this Plan without electing COBRA Continuation Coverage for a period of twenty-four (24) months, until he or she reaches age 65, remarries or becomes eligible under another plan, whichever occurs first. Dependent children can continue coverage under this provision, as long as the surviving spouse is covered under this provision and they remain eligible Dependents. In the event there is no surviving spouse, Dependent children who are covered under this Plan on the date of the Retiree's death can continue coverage without electing COBRA Continuation Coverage until the earliest of the following events:

1. They cease to be eligible Dependents; or

2. They become eligible for another group plan; or

3. Another person/agency obtains legal guardianship; or

4. They have been covered under this provision for a period of twenty-four (24) months.

FRAUD AND ABUSE

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

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

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

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

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

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

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

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

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment form or claim, the Covered Person's eligibility or amount of benefits, or both, will be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age will not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Retiree misrepresents a Dependent's eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

MISUSE OF IDENTIFICATION CARD

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

REIMBURSEMENT TO PLAN

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

RECOVERY/REIMBURSEMENT/SUBROGATION

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

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefited from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf. In addition, if Benefits are assigned or payment to a Participating Provider is made, the Plan reserves the right to offset Benefits to be paid to the Participating Provider by any amounts that such provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to this section.

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

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

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

REIMBURSEMENT

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

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan. The Plan

may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

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

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

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

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

2. If the Plan makes a payment that the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment.

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

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

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

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

CREDITABLE COVERAGE PROCEDURES

CERTIFICATION OF CREDITABLE COVERAGE

The Plan will provide Certification of Creditable Coverage for coverage under this Plan as required by the United States Department of Labor to any Covered Person or the Covered Person's designated and authorized agent, guardian, conservator, health care plan or health insurance as follows:

1. At the time the Covered Person ceases to be covered under this Plan; and,

2. At the time a Covered Person ceases to be covered by the COBRA Continuation Coverage provided by this Plan, if any; and,

3. At any other time that a request is made on behalf of the Covered Person for such certification, but not later than twenty four (24) months after cessation of coverage as set out in subparagraphs 1 and 2 above, whichever is later.

CREDITABLE COVERAGE

An eligible Retiree or Dependent under this Plan may submit to the Plan, Certification of Creditable Coverage from any prior health insurance or health care plan under which said Retiree or Dependent had coverage, for the purpose of reducing, on a day for day basis, any exclusion imposed by this Plan for any Pre-Existing Condition for which the eligible Retiree or Dependent had applicable Creditable Coverage under any prior insurance or health care coverage.

An eligible Retiree or Dependent has a right to request and receive a Certification of Creditable Coverage from any insurance carrier or health care plan under which he/she had coverage on or after July 1, 1996.

In the event that the eligible Retiree or Dependent is unable to obtain a Certification of Creditable Coverage from a prior insurance carrier or health care plan, the Plan Administrator may provide assistance to obtain the same.

CREDITABLE COVERAGE REVIEW

Upon the Plan's receipt of a Certification of Creditable Coverage regarding prior coverage by any enrollee for coverage under this Plan, the Plan acting on its own or through a firm contracted to provide services to the Plan, will send to such enrollee a written confirmation of the amount of prior Creditable Coverage, if any, to which the enrollee will be entitled against any Pre-Existing Condition exclusionary period under this Plan. Such written confirmation will be provided to the enrollee within thirty (30) days of receipt of the Certification by the Plan.

In the event that an enrollee disagrees with the Plan's calculation of any prior Creditable Coverage, the enrollee will send written notice of said disagreement to the Plan, together with a written request for review of the calculation, within fifteen (15) days of receipt of the Plan's written confirmation. Failure to submit a written notice of disagreement and request for review of the calculation within the time limit required in this section will be deemed a waiver of any further review.

Upon receipt by the Plan of a notice of disagreement and request for review, the Plan will review the calculations, and will either affirm those calculations or revise its calculation and determination of prior Creditable Coverage. The Plan Administrator will notify the enrollee, in writing, of its decision after review within thirty (30) days after receipt of the notice of disagreement and request for review. The Plan Administrator's decision regarding prior Creditable Coverage will be final and binding upon the Plan and any Covered Person under the Plan.

DETERMINATION OF PRIOR CREDITABLE COVERAGE WHEN A CERTIFICATION IS UNAVAILABLE

If an enrollee is unable to obtain a Certification of Creditable Coverage, for prior coverage, after having exhausted all reasonable efforts to obtain the same, such an enrollee may request in writing that the Plan make a determination whether he or she is entitled to prior Creditable Coverage based upon other evidence and information. Said request must be submitted to and received by the Plan within sixty (60) days of the effective date of coverage of the person for whom the request is made.

Upon receipt by the Plan of a request to determine prior Creditable Coverage in the absence of a Certification, the Plan will require that the person for whom the request is made provide to the Plan all evidence in support of such request within sixty (60) days of the initial request. A longer period of time, up to an additional sixty (60) days, may be granted, to submit evidence, upon written request and good cause for the same. Evidence submitted will include in every case, a sworn affidavit by the person for whom the determination is to be made, or by that person's parent or guardian, if the person is a minor, or is incompetent or unable to execute such an affidavit. The affidavit will contain the following information:

1. The name of the prior insurance carrier(s), benefit plan(s) or other payer(s) of medical benefits under which prior Creditable Coverage is asserted to exist.

2. The date(s) that coverage commenced and ended under any such prior insurance, benefit plan or other payer.

3. The address, if known, of the insurance carrier(s), benefit plan(s) or other payer(s).

4. The nature of the coverage under the prior insurance, benefit plan(s) or other benefit payer(s).

5. A description of the efforts undertaken to obtain Certifications of prior Creditable Coverage, and the results of those efforts.

6. The names, and addresses or telephone numbers, of former employers, insurance agents, human resource personnel, third party administrators, HMO's or medical providers that may have knowledge of the asserted prior coverage.

7. Any other information that the affiant deems relevant.

PLAN ADMINISTRATION

PURPOSE

The purpose of this Plan Document is to set forth the provisions of the Plan that provide for the payment or reimbursement of all or a portion of Covered Medical Expenses, Covered Prescription Drug Products and Covered Dental Expenses. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Retirees and their covered Dependents.

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

EFFECTIVE DATE

The effective date of the Plan is January 1, 2012.

PLAN YEAR

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

PLAN SPONSOR

The Plan Sponsor is NorthWestern Corporation dba NorthWestern Energy.

CLAIM ADMINISTRATOR

The Claim Administrator for the medical benefits provided under the Plan is Blue Cross and Blue Shield of Montana.

The Claim Administrator for the prescription drug benefits provided under the Plan is Express Scripts, Inc.

The Claim Administrator for the dental benefits provided under the Plan is Delta Dental Insurance Company.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

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

OTHER CLAIM APPEALS

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

circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to the Participant within the initial ninety (90) day period).

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

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

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

PLAN INTERPRETATION

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

CONTRIBUTIONS TO THE PLAN

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

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

2. The Company provides contributions for Retiree and Dependent coverage under this Plan. The Company or the Plan will pay no portion of contributions for COBRA Continuation Coverage. Specific information regarding the actual amount of any contribution for coverage under this Plan may be obtained from the Plan Sponsor, by contacting the NWE Benefits department at (888) 236-6656 and requesting that information. The amount of any contribution for Retiree or Dependent coverage, except the amounts for COBRA Continuation Coverage, may be increased, decreased or modified at any time by the Plan.

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

PLAN AMENDMENTS/MODIFICATION/TERMINATION

This Plan Document contains terms applicable to this Plan, which is a component of the NorthWestern Energy Flexible Compensation Plan. A separate plan document has been prepared for the NorthWestern

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

NOTICE OF REDUCTION OF BENEFITS

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

TERMINATION OF PLAN

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

SUMMARY PLAN DESCRIPTION

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

GENERAL PROVISIONS

CLERICAL ERRORS

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

NOTICES

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

RESCISSION

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

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim when and as often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

Claim Payment Assignment

All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any provider furnishing Covered Medical Expenses for which such payment is due, and the Claim Administrator is authorized by such Covered Person to make such payments directly to such providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or provider furnishing Covered Medical Expenses. If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate.

Claim Dispute

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

Plan Coverage Assignment

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

LEGAL PROCEEDINGS

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

NO WAIVER OR ESTOPPEL

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

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

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

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

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

MISCELLANEOUS

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

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

FACILITY OF PAYMENT

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

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

IDENTIFICATION OF FUNDING

Your benefits under this plan will be paid from your or employer contributions up to the limits defined in the Plan Document and Summary Plan Description (SPD). Benefits in excess of the amount stated in the stop loss policy are reimbursable to the employer by stop loss insurance, pursuant to the stop loss insurance contract or policy, subject, however, to the terms of this Plan and the stop loss insurance contract.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

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

RELATIONSHIP BETWEEN THE CLAIM ADMINISTRATOR AND PROFESSIONAL PROVIDERS

The choice of a provider is solely the choice of the Covered Person and the Claim Administrator will not interfere with the Covered Person's relationship with any provider. Each provider provides covered services only to Covered Persons and does not otherwise interact with or provide any services to the Employer or the Plan.

Participating Providers furnishing care to a Covered Person do so as independent contractors with the Claim Administrator. The Claim Administrator does not itself undertake to furnish Hospital, medical or dental services, but acts solely to make claim payments to a Participating Provider for the Covered Services received by a Covered Person. The relationship between a provider and a patient is personal, private, and confidential. The Claim Administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a provider are not provided by the Claim Administrator. Any contractual relationship between a provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional service. Any reference

or statement by the Claim Administrator to a provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by the Claim Administrator as to the ability or quality, positive or negative, of such provider.

Neither the Plan nor the Claim Administrator is responsible for the negligence, wrongful acts, or omissions of any provider, or provider's employees, providing services, or a Participant receiving services. Neither the Plan nor the Claim Administrator is liable for services or facilities that are not available to a Participant for any reason.

GENERAL DEFINITIONS

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

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

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

ACCIDENTAL INJURY

"Accidental Injury" means an unexpected traumatic incident or unusual strain which is:

1. Identified by time and place of occurrence;
2. Identifiable by part of the body affected; and
3. Caused by a specific event on a single day.

Some examples include:

1. Fracture or dislocation.
2. Sprain or strain.
3. Abrasion, laceration.
4. Contusion.
5. Embedded foreign body.
6. Burns.
7. Concussion.

ACTIVE SERVICE

"Active Service" means that an Employee is in service with the Company on a day which is one of the Company's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the Company on a regular basis, either at one of the Company's business establishments or at some location to which the Company's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

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

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers' billed charge; or

2. Diagnosis-related group (DRGs) methodology is a system used to classify hospital cases into one of approximately 500 to 900 groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the DRG system can be considerably less than the nonparticipating providers' billed charge; or

3. Billed Charge is the amount billed by the provider; or

4. Case Rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Case Rate system can be considerably less than the nonparticipating providers' billed charge; or

5. Per Diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Per Diem system can be considerably less than the nonparticipating providers' billed charge; or

6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the Flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or

7. Flat fee per unit of service fixed payment amount for a unit of service, For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or

8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or

9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or

10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or

11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.

12. The Allowable Fee is first determined based on the Provider's status:

i. ***For Participating Providers.*** A Participating Provider is a provider who has a written agreement with Blue Cross and Blue Shield of Montana or another Blue Cross and/or Blue Shield Plan for compensation terms for care provided to a Covered Person at the time Covered Services for medical benefits are rendered ("Participating Provider"). The Allowable Fee for Participating Providers is based on the compensation terms of the Participating Provider's contract and the payment methodology in effect on the date of the Covered Service. The payment methodologies used include fixed fee schedules, per unit fee schedules, diagnosis-related groups (DRG), per diems, case rates, package pricing, global pricing, discounts off eligible billed charge, or other payment methodologies. Claim administrator claim processing rules and/or edits may also alter the Allowable Fee for particular service.

ii. ***For non-participating providers.*** For a Provider who does not have a written agreement with Blue Cross and Blue Shield of Montana or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("non-participating provider"),

a. For a non-participating provider in Montana, the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. Blue Cross and Blue Shield of Montana will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

   Any change to the Medicare reimbursement amount will be implemented by the Plan within 90 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

b. For a non-participating provider outside Montana, the Allowable Fee (i) for professional providers is based on publicly available data and historic reimbursement to providers for the same or similar professional services, adjusted for geographic differences where applicable, or (ii) for Hospital or other facility providers is based on publicly available data reflecting the approximate cost that Hospitals or other facilities have incurred historically to provide the same or similar service, adjusted for geographic differences where applicable, plus a margin factor for the Hospital or facility.

   In the event the nonparticipating Allowable Fee does not equate to the non-participating provider's billed charges, the Participant will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's nonparticipating Allowable Fee for a particular service, Participants may call the customer service number shown on the back of their identification card.

AMBULANCE SERVICE

“Ambulance Service” means an entity, its personnel and equipment, including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Covered Medical Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

“Benefit Period” refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or

2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or

3. The date the Plan terminates.

BIRTHING CENTER

A “Birthing Center” means a freestanding or hospital based facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

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

CARE MANAGEMENT

“Care Management” is a process that assesses and evaluates options and services required to meet the Covered Person’s health care needs. Care Management may involve a team of health care professionals, including Participating Providers, the Claim Administrator and other resources to work with the Covered Person to promote quality, cost-effective care.

CLAIM ADMINISTRATOR

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

CLAIM FORM

“Claim Form” means the standard form used to file a claim or request a Pre-Treatment Estimate for treatment.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

”COBRA” means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

”COBRA Continuation Coverage” means the coverage provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments.

COMPANY

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

CONTRACT ALLOWANCE (DENTAL BENEFITS)

“Contract Allowance” means the maximum amount the Claim Administrator for dental benefits will use for calculating benefits for a Single Procedure. The Contract Allowance for services provided:

1. By Delta Dental PPO^{SM} Dentists is the lesser of the Dentist’s submitted fee, the Delta Dental PPO Dentist’s fee or the Dentist’s filed fee with Delta Dental in the Participating Dentist Agreement;

2. By Delta Dental Premier Dentists (who are not PPO Dentists) is the lesser of the Dentist’s submitted fee, the Dentist’s filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or

3. By Non-Delta Dental Dentists is the lesser of the Dentist’s submitted fee or the Maximum Plan Allowance.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

CONVALESCENT PERIOD

“Convalescent Period” means a period of time commencing with the date of confinement by a Covered Person in a Skilled Nursing Facility. Such confinement must meet all of the following conditions:

1. Such confinement must commence within fourteen (14) days of being discharged from an accredited Hospital; and

2. Said Hospital confinement must have been for a period of not less than three (3) consecutive days; and

3. Both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period will not commence until a previous Convalescent Period has terminated.

COSMETIC

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

COVERED MEDICAL EXPENSES AND COVERED DENTAL EXPENSES

"Covered Medical Expenses" and "Covered Dental Expenses" means the maximum amount of any charge for a covered service, treatment or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible, Copayment or used to satisfy the Out-of-Pocket Maximum. Covered expenses are equal to the actual billed charge, Allowable Fee, Contract Allowance, or negotiated provider charge, whichever applies.

COVERED PERSON

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

COVERED PROVIDER

"Covered Provider" means a Participating Provider or nonparticipating provider which has been recognized by Blue Cross and Blue Shield of Montana as a provider of services for medical benefits provided in this Plan. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, the Plan looks to the nature of the services rendered, the extent of licensure and the Plan's recognition of the provider. Refer to the section entitled Medical Providers of Care for Participants.

CREDITABLE COVERAGE

"Creditable Coverage" means health or medical coverage under which a Covered Person was covered, prior to that Covered Person's Enrollment Date under this Plan, which prior coverage was under any of the following:

1. A group health plan.

2. Health Insurance coverage.

3. Part A, Part B or Part C of Title XVIII of the Social Security Act (Medicare).

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928.

5. Chapter 55 of Title 10, United States Code (active military and CHAMPUS).

6. A medical care program of the Indian Health Service or a tribal organization.

7. A state health benefits risk pool.

8. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefits).

9. A public health plan.

10. A health benefit plan under Section 5 (e) of the Peace Corps Act.

CUSTODIAL CARE

"Custodial Care" means any service, primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the

Participant's condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE

"Deductible" means a specified dollar amount of Covered Medical Expenses and Covered Dental Expenses that must be incurred before the Plan will pay any amount for any Covered Medical Expenses or Covered Dental Expenses during each Benefit Period.

DELTA DENTAL PPO DENTIST (PPO DENTIST)

"Delta Dental PPO Dentist (PPO Dentist)" means a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO Dentist's Fees as payment in full and comply with Delta Dental's administrative guidelines. All PPO Dentists are also Premier Dentists. All PPO Dentists must be contracted in the Premier network.

DELTA DENTAL PPO DENTIST'S FEE (PPO DENTIST'S FEE)

"Delta Dental PPO Dentist's Fee (PPO Dentist's Fee)" means the fee outlined in the Participating PPO Dentist Agreement. PPO Dentists agree to charge no more than this fee for treating PPO Participants.

DELTA DENTAL PREMIER DENTIST (PREMIER DENTIST)

"Delta Dental Premier Dentist (Premier Dentist)" means a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's MPA for each Single Procedure as payment in full.

DENTALLY NECESSARY

"Dentally Necessary" means services that are necessary and appropriate for the diagnosis or treatment of a covered person's dental condition according to accepted standards of dental practice and that are not provided only as a convenience.

DEPENDENT

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

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of covered expense for an Illness or Injury of a Dependent.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment that is:

1. Able to withstand repeated use, i.e., could normally be rented, and used by successive patients; and

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful to a person in the absence of Illness or Injury.

EMERGENCY OR MEDICAL EMERGENCY

"Emergency" or "Medical Emergency" means a medical condition manifesting itself by acute symptoms which occur suddenly and unexpectedly and for which the Covered Person receives medical care no later than 48 hours after the onset of the condition. Emergency is any medical condition for which a reasonable and prudent layperson, possessing average knowledge of health and medicine, would expect that failure to seek immediate medical attention would result in death, more severe or disabling medical condition(s), or continued severe pain without cessation in the absence of medical treatment. Emergency may include, but is not limited to, severe Injury, hemorrhaging, poisoning, loss of consciousness or respiration, fractures, convulsions, injuries reasonably likely to require sutures, severe acute pain, severe burns, prolonged high fever and symptoms normally associated with heart attack or stroke.

"Emergency" or "Medical Emergency" will specifically exclude usual out-patient treatment of childhood diseases, flu, common cold, pre-natal examinations, physical examinations and minor sprains, lacerations, abrasions and minor burns, and other medical conditions usually capable of treatment at a clinic or doctor's office during regular working hours.

EMPLOYEE

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

EMPLOYER

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

ENROLLMENT DATE

"Enrollment Date" means the date a person becomes eligible for coverage under this Plan or the eligible person's effective date of coverage under this Plan, whichever occurs first

ERISA

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

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

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

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

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

FAMILY

"Family" means a Participant and his or her eligible Dependents as defined herein.

FORMULARY

"Formulary" means a list that identifies those Prescription Drug Products that are preferred by the Plan for dispensing to a Participant, when appropriate. This list is reviewed quarterly and subject to modification. Formulary details can be found at www.express-scripts.com.

FORMULARY DRUG

"Formulary Drug" means a Prescription Drug Product identified on the Formulary.

GENERIC

"Generic" means a medication that is comparable to brand/reference listed drug product, has the same active ingredient(s), is expected to have the same clinical effect, and is available by multiple manufacturers.

HIPAA

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

HOSPICE

"Hospice" means a facility, agency, or service that:

1. Is licensed, accredited, or approved by the state to establish and manage Hospice care programs;

2. Arranges, coordinates, and/or provides Hospice care services for terminally ill patients and their families; and

3. Maintains records of Hospice care services provided and bills for such services on a consolidated basis; or

4. Is a Home Health Agency that provides Hospice care.

HOSPICE BENEFIT PERIOD

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, the Plan Administrator will require additional proof before a new Hospice Benefit Period can begin.

HOSPITAL

"Hospital" means an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or inpatient basis at the patient's expense; and

2. It is licensed as a hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and

3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and

4. It provides treatment by or under the supervision of a physician or osteopathic physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and

5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and

6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for Substance Use Disorder, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

"Hospital Miscellaneous Expenses" mean the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person that are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services, regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

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

INCURRED EXPENSES OR EXPENSES INCURRED

"Incurred Expenses" or "Expenses Incurred" means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

"Initial Enrollment Period" means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

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

INPATIENT

"Inpatient" means the classification of a Covered Person when that Person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment from a Covered Provider, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INPATIENT CONFINEMENT DAY

"Inpatient Confinement Day" means any day a person is classified as Inpatient. An Inpatient Confinement Day will commence at 12:01 A.M. and will be calculated using a calendar day.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

3. It provides constant observation and treatment by Registered Nurses (RNs) or other highly trained Hospital personnel.

LATE ENROLLMENT OR LATE ENROLLEE

"Late Enrollment" or "Late Enrollee" means an eligible person who makes application for Retiree or Dependent Coverage under this Plan other than during the Initial Enrollment Period or a Special Enrollment Period.

LICENSED HEALTH CARE PROVIDER

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

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED SOCIAL WORKER

"Licensed Social Worker" means a person holding a Masters Degree (M.S.W.) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MAXIMUM LIFETIME BENEFIT

"Maximum Lifetime Benefit" means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage or benefits for a person's Illness or Injury after coverage terminates under this Plan.

MAXIMUM PLAN ALLOWANCE (MPA) (DENTAL BENEFITS)

"Maximum Plan Allowance (MPA)" means the maximum amount the Claim Administrator for dental benefits will reimburse for a covered procedure. The Claim Administrator establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of participating Dentist.

MAXIMUM AMOUNT (DENTAL BENEFITS)

Maximum Amount payable is shown on the Schedule of Dental Benefits page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

MEDICAID

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

MEDICALLY NECESSARY/MEDICAL NECESSITY

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

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

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

3. not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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

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

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

MEDICAL POLICY

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

1. Final approval from the appropriate governmental regulatory agencies;

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

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

Medical Policy is reviewed and modified periodically as is necessary.

MEDICARE

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

MENTAL ILLNESS

"Mental Illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

1. Present distress or a painful symptom;

2. A disability or impairment in one or more areas of functioning; or

3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom. Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. Developmental disorders;

2. Speech disorders;

3. Psychoactive substance use disorders;

4. Eating disorders (except for bulimia and anorexia nervosa); or

5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).

NAMED FIDUCIARY

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

NON-DELTA DENTAL DENTIST

"Non-Delta Dental Dentist" means a Dentist who is neither a Premier nor a PPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

NON-PREFERRED BRAND

"Non-Preferred brand means a Prescription Drug Product that is not identified on the Formulary.

OCCUPATIONAL THERAPY

"Occupational Therapy" means therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount, as stated in the Schedule of Medical Benefits, that any Covered Person or Family will pay in any Benefit Period for Covered Medical Expenses.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services or supplies from a Covered Provider at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bed patient at that Hospital, Psychiatric Facility or Substance Use Disorder Treatment Facility.

PARTIAL HOSPITALIZATION

“Partial Hospitalization” means a time - limited ambulatory (outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening, and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas. A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPANT

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

PARTICIPATING DENTIST AGREEMENT

“Participating Dentist Agreement” means an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

PARTICIPATING FACILITY PROVIDER

“Participating Facility Provider” means a facility that has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana. Participating Facility Providers include, but are not limited to, Hospitals, Home Health Agencies, Convalescent Homes, Freestanding Inpatient Facilities, and freestanding surgical facilities that have a Preferred Provider Organization (PPO) contract with the Claim Administrator. Refer to the section entitled Medical Providers of Care for Participants.

PARTICIPATING PHARMACY

“Participating Pharmacy” means a pharmacy that has entered into an agreement with the Pharmacy Benefit Manager to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates. To find a Participating Pharmacy access the Express Scripts, Inc. website at www.express-scripts.com.

PARTICIPATING PPO DENTIST AGREEMENT (PPO DENTIST AGREEMENT)

“Participating PPO Dentist Agreement (PPO Dentist Agreement)” means an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a PPO program.

PARTICIPATING PROFESSIONAL PROVIDER

“Participating Professional Provider” means a professional health care provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana. Participating Professional Providers include, but are not limited to, Physicians, physician assistants, nurse specialists, Dentists, podiatrists, Home Infusion Therapy Agencies, speech therapists, physical therapists, and occupational therapists. Refer to the section entitled Medical Providers of Care for Participants.

PARTICIPATING PROVIDER

“Participating Provider” means a provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana.

PHARMACY BENEFIT MANAGER

"Pharmacy Benefit Manager" means the company with whom the Plan Sponsor has entered into an agreement for the processing of prescription drug claims. Information for the Plan's Pharmacy Benefit Manager can be found on the inside cover of this Plan Document.

PHYSICAL THERAPY

"Physical Therapy" means the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.

PHYSICIAN

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

PLAN

"Plan" means the Health Benefit Plan for Retirees under Age 65 of NorthWestern Corporation DBA NorthWestern Energy, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

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

PPO – A PREFERRED PROVIDER ORGANIZATION

"PPO – A Preferred Provider Organization" means a provider or group of providers which have contracted with the Plan to provide services to Participants covered under PPO benefit contracts.

PREAUTHORIZATION

"Preauthorization" means the process of determining in advance the Medical Necessity or the Experimental/Investigational/Unproven nature of a health care service or supply proposed to be provided to a Participant. Preauthorization does not guarantee that a health care service or supply received by a Participant is a Benefit of the Plan. Coverage for Benefits under the Plan can only be determined once a claim for a health care service or supply is received by the Claim Administrator and reviewed in accordance with the terms of the Plan.

PRE-EXISTING CONDITION

"Pre-Existing Condition" means an Injury or Illness of a Covered Person, except for Pregnancy, for which the Covered Person has been under the care of a Physician or Licensed Health Care Provider, or has received medical advice, diagnosis, treatment, services or care, including prescription drugs, within the six (6) month period immediately preceding his/her Enrollment Date. Pregnancy will never be considered a Pre-Existing Condition for any reason.

PRE-TREATMENT ESTIMATE (DENTAL BENEFITS)

"Pre-Treatment Estimate" means an estimation of the allowable benefits under this Plan for the services proposed, assuming the person is an eligible Participant.

PREFERRED BRAND

"Preferred Brand" means a Prescription Drug Product identified on the Formulary.

PREGNANCY

“Pregnancy” means a physical condition commencing with conception, and ending with miscarriage or birth.

PRESCRIPTION DRUG PRODUCT

“Prescription Drug Product” means a medication, product, or device approved by the Food and Drug Administration and dispensed under federal or state law only pursuant to a prescription order or refill.

PREVENTIVE CARE

“Preventive Care” means routine examinations or services provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided for treatment or diagnosis of any Injury or Illness.

PRIOR AUTHORIZATION

“Prior Authorization” means a process to inform the Participant whether or not a proposed self-administered prescription drug product is Medically Necessary and whether or not it is a covered Benefit under the Plan. Please refer to the Prescription Drug Benefit Program section of this Plan Document.

PRIVACY OFFICER

“Privacy Officer” means the person designated by the Plan Sponsor to develop, implement and oversee the Plan Sponsor’s compliance with the data privacy and security rules and provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PROCEDURE CODE

“Procedure Code” means the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

PROSTHETIC APPLIANCE

“Prosthetic Appliance” means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of covered dental benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

“Psychiatric Care,” also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Substance Use Disorder by a licensed psychiatrist, psychologist, Licensed Social Worker or licensed professional counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

“Psychiatric Facility” means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

“Psychologist” means a person currently licensed in the state in which services are rendered as a psychologist and acting within the scope of his/her license.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means a Retiree or Dependent of a Retiree who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO's.

“Qualified Beneficiary” will also include a child born to, adopted by or placed for adoption with a Retiree at any time during COBRA Continuation Coverage.

QMCSO

“QMCSO” means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

REGISTERED NURSE

“Registered Nurse” means an individual who has received specialized nursing training and is authorized to use the designation of “RN” and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

RESIDENTIAL TREATMENT CENTER

“Residential Treatment Center” means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorder. Blue Cross and Blue Shield of Montana requires that any Mental Health and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Montana as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RETIREE

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

ROOM AND BOARD

“Room and Board” refers to all charges that are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SINGLE PROCEDURE

“Single Procedure” means a dental procedure that is assigned a separate CDT number.

SKILLED NURSING FACILITY

“Skilled Nursing Facility” means an institution, or distinct part thereof, that meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;

2. It is not, other than incidentally, a place for rest, the aged, Substance Use Disorder, mentally disabled persons, custodial or educational care, or care of mental disorders; and

3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPECIALTY MEDICATIONS

"Specialty Medications" means high cost, hard to manage injectables, select orals, and/or infused therapies that are administered by the patient or Physician for the treatment of chronic Illness.

SPEECH THERAPY

"Speech Therapy" means treatment of communication impairment and swallowing disorders.

SUBSTANCE USE DISORDER

"Substance Use Disorder" means the uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner

SUBSTANCE USE DISORDER TREATMENT FACILITY

"Substance Use Disorder Treatment Facility" means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Substance Use Disorder; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

TELEHEALTH

Telehealth means the use of interactive audio, video, or other telecommunications technology that is:

1. Used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and
2. Delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. For purposes of coverage under this Plan during the period outlined in the Schedule of Medical Benefits, the term also includes the use of audio-only telephone transmissions. The term does not include email or facsimile transmissions.

ERISA STATEMENT OF RIGHTS

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

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

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

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report upon request.

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

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred and ten dollars ($110.00) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part (an Adverse Benefit Determination), you may file suit in a state or federal court once you have exhausted your appeal rights under the Plan's claims and appeals procedures. If you believe the Plan fiduciaries have misused Plan assets, or that you have been discriminated against for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide which party will pay the court costs and legal fees. The court may order the losing party to pay these court

costs and fees. You may be ordered to pay these costs and fees if you lose and the court finds your claim to be frivolous.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

HIPAA PRIVACY AND SECURITY STANDARDS

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

DEFINITIONS

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

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

PRIVACY NOTICE

The Plan Sponsor's HIPAA Privacy Notice describes the health information practices for the benefits provided under this Plan and that of the Claim Administrators and Pharmacy Benefit Manager under this Plan. Questions regarding this notice should be directed to the Plan Sponsor's Privacy Officer identified in the Plan Summary section of this Plan.

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

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

The Plan Sponsor is required by law to:

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

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

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

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

A. Use and Disclosure of Health Information About a Participant

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

There are nevertheless several circumstances under which it is necessary and lawful for the Plan Sponsor to use and disclose a Participant's health information. These are described by category in this

section under the headings "**Permitted Disclosures of Health Information"** and "**Special Disclosure Situations."**

B. A Participant's Rights Regarding Personal Health Information

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

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

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

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

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

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

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

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

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

   4) Is accurate and complete.

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

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

4. **Right to Request Restrictions.** A Participant has the right to request a restriction or limitation on the health information the Plan Sponsor uses or discloses about the Participant for treatment, payment or health care operation. A Participant also has the right to request a limit on the health

information the Plan Sponsor discloses about the Participant to someone who is involved in their care or the payment for their care, like a family member or friend. For example, a Participant could ask that the Plan Sponsor not use or disclose information about a surgery the Participant had. The Plan Sponsor is not required to agree to the Participant's request.

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

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

5. **Right to Request Confidential Communications.** A Participant has the right to request that the Plan Sponsor communicate with them about health matters in a certain way or at a certain location. For example, a Participant can ask that the Plan Sponsor only contact them at work or by mail.

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

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

C. Changes to The Plan Sponsor's Privacy Notice

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

D. Complaints

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

E. Other Uses of Health Information

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

F. Permitted Disclosures of Health Information

For each category of uses or permitted disclosures the Plan Sponsor will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the following categories:

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

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

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

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

G. Special Disclosure Situations

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

2. **Organ and Tissue Donation**. If a Participant is an organ donor, the Plan Sponsor may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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

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

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

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

2) To report births and deaths;

3) To report child abuse or neglect;

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

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

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

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

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

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

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

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

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

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

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

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

   5) About criminal conduct at the hospital; and

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

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

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

11. **Inmates.** If a Participant becomes an inmate of a correctional institution or under the custody of a

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

PRIVACY CERTIFICATION

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

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

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

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

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

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

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

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

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

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

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

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

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or Retirees designated by the Plan Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

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

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

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

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

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

PLAN SUMMARY

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

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

1. PLAN

The name of the Plan is the Health Benefit Plan For Retirees under Age 65 of NorthWestern Corporation DBA NorthWestern Energy, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for covered expenses incurred by eligible participants for:

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

3. PLAN EFFECTIVE DATE

This Plan was established effective January 1, 2012.

4. PLAN SPONSOR

Name:	NorthWestern Corporation dba NorthWestern Energy
Address:	11 E Park St
	Butte, MT 59701-1711
Phone:	(406) 497-2734

5. PLAN ADMINISTRATOR AND NAMED FIDUCIARY

Name:	NorthWestern Corporation dba NorthWestern Energy
	Attn: Employee Benefits Administration Committee
Address:	11 E Park St
	Butte, MT 59701-1711
Phone:	(406) 497-2734

6. PLAN FISCAL YEAR

The Plan fiscal year ends December 31st.

7. PLAN TERMINATION

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

8. IDENTIFICATION NUMBER

Plan Number:	531
Group Number:	X15474
Employer Identification Number:	46-0172280

9. CLAIM ADMINISTRATOR FOR MEDICAL

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

9. CLAIM ADMINISTRATOR FOR PHARMACY

Name: Express Scripts, Inc.
Address: 1 Express Way
St. Louis, MO 63121

11. CLAIM ADMINISTRATOR FOR DENTAL

Name: Delta Dental Insurance Company
Address: PO Box 1809
Alpharetta, GA 30023-1809

12. ELIGIBILITY

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

13. PLAN FUNDING

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

14. AGENT FOR SERVICE OF LEGAL PROCESS

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

15. PRIVACY OFFICER

Name: Director, Compensation and Benefits
Address: NorthWestern Energy
11 E Park Street
Butte, MT 59701
Phone: (406) 497-2734
Confidential
Fax: (406) 497-2083

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BlueCross BlueShield of Montana

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