NorthWestern Energy

Employee Benefit Plan

SUMMARY PLAN DESCRIPTION

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As in effect on January 1, 2025

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INTRODUCTION

The purpose of the NorthWestern Energy (Company) Employee Benefit Plan (Plan) is to provide employees with a cafeteria plan pursuant to Section 125 of the Internal Revenue Code and to consolidate the Company's various welfare benefit plans into a single plan for reporting and disclosure. The Plan Administrator is the Company's Employee Benefits Administration Committee (EBAC). EBAC is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. Additional information regarding EBAC's powers and duties related to the Plan are described in the "General Provisions" section on page 27.

As noted above, the Plan includes a cafeteria plan. A cafeteria plan provides the opportunity for you to choose the benefit plans and coverage levels that best meet your individual needs. Normally, the benefits offered are those that you would pay for with out-of-pocket taxable dollars. However, a cafeteria plan allows you the choice of receiving full wages or salary in cash or having the Company reduce your wages or salary before income and Social Security taxes are withheld to pay for certain benefits that you choose.

Each of the benefits offered under this Plan is sometimes referred to in this Summary Plan Description (SPD) as a "component plan."

The benefits provided under the following "component plans" are subject to the cafeteria plan provisions of the Plan:

- Group Benefit Plan
    - Group Medical Plan for Active Employees
    - Group Dental Plan for Active Employees
    - Group Vision Care Plan for Active Employees
- Health Care Reimbursement Account
- Dependent Care Reimbursement Account
- Health Savings Account (HSA)

The Plan also offers benefits under the following "component plans" that are not subject to the cafeteria plan provisions:

- Group Benefit Plan
    - Group Medical Plan for Retirees Under Age 65
    - Group Medical Plan for Retirees Age 65 or older
    - Group Dental Plan for Retirees Under Age 65

    - Group Vision Care Plan for Retirees Under Age 65
- Group Long Term Disability Plan
- Group Life Insurance Plan
- Employee Assistance Program (EAP)

The Company contributes significantly towards the cost of the benefits offered to you under the Plan which results in quality benefits at a very competitive cost to you. The Company's contributions are referred to under the Plan as "Benefit Dollars".

This SPD has been prepared to provide you with a general description of the major features of the Plan to include:

- Who is eligible to participate in the Plan;
- When you are eligible to participate in the Plan;
- The benefits offered under the Plan;
- Other important information about the Plan that you should know.

Additional information is provided in separate summary plan descriptions for the component plans, which are incorporated herein and made part of this SPD.

Many complex concepts have been simplified in the interest of presenting information that is easily understood. This is a summary of the official Plan document which is written in much more technical and precise language and is designed to comply with applicable legal requirements. If there are any inconsistencies between this SPD and the Plan document, the Plan document will govern in all cases. You can request a copy of the Plan document by contacting the Benefits department at (888) 236-6656 or by sending your request to:

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

This SPD and the summary plan descriptions for the component plans covered by this Plan are also available on the Company's intranet site.

This SPD does not constitute an implied or expressed contract or guarantee of employment.

ELIGIBILITY

Eligible Employee

Employees are eligible to participate in the Plan ("Eligible Employees") if they are classified by a participating employer as regular full-time or part-time or seasonal full-time or part-time, except for those who are:

- Covered by a collective bargaining agreement that does not provide for participation in the Plan;
- Employed in a classification of temporary or limited; or
- Leased employees, independent contractors or nonresident aliens.

For purposes of the Group Medical Plan(s), Group Dental Plan(s), Group Vision Care Plan, EAP and Group Life Insurance Plan only, Eligible Employee shall also include a former employee, such as a retiree or an individual receiving long-term disability benefits, who is eligible for coverage under the provisions of those component plans.

For purposes of the wellbeing program, an employee who is participating in a Group Medical Plan under a continuation provision of such Plan for a former employee on long-term disability shall not be an Eligible Employee.

Additional requirements may apply in order to be eligible for benefits under the specific component plans. These requirements are described in the summary plan descriptions for those plans, which are incorporated herein and made part of this summary plan description.

Eligible Dependent

An individual may qualify as an eligible dependent under the Plan subject to the following:

1. The eligibility requirements for coverage of dependents under the Group Benefit Plan, Group Life Insurance Plan, and EAP are described in the specific summary plan descriptions for these component plans.

2. "Dependent" with regard to the Health Savings Account generally means any person you claim as an exemption on your federal tax return. Refer to IRS Publication 502 at www.irs.gov for exceptions.

3. "Dependent" with regard to the Dependent Care Reimbursement Account Plan means any person who is:

    a. your dependent child who is under the age of thirteen (13) years and with respect to whom you are entitled to an income tax exemption;

    b. your spouse who is physically or mentally incapable of caring for himself or herself and who lives with you for more than half the year; or

c. another dependent with respect to whom you are entitled to an income tax exemption and who is physically or mentally incapable of caring for himself or herself, lives with you for more than half the year, and receives more than one-half (½) of his or her support from you.

4. "Dependent" with regard to the Health Care Reimbursement Account means any person who falls within the definition of a dependent provided in Section 152 of the Internal Revenue Code, determined without regard to subsections 152(b)(1), 152(b)(2) or 152(d)(1)(B) and also means a participant's adult child who is eligible for coverage under the Group Medical Plan whose coverage or medical expenses are excludible from the participant's income under Section 105(b). A participant's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the participant for adoption. A participant's Child will be an eligible Dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency or residency status with the Eligible Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

   The phrase "placed for adoption" refers to a child whom the participant intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Eligible Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

5. An individual will not qualify as an eligible dependent under the Plan unless you provide documentation to confirm that the individual meets the eligibility requirements described above. Once you enroll an individual for coverage, you will have a certain amount of time to provide the required documentation. The Plan may begin paying benefits for that individual before the deadline for providing the documentation. If so, and if you don't provide the necessary documentation by the deadline, you will be responsible for repaying those benefits. The Plan Administrator should provide you with information regarding the necessary documentation and the deadline for providing it.

Effective Date of Coverage

In general, an Eligible Employee can participate in the Plan on the first day that he or she participates in any of the component plans. The effective date of coverage under each of the component plans may differ as described in the specific summary plan description for such benefit.

To be eligible for a Health Savings Account ("HSA"), you must be an Eligible Employee with coverage under the Company's HSA-qualified health plan. By signing up for the HSA, you are certifying to the Plan Administrator the following:

1. You cannot be claimed as another person's dependent.

2. You are not enrolled in Medicare benefits.

3. If you have any health coverage, other than the Company's HSA-qualified health plan, that coverage is either:

    a. under a health plan that qualifies as a high deductible health plan; or

    b. permitted non-high deductible health plan insurance or coverage such as accident, disease, disability, dental or vision insurance.

4. If you are married, you are not covered under any spouse plan that is not a high deductible health plan.

A high deductible health plan is a health plan with an annual deductible and out of pocket expense maximum that meet certain limits established each year by the Internal Revenue Service. These limits are subject to change.

PARTICIPATION

Initial Benefit Election

When you become eligible to participate in the Plan, the Company will provide you with an election form under which you can elect to reduce your salary to:

- Pay for your share, if any, of the cost of benefits offered through the cafeteria plan for yourself and your family;
- Contribute to an FSA;
- Contribute to your HSA; and
- Pay for your share, if any, of the cost of benefits offered outside the cafeteria plan.

You must return the election form to the Plan Administrator within thirty one (31) days after you become eligible to participate in the Plan. Once the election is effective, the Company will withhold the amount of your share of the cost of coverage for the benefits you choose under the Plan. If you do not file an election form with the Plan Administrator, you will be deemed to have elected all cash compensation. Other benefits may be available to you at no cost, or on an after-tax basis, as provided in the Company's election materials.

Annual Open Enrollment Election

Once a year, you can make benefit changes for the upcoming Plan Year. Changes made during this open enrollment will be effective at the start of the next Plan Year, on January 1.

The Plan Administrator will communicate each year whether the open enrollment is active or passive. If the enrollment period is active, and if you fail to return your election form before the due date specified by the Plan Administrator, you will not have coverage for the upcoming Plan Year. If the enrollment period is passive, and if you fail to return your election form before the due date specified by the Plan Administrator, you will be deemed to have elected the same participation in the component plans as the previous year. Regardless of whether the enrollment is active or passive, your participation in the Health Care or Dependent Care Reimbursement Account Plans will not automatically be defaulted to your prior year election. If you want to participate in the Health Care or Dependent Care Reimbursement Account Plans for the next Plan Year, you must indicate so on your election form, along with your annual contribution amount, and return the form by the due date.

Mid-Year Change

Elections made under the Plan for most benefits are irrevocable during the Plan Year, except under the following conditions. Any revocation and new election must be on

account of and consistent with one of the events listed below (except as otherwise noted below):

1. A Change in Status Event (described below);

2. With respect to medical coverage, special enrollment events provided in Internal Revenue Code Section 9801(f);

3. With respect to medical dental, and/or vision coverage, or the Health Care Reimbursement Account Plan, compliance with a Qualified Medical Child Support Order or other judgment, decree or order requiring health coverage for your dependent (a copy of the plan's procedures for addressing Qualified Medical Child Support Orders is available upon request to the Plan Administrator);

4. With respect to medical, dental, and/or vision coverage, or the Health Care Reimbursement Account Plan, the election of COBRA continuation coverage by you, your spouse or dependent;

5. With respect to medical coverage, entitlement to Medicare or Medicaid or the loss of eligibility for such coverage;

6. With respect to benefit options other than the Health Care Reimbursement Account Plan, cost changes due to an increase or decrease in the cost of a qualified benefits plan and significant cost changes during a period of coverage. For purposes of cost changes under the Dependent Care Reimbursement Account Plan, the cost changes must be imposed by a dependent care provider who is not your relative;

7. With respect to benefit options other than the Health Care Reimbursement Account Plan, significant coverage changes with or without a loss of coverage, or the addition or improvement of a benefit package option; or

8. With respect to benefit options other than the Health Care Reimbursement Account Plan, a change in coverage under another employer plan on open enrollment if the other plan allows participants to make a change or the other plan permits participants to make an election for a different period of coverage than the period of coverage under the component plan.

Your election change will not be effective unless you provide documentation to confirm that the change you are requesting is on account of and consistent with one of the events described above. Once you request an election change, you will have a certain amount of time to provide the required documentation. The Plan may begin paying benefits in connection with that request before the deadline for providing the documentation. If so, and if you don't provide the necessary documentation by the deadline, you will be responsible for repaying those benefits. The Plan Administrator should provide you with information regarding the necessary documentation and the deadline for providing it.

With respect to your life insurance election, you may commence, modify, end, or recommence your contribution election at any time as necessary to reflect a change in coverage under the applicable life insurance policy.

With respect to your HSA, you may modify, end or recommence your contribution election at any time, effective as soon as administratively practicable after the Plan Administrator receives your election change request; and

The Plan Administrator may permit you to make other mid-year election changes if the Plan Administrator determines that the change is permitted during the Plan Year under regulations and rulings of the Internal Revenue Service. The Plan Administrator may require you to provide documentation before the change is approved.

Change in Status Events

You can change your election during the Plan Year if you experience one (1) of the following events. For changes to your coverage under the Group Medical Plan(s), Group Dental Plan(s), Group Vision Care Plan, Group Life Insurance Plan and the Health Care and Dependent Care Reimbursement Account Plans, you must notify the Plan Administrator within sixty (60) days of the event. If you provide documentation as described above, a change will be effective with the date of:

1. A change in your legal marital status, including marriage, death of your spouse, divorce, or annulment;

2. A change in your number of dependents, including birth, death, adoption or placement for adoption;

3. A change in the employment status of you, your spouse or your dependent if such change affects coverage under a health plan, including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in worksite. In addition, if eligibility conditions of the benefit plan of your employer, or your spouse's or dependent's employer, 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 your 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 place of residence of you, your spouse or dependent, if such change affects coverage under a health 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 Service.

With respect to a Mid-Year Change or Change in Status Event described above, a change in the company contribution to your HSA, outlined in Appendix I, will generally be effective on the first day of the month beginning after the Plan Administrator's receipt of the required documentation that validates the event.

Conditions of Participation

You must also agree to the following in order to participate in the Plan:

- Observe all rules and regulations under the Plan;
- Agree to inquiries by the Plan with respect to any physician, hospital, or other provider of health care or other services involved in a claim under this Plan or any plan paid for through this Plan; and
- Submit to the Plan, or the Plan's designated agent, all reports, bills, and other information, which the Plan may reasonably require.

FAMILY AND MEDICAL LEAVE

Your Rights and Obligations If You Take Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") provides an employee the right to take paid or unpaid leave for the birth of the employee's child, the placement of a child for adoption with or foster care by the employee, the employee's own serious health condition, the employee's need to care for an immediate family member or parent who has a serious health condition, or any qualifying exigency arising out of the active duty or call to active duty of the employee's immediate family member. In general, employees eligible under the FMLA are entitled to twelve (12) work weeks of leave in a twelve (12) month period ("FMLA Leave").

The rules governing the applicability of FMLA and an employee's eligibility for coverage under the FMLA are established by the FMLA and regulations issued by the Department of Labor. The FMLA protects your right to group health benefits under the Plan in several ways. It also imposes certain obligations on you if you wish to continue to participate in the group health plans. In order to take advantage of the protections offered by the FMLA, you must satisfy the notice requirements included in the statute and regulations. Contact the Benefits department at (888) 236-6656 regarding these notice requirements and additional information regarding the FMLA.

Generally, under Company policy, your FMLA Leave will be paid. While on paid leave, your participation in the Plan will continue on the same basis as you participated prior to commencement of your leave and your share of the cost of coverage will continue to be withheld from your paycheck.

If your FMLA leave is unpaid, coverage under the Plan will also be continued on the same basis as you participated prior to the commencement of your FMLA Leave. However, you must make all payments or contributions that are required to maintain that coverage. If you fail to make a payment or contribution that comes due during your FMLA Leave, payments will be recouped by the Company upon return from FMLA Leave.

If you fail to make a contribution to your Health Care Reimbursement Account while you are on unpaid FMLA leave, your contributions for the remainder of the Plan Year will be reamortized upon your return to work. For example, if you elect $1,200 for the Plan Year and you do not make contributions while you are on FMLA Leave for the three-month period from April through June, your remaining contributions will be increased from $100 per month to $150 per month to allow for full funding of your annual election.

If you fail to return to work after the conclusion of your FMLA Leave, the Company is entitled to recover from you any premium payments or contributions paid on your behalf during your FMLA Leave.

An Eligible Employee on FMLA Leave can make elections or revoke elections to the same extent as an Eligible Employee not on FMLA Leave.

APPROVED PAID LEAVE

While on approved paid leave, your participation in the Plan will continue on the same basis as you participated prior to the commencement of your leave and your share of the cost of coverage will continue to be withheld from your paycheck.

MILITARY LEAVE

Your Rights and Obligations If You Take Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") protects the employment and benefit rights of employees who take a leave of absence to serve in the uniformed services. The statute's definition of "uniformed services" is broad, and covers both voluntary and involuntary service. The following paragraphs summarize your benefit rights if you take a military leave that qualifies for USERRA's protections ("USERRA Leave"). USERRA's coverage provisions are detailed and contain a number of conditions. If you intend or are required to take a leave of absence for military duty, contact the Benefits department at (888) 236-6656 for detailed information concerning your rights and obligations under USERRA.

Continuation of Coverage under the Plan

You are entitled to continue your coverage while on USERRA Leave under the Group Medical, Dental and Vision Care Plans for up to twenty-four (24) months. You can also elect to continue to participate in the Health Care Reimbursement Account Plan through the end of the Plan Year in which your USERRA leave begins. Continued coverage under the Health Care Reimbursement Account Plan will be provided to you under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The cost of continuing your COBRA coverage will be no more than one hundred two percent (102%) of the plan's cost for coverage.

You are also entitled to revoke any or all of your existing benefit elections with respect to your contributions for medical, dental and vision coverage and your contributions to your Health Care Reimbursement Account.

To maintain the above coverage during your USERRA Leave, you must notify the Company that you intend to take a leave of absence for service in the uniformed services and that you intend to continue or revoke your coverage under these plans. If you do not elect to continue your coverage during your USERRA Leave, your coverage under the plans will cease on the last day of the month in which you begin your USERRA Leave. This coverage runs concurrently with any COBRA continuation coverage.

You may also be eligible to continue your coverage under the other component plans. Contact the Benefits department at (888) 236-6656 for additional information.

Conditions of Coverage

If you elect to continue coverage under one (1) or more of the plans, you must make all payments or contributions that are required to maintain that coverage. If you fail to make a payment or contribution that comes due during your USERRA Leave, your coverage will terminate effective with the last day of the month in which a required payment was not made.

During the first six (6) months of your USERRA Leave, the Company will continue to provide Benefit Dollars towards the cost of your medical, dental and vision coverage. Continued coverage for the remaining eighteen (18) months will be extended to you under COBRA. The cost of continuing your COBRA coverage will be no more than one hundred two percent (102%) of the plan's cost for the coverage. You will be required to:

1. Make the required payments for your share of the cost for your medical, dental and vision coverage as they come due during your USERRA leave. You can continue to elect to pay your share of the cost of coverage for these benefits through this Plan to the extent that you have taxable compensation payable during the leave. Otherwise, you will be billed on a monthly basis for your costs and required to remit to the Company cash equal to the amount due by the required payment date.

2. Make the required contributions for your continued coverage (if elected) under the Health Care Reimbursement Account Plan as they come due during your USERRA leave.

An Eligible Employee on USERRA Leave may make elections or revoke elections to the same extent as an Eligible Employee not on USERRA Leave.

Right to Reenroll

If your participation in the Plan or a component plan under the Plan ended while you were on USERRA leave due to your revocation of the benefit or your non-payment of a required contribution, you are entitled to reenroll in the Plan and the component plan upon your return from USERRA Leave. You will not be required to fulfill any requalification requirements. You will be entitled to either reenroll in your benefits on the same terms as existed prior to your USERRA Leave (subject to any changes that the Company may have made to the Plan or component plans during your USERRA Leave) or make new elections upon your return from USERRA Leave.

If you elected to revoke your coverage and elections under the Health Care Reimbursement Account Plan during your USERRA Leave:

- You will not be entitled to reimbursement for qualifying health care expenses that you incurred during your USERRA Leave; and

- You are not entitled to retroactive reimbursement of qualifying expenses incurred during your USERRA Leave even if you exercise your right to reinstatement; and

- You will not be entitled to the usual maximum for reimbursements under the Health Care Reimbursement Account Plan. Your maximum reimbursement will equal a pro rata amount that reflects the period of your non-participation in the Health Care Reimbursement Account Plan.

Qualified Reservist Distribution

If you have been ordered or called to active duty for 180 days or more or for an indefinite period, you can request a Qualified Reservist Distribution (QRD) from your Health Care Reimbursement Account. A QRD allows for a cash distribution of all or a portion of the balance remaining in your Health Care Reimbursement Account. The QRD must be requested during the period beginning with the date of the order or call to active duty and ending on the last day of the Grace Period for the Plan Year, which is March 15th.

You are eligible to receive the amount you have contributed minus any reimbursements you have already received (or are in process of receiving). The amount you request may be adjusted if necessary to conform with your actual account balance when the QRD is made. Any claims you submit after the date you request the QRD will not be processed. You may only request one QRD per Plan Year.

GROUP BENEFIT PLAN

The Group Benefit Plan currently includes the following component plans:

- Group Medical Plan(s) – Active employee plan, pre-65 retiree plan, and 65+ retiree plan
- Group Dental Plan(s) – Active employee plan and pre-65 retiree plan
- Group Vision Care Plan - Active employee plan and pre-65 retiree plan

You are allowed to reduce your wages or salary to pay your share of the costs for medical, dental, and vision benefits under the Group Benefit Plan on a pre-tax basis. If you elect any of these benefits, your wages or salary will be reduced by the employee portion of the cost of coverage under the component plan. Your reduction in salary will be reflected on your paycheck. If your share of the cost changes during the Plan Year, the amount of the reduction in your salary will also change. If you elect coverage for other benefits, such as additional life insurance, accidental death & dismemberment insurance or dependent life insurance, your share of the cost for these benefits must be paid on an after-tax basis.

A retiree or an individual receiving long-term disability benefits that are paid by an insurer must pay their share of the cost for benefits provided under the Group Benefit Plan on an after-tax basis.

Your election filed with the Plan Administrator is effective for an entire Plan Year. Once you have filed an election, **you may not change that election during the Plan Year** except under the Mid-Year Change events described on page 6.

Each year during open enrollment, you are given the opportunity to change your elections under the Group Benefit Plan for the upcoming Plan Year. See “Annual Open Enrollment Election” on page 5 for more information. When you are no longer employed by the Company, you may be able to continue your coverage under the component plans to the extent provided by law or the provisions of the plans. However, you will not be able to pay the cost of coverage on a pre-tax basis through the Plan.

If you are reemployed by the Company in a position that is eligible for coverage, you can re-enroll in coverage and become a participant in the Group Benefit Plan on the first day of the month that begins on or after your rehire date, if you again meet the eligibility requirements discussed in the “Eligibility” section on page 3.

The summary plan description for each of the Group Benefit Plans provides you with additional information about that plan. The summary plan descriptions, along with periodic updates, are provided to you as separate documents.

BENEFIT DOLLARS

As an Eligible Employee, you may be eligible to receive Benefit Dollars from the Company in the amount and at the times specified by the Company. Each Plan Year, the Company may change the amount of Benefit Dollars available for the year. Benefit Dollars are the contributions made by the Company towards the cost of your coverage under the Group Benefit Plan, the Group Life Insurance Plan, and the Health Savings Account. You do not have a choice to receive cash instead of Benefit Dollars.

The Company may, in future years, change the amount of Benefit Dollars, or decide to provide Benefit Dollars under different conditions, and will provide information about any such changes.

Additional information regarding Benefit Dollars from the Company can be found in Appendix I of this SPD.

HEALTH CARE REIMBURSEMENT ACCOUNT PLAN

The Health Care Reimbursement Account Plan allows you to reduce your wages or salary on a pre-tax basis to pay for qualified health care expenses incurred by you and your eligible dependents, as described in “Eligibility” on page 3.

Contributing to the Plan

If you elect to participate in the Health Care Reimbursement Account Plan, the minimum amount that you can elect for any Plan Year is $25. The maximum amount is established each year by the Plan Administrator and will not exceed the maximum allowed under IRS guidelines. The maximum amount will be communicated when initially eligible and each year thereafter during the annual open enrollment process.

If you elect to participate in this benefit, your wages or salary will be reduced by the amount you have elected to have withheld from your paycheck.

NOTE: If you are making contributions to a health savings account (HSA), you cannot participate in the Health Care Reimbursement Account Plan.

Changing your Election

Each election that is filed with the Plan Administrator is effective for an entire Plan Year. Once you have filed an election, you may not change that election during the Plan Year except under a Mid-Year Change event. If you experience a Mid-Year Change event that would allow you to change your election, you may change your election in a manner consistent with that change. However, you cannot reduce your election below the amounts of expenses you have incurred and submitted for reimbursement before the effective date of the change. If you want to change your election, see “Mid-Year Change” on page 6 for more information. The change in your election will not be effective until after you notify the Plan Administrator.

If you change the amount of your contributions during the Plan Year, you will be treated as having two separate periods of coverage: (1) the period from the beginning of the Plan Year to the day before the date of the election change, and (2) the period from the date of the election change to the end of the Plan Year. Expenses incurred during the first period may be reimbursed based on the amount initially elected for the Plan Year. Expenses incurred during the second period may be reimbursed based on the modified election amount. If you elect to stop contributions during the Plan Year, you will not be reimbursed for expenses incurred on or after the date that your contributions stop.

Each year during open enrollment, you are given the opportunity to change your election for the upcoming year. See “Annual Open Enrollment Election” on page 5 for more information. **You must make an election each year to continue under the Health Care Reimbursement Account Plan. If you do not make an election under the Health Care Reimbursement Account Plan, you will be deemed to have elected**

cash compensation instead of any such benefits regardless of the election in effect during the prior Plan Year.

Qualified Expenses

The following list gives examples of the types of health care expenses eligible for reimbursement. A complete list can be found in IRS Publication 502 at www.irs.gov:

Surgical services	X-ray treatments
Hospital services	Nursing services
Laboratory services	Dental services
Medicines and drugs (with or without a prescription)	Insulin
Contact lenses	Chiropractic and osteopathic services
Ambulance services	Chemical dependency services
Pre-natal care	Psychiatric care
Orthodontia	Prescription eyeglasses
Vision care	Hearing aids
Crutches	Wheelchairs
Service animal	Tape recorders for blind persons
Menstrual care products	

However, you cannot pay premiums for health and/or dental insurance, long term care insurance, or any long term care expenses through the Health Care Reimbursement Account Plan (even if they are listed in Publication 502). You may not request reimbursement for any expense that is covered or paid by any health or insurance policy, or if you will be reimbursed for the expense from another source.

Reimbursement of Qualified Expenses

Qualified expenses under the Health Care Reimbursement Account Plan are reimbursable for the Plan Year in which the expenses are incurred. If you are participating in the Health Care Reimbursement Account and have funds left over at the end of the Plan Year, you may also be reimbursed for qualifying expenses incurred during the two and one-half (2½) month period after the end of the Plan Year (the "Grace Period"). An expense is incurred when the services are performed, not when the bill for the services is received.

You can only be reimbursed for expenses incurred during the period you were covered by the Health Care Reimbursement Account Plan. If you joined the Health Care Reimbursement Account Plan after the beginning of the Plan Year, then expenses you incurred before you joined the Plan cannot be reimbursed. If you were covered by the Health Care Reimbursement Account Plan on the last day of the Plan Year, you can be

reimbursed for expenses incurred during the Grace Period even if you stop participating in the Health Care Reimbursement Account Plan before the end of the Grace Period.

The Plan Administrator has designated responsibility for administration of the Health Care Reimbursement Account Plan to a third-party, referred to as the "Plan Supervisor". Information regarding the Plan Supervisor can be found on page 31. For reimbursement of a qualified expense, you must submit a written request to the Plan Supervisor that includes: the amount, date and nature of the expense, the name of the person or entity to which the expense was or is to be paid, the name of the person for whom the expense was incurred, and the amount recovered (or expected to be recovered) under any insurance arrangement. Your request should be accompanied by original bills, invoices, receipts, or other statements showing the amount of such expenses, along with any additional documentation that the Plan Supervisor requests.

The Plan Supervisor may provide you with a debit card that draws directly from your account. You may use this debit card only for qualified expenses and you must provide receipts for those expenses upon request. If you use your debit card for ineligible expenses or you do not provide sufficient information to verify an eligible expense, the Plan Supervisor will turn off your debit card and ask you to repay any ineligible amounts.

The Plan Supervisor will make reimbursement payments as soon as administratively practicable after receipt of your request. **Reimbursement claims for expenses incurred through the end of the Plan Year or Grace Period must be filed on or before the ninetieth (90th) day following the close of the Grace Period. If you terminate employment, claims for expenses incurred before your termination must be filed by the end of the Plan Year (or Dec. 31st) in which your termination occurred.** Reimbursement claims filed after this date will not be valid.

Reimbursement payments will be made in the order that your requests are received until the funds held in your Health Care Reimbursement Account for the Plan Year are exhausted or forfeited. If you incur a claim during the Grace Period, it will be reimbursed first from your balance for the year before the Grace Period, and then from your current year balance. You should carefully consider the order in which you submit your receipts. For example, say that you have a $500 balance in your account on December 31, you have a receipt for a $400 expense incurred in December, and you have a receipt for a $300 expense incurred in January. If you submit the January receipt first, the $300 will be paid from your prior year balance, leaving only $200 to pay the December expense. By contrast, if you submit the December receipt first, all $400 will be paid from the prior year account, leaving $100 to pay the January expense (with the remaining $200 to be paid from the current year's account).

You will forfeit any amounts by which you have elected to have your salary reduced for health care expenses and for which a claim for reimbursement is not filed within the required time period. **Such amounts cannot be carried over to another year or used for any other benefit plan.**

When your Employment Ends

If your employment ends, you will no longer be able to participate in the Health Care Reimbursement Account Plan unless you are eligible for and choose to continue participation as discussed below.

Continuation Coverage

You can elect to continue your Health Care Reimbursement Account Plan coverage under COBRA until the end of the Plan Year in which your termination occurred.

In addition, if expenses incurred by your spouse or dependent children are not eligible for reimbursement due to your termination of employment or reduction of hours, divorce, death, or a dependent child ceasing to qualify as a dependent, your spouse and/or children (as applicable) may elect to continue coverage.

The Plan Administrator has designated responsibility for administration of COBRA to a third-party, referred to as the "Plan Supervisor". Information regarding the Plan Supervisor can be found on page 31.

If you have a qualifying event that is a divorce or a child ceasing to be a dependent, you must notify the Plan Supervisor in writing at address listed in the "Administrative Information" section on page 41 within 60 days of the date you would otherwise lose coverage for the spouse or child. The notification must identify the applicable qualifying event and request COBRA continuation coverage. If you, your spouse, or your dependent child does not notify the Plan Supervisor within those 60 days, your spouse and/or dependent children will not be entitled to COBRA coverage.

If you are entitled to elect COBRA coverage, or if the Plan Supervisor receives timely notice of a divorce or a child ceasing to be a dependent, the Plan Supervisor will send you and/or your spouse or dependent child a notice explaining how to elect COBRA coverage and the deadline for making that election.

If you elect to continue your coverage, you will be responsible for paying the monthly contribution on an after-tax basis. Your costs will be one hundred two percent (102%) of the Plan's cost for the coverage. If you fail to make a required payment, your COBRA continuation coverage will be terminated. In that event, you will have until the end of the Plan Year (or Dec. 31st) to submit any claims for reimbursement incurred prior to the date your coverage was terminated.

If you maintain COBRA coverage until the end of the Plan Year and you have funds remaining in your Health Care Reimbursement Account at that time, you will be able to use those funds to reimburse eligible expenses incurred during the Grace Period for that Plan Year. You will not be required to make COBRA payments during the Grace Period.

Reemployment

If you are reemployed by the Company as an Eligible Employee, you can participate in the Health Care Reimbursement Account Plan on the first day of the month that begins on or after your rehire date if you again meet the Health Care Reimbursement Account Plan's eligibility requirements.

Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") governs the use and disclosure of "protected health information" ("PHI") by the Health Care Reimbursement Account Plan. PHI is defined as information which identifies you (directly or indirectly) that is created or received by a health plan and that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for the provision of health care to you. The Health Care Reimbursement Account Plan is subject to HIPAA's privacy rules; the Dependent Care Reimbursement Account Plan is not. Other benefit programs of the Company may also be subject to HIPAA.

The Health Care Reimbursement Account Plan (and any other employee group health care benefits subject to HIPAA's privacy rules) (each referred to in this section as a "HIPAA-covered plan") may disclose to the Company information on whether an individual is participating in the HIPAA-covered plan, or is enrolled or was enrolled in the HIPAA covered plan. The HIPAA-covered plan may also disclose Summary Health Information (information similar to PHI from which certain data elements such as participant names have been removed) to the Company, provided that the Company requests this information for the purpose of (i) obtaining premium bids for providing insurance coverage; or (ii) modifying, amending or terminating the HIPAA-covered plan.

The Company may use and disclose PHI that it receives from a HIPAA-covered plan only in the performance of administrative functions for such Plan or as otherwise permitted by law, including for purposes of determining claims under the HIPAA-covered plan. The following classes of employees of the Company may receive information for these purposes: **Chief Financial Officer, Benefits department (and Data Proxies, as needed), Accounting department, Legal department, and Business Technology department.** You will be informed of changes in the classes of employee who can receive PHI through a change in the summary plan description or a change in the Plan's Notice of Privacy Practices. Your PHI also may be provided to a third party retained by the HIPAA-covered plan to perform administrative services on its behalf, and may be disclosed as necessary to obtain or make payments for benefits.

For more information about your rights and the Company's health plans' use and disclosure of PHI, please refer to the Privacy Notice section of this SPD.

PRIVACY NOTICE

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

DEPENDENT CARE REIMBURSEMENT ACCOUNT PLAN

The Dependent Care Reimbursement Account Plan allows you to reduce your wages or salary on a pre-tax basis to pay for expenses incurred for the care of an eligible dependent, as described in “Eligibility” on page 3.

Contributing to the Plan

If you elect to participate in the Dependent Care Reimbursement Account Plan, the minimum amount that you can elect for any Plan Year is $25; the maximum amount is the lesser of:

1. Your earned income; or
2. Your spouse’s earned income; or
3. $5,000 ($2,500 if you are married and file separate tax returns).

If your spouse is a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, he or she is considered to have earned income of $250 per month if you have one (1) dependent or $500 per month if you have two (2) or more dependents.

Changing your Election

Each election that is filed with the Plan Administrator is effective for an entire Plan Year. Once you have filed an election, you may not change that election during the Plan Year except under a Mid-Year Change event. If you experience a Mid-Year Change event that would allow you to change your election, you may change your election in a manner consistent with that change. If you want to change your election, see “Mid-Year Change” on page 6 for more information. The change in your election will not be effective until after you notify the Plan Administrator.

Each year during open enrollment, you are given the opportunity to change your election for the upcoming year. See “Annual Open Enrollment Election” on page 5 for more information. **You must make an election each year to continue under the Dependent Care Reimbursement Account Plan. If you do not make an election under the Dependent Care Reimbursement Account Plan, you will be deemed to have elected cash compensation instead of any such benefits regardless of the election in effect during the prior Plan Year.**

Qualified Expenses

To be reimbursed, expenses must meet all of the following criteria:

1. They must be incurred for the care of your dependent or for related household services; and

2. They must be paid to a dependent care service provider; and

3. They must be incurred to enable you to be gainfully employed for the period for which you have one (1) or more eligible dependents.

If your eligible dependent is a child under the age of thirteen (13), you can be reimbursed for expenses incurred for services outside your household. If your dependent is not a child, but instead is another qualifying dependent (see "Dependent Eligibility" on page 3), you can be reimbursed for such outside expenses only if the qualifying dependent regularly spends at least eight (8) hours a day in your household.

Payments to a facility that provides care to more than six (6) individuals who do not live there (for example, a child care center or some family day care arrangements) may not be reimbursed unless the facility complies with all state and local laws.

You may not be reimbursed for payments to a relative whom you could claim as your dependent or to your child who is under the age of nineteen (19). You also may not receive reimbursement for overnight camp expenses. In addition, you will have to supply the taxpayer identification number of your day care provider in order to receive reimbursement.

Additional information regarding qualifying expenses under the Dependent Care Reimbursement Account Plan can be found in IRS Publication 503 at www.irs.gov.

Dependent care expenses reimbursed by the Plan are not eligible for the dependent care tax credit available under Section 21 of the Internal Revenue Code. Whether or not you should use the tax credit or the reimbursement provided under this Plan depends upon your personal tax situation including your filing status and the amount of your taxable income. Taxable income means your gross income minus allowable deductions and exemptions. The choice also depends upon the tax rates and tax brackets (which are indexed annually for inflation). Please consult your own personal tax advisor or investigate this issue yourself to determine whether the tax credit or Plan reimbursement offers greater savings.

Reimbursement of Qualified Expenses

Qualified expenses under the Dependent Care Reimbursement Account Plan are reimbursable for the Plan Year in which the expenses are incurred. If you have funds left over in the Dependent Care Reimbursement Account at the end of the Plan Year, you may also be reimbursed for qualifying expenses incurred during the two and one-half (2½) month period after the end of the Plan Year (the "Grace Period"). An expense is incurred when the dependent care services are performed, not when the bill for the services is received.

You can only be reimbursed for expenses incurred during the period you were covered by the Dependent Care Reimbursement Account Plan or following your termination of employment as described in the "When your Employment Ends" section on page 30. If you joined the Dependent Care Reimbursement Account Plan after the beginning of the

Plan Year, then expenses you incurred before you joined the Dependent Care Reimbursement Account Plan cannot be reimbursed. If you have funds left over in the Dependent Care Reimbursement Account at the end of the Plan Year, you can be reimbursed for expenses incurred during the Grace Period even if you terminated employment during the Plan Year or stopped participating in the Dependent Care Reimbursement Account Plan before the end of the Grace Period.

The Plan Administrator has designated responsibility for administration of the Dependent Care Reimbursement Account Plan to a third-party, referred to as the "Plan Supervisor". Information regarding the Plan Supervisor can be found on page 31. For reimbursement of a qualified expense, you must submit a written request to the Plan Supervisor that includes: the amount, date and nature of the expense, the name and taxpayer identification number of the person or entity to which the expense was or is to be paid, the name of the person for whom the expense was incurred, and such other information as the Plan Supervisor may require from time to time. Your request should be accompanied by original bills, invoices, receipts, or other statements showing the amount of such expenses, along with any additional documentation that the Plan Supervisor requests.

The Plan Supervisor will make reimbursement payments as soon as administratively practicable after receipt of your request. **Reimbursement claims for expenses incurred through the end of the Plan Year or Grace Period must be filed on or before the ninetieth (90th) day following the close of the Grace Period**. Reimbursement claims filed after this date will not be valid.

Under the Dependent Care Reimbursement Account Plan, you cannot be reimbursed for any more than the amount contributed to the Dependent Care Reimbursement Account Plan through payroll deduction for the Plan Year. You will not be reimbursed under the Plan for a qualified expense until or unless the amount contributed to the Dependent Care Reimbursement Account Plan equals or exceeds your reimbursement request. If you incur a claim during the Grace Period, it will be reimbursed first from your balance for the year before the Grace Period, and then from your current year balance.

Reimbursement payments will be made in the order your requests are received until the funds held in your Dependent Care Reimbursement Account for the Plan Year are exhausted or forfeited. You should carefully consider the order in which you submit your receipts. For example, say that you have a $500 balance in your account on December 31, you have a receipt for a $400 expense incurred in December, and you have a receipt for a $300 expense incurred in January. If you submit the January receipt first, the $300 will be paid from your prior year balance, leaving only $200 to pay the December expense. By contrast, if you submit the December receipt first, all $400 will be paid from the prior year account, leaving $100 to pay the January expense (with the remaining $200 to be paid from the current year's account).

On or before January 31 each year, the Plan Supervisor will provide a statement showing your contributions and reimbursements under the Dependent Care Reimbursement Account Plan for the prior Plan Year.

You will forfeit any amounts by which you have elected to have your salary reduced for dependent care assistance and for which a claim for reimbursement is not filed within the required time period. **Such amounts cannot be carried over to another year or used for any other benefit plan.**

When your Employment Ends

If your employment ends, you will no longer be able to participate in the Dependent Care Reimbursement Account Plan. If you have a balance remaining in your dependent care reimbursement account when your employment ends, the Plan allows for a "spend-down" of the account for qualified dependent care expenses necessary for you to seek gainful employment or become gainfully employed. If you are married, your spouse must also be gainfully employed or seeking gainful employment unless he or she is a full-time student or physically or mentally unable to care for himself or herself. This means that you can continue to incur qualified expenses after your employment ends and request reimbursement of those expenses, subject to the Plan's provisions regarding reimbursement. You will no longer be eligible to contribute to the account; the maximum amount available for reimbursement will be the funds remaining. See "Reimbursement of Qualifying Expenses" above for additional information.

Reemployment

If you are reemployed by the Company, you can participate in the Dependent Care Reimbursement Account Plan on the first day of the month that begins on or after your rehire date if you again meet the Dependent Care Reimbursement Account Plan's eligibility requirements.

HEALTH SAVINGS ACCOUNT

You can establish a Health Savings Account (HSA) if you satisfy the eligibility requirements described in “Eligibility” on page 3.

You cannot contribute to an HSA while you are participating in the Health Care Reimbursement Account. If you have funds remaining in your Health Care Reimbursement Account at the end of a Plan Year, you will not be able to establish an HSA until the first day of the month that begins after the end of the Grace Period. For example, if you have funds remaining in your Health Care Reimbursement Account on December 31, 2023, you may not establish an HSA until April 1, 2024.

Contributing to the HSA

If you elect to contribute to an HSA, you must specify a dollar amount to be transferred to your HSA each payroll period through payroll reduction. You do not need to contribute to your HSA in order to receive Company contributions.

Each payroll period, the Company may make an additional discretionary contribution to your HSA. Such contributions may be a percentage of the deductible, a matching contribution, or a contribution determined on any other basis. The Company’s contributions to your HSA are described in Appendix I of this SPD.

You may be required to take certain steps to open an HSA. If so, the Plan Administrator will explain those steps. If you elect to participate in an HSA and do not take the necessary steps to open your HSA by the earlier of 90 days after you submit your election or the end of the calendar year in which your (or the Company’s) contributions would otherwise begin, your election will be canceled, any contributions made through payroll reductions will be returned, and you will forfeit any Company contributions for that year.

Each year, the IRS establishes the maximum amount that can be contributed to your HSA. This amount is subject to change. The maximum amount will be communicated when initially eligible and each year thereafter during the annual open enrollment period. All of the contributions made to your HSA, including any Company contributions, count towards the annual maximum amount described above. Any contribution made to an Archer Medical Savings Account (MSA) under Code Section 220 for the same taxable year will reduce the annual maximum amount that you can contribute to your HSA.

You cannot make any contributions to your HSA for months for which you are receiving Medicare benefits. In certain circumstances, Medicare coverage can be effective for up to six months before the date you enroll in Medicare. If you are eligible for Medicare or approaching Medicare eligibility, please be sure you understand when and how your Medicare coverage will be effective so you don’t overcontribute to your HSA.

If you are or will be at least age fifty-five (55) prior to the end of the tax year and you are eligible to contribute to an HSA for that year, you can contribute an additional $1,000 over and above the annual maximum amount described above to your HSA.

If you become eligible to fund an HSA after the beginning of the Plan Year, for example, because you were hired after the beginning of the year, you are allowed to contribute the entire annual maximum amount to your HSA. However, you will be subject to a tax penalty if you do not maintain eligibility for HSA contributions through the end of the following year. If you do not maintain that eligibility, then the amounts that you contributed that are in excess of one-twelfth (1/12th) of the annual maximum for each month that you are eligible to fund an HSA will be considered taxable income for the year in which you stopped being eligible to fund an HSA. In addition, you will have to pay a ten percent (10%) tax penalty on those excess contributions. If you withdraw the excess contributions, you will also have to pay tax on them if they are not used to pay for qualified health care expenses. You should consult with a tax advisor before funding your HSA in amounts greater than one-twelfth (1/12th) of the annual limit for each month that you are eligible to fund that account.

The Plan Administrator is only responsible for determining the maximum contributions made pursuant to the Plan. You are responsible for ensuring that your contributions do not exceed the maximum amount allowed by law.

An HSA is not an employee benefit plan as described in ERISA. As such, it is not subject to the family leave protections of FMLA, the military leave protections of USERRA, or the continuation of coverage options provided under COBRA.

Changing your Election

You can prospectively suspend, recommence or change your contribution election at any time. The change will become effective as soon as administratively practicable after the date the Plan Administrator receives your request to change your election.

Termination of Participation

Your participation in the HSA will be terminated when your employment ends or when you no longer meet the eligibility requirements for an HSA. At that time, the Company will stop making or transferring contributions to your HSA. Any amounts held in your HSA will remain vested and yours to keep.

Distribution from Account

In general, if the distribution from your HSA is for a qualified health care expense, you will not have to pay taxes or penalties on the amount withdrawn from the account. Information regarding qualified health care expenses can be found in IRS Publication 502 at www.irs.gov. Information regarding the taxation of distributions and how to take a distribution from your HSA is available by logging onto the Plan's HSA custodian's website or contacting them on their toll free number. See page 31 for information regarding the HSA custodian. As a participant, you are responsible for demonstrating that any distributions from your HSA are eligible for tax-favored treatment.

TERMINATION OF COVERAGE

Termination Events

Coverage for you and your eligible dependents generally ends on the earliest of the following dates:

1. The date on which the Plan terminates.

2. The date on which you are no longer eligible.

3. The last date for which you have made any required contributions.

4. The date the Plan Administrator determines to terminate your coverage because you have not timely responded to a reasonable information or document request.

5. For the Group Benefit Plan, Group Life Insurance Plan, and the Benefit Dollars provided for coverage under these plans, the date on which your coverage is terminated under the provisions of the applicable plan.

6. For the Dependent Care Reimbursement Account Plan and the Health Care Reimbursement Account Plan, the date: (a) you no longer meet the eligibility requirements, (b) you request that coverage be revoked as permitted under the Plan, (c) you begin qualified military service leave or commence an unpaid family and medical leave, and do not elect (or are not eligible to elect) to continue coverage (or fail to make a requested contribution) during your leave.

7. For the HSA, the date you notify the Plan that you no longer meet the eligibility requirements.

If you terminate and are subsequently rehired in a position that is eligible for coverage, you will become a Participant in the Plan on the date of rehire. However, coverage under some of the component plans will not be effective until the first day of the month that begins on or after your date of rehire.

If you revoked benefits under the Plan in connection with a USERRA Leave, you may reenroll in the Plan with coverage effective immediately upon your return to work.

Continuation of Coverage

You or your covered dependents may continue coverage under certain component plans as described in the summary plan descriptions for such plans. You may also be eligible to continue your Health Care Reimbursement Account Plan.

Conversion of Coverage

Benefits provided under the Group Life Insurance Plan may be eligible to be converted to an individual policy after coverage ends under the plan. You will be informed of any conversion rights available to you upon the termination of your group policies.

PLAN BENEFITS

The Company intends that payments made for cafeteria plan benefits under the Plan will be tax-free to the employees under the Internal Revenue Code. Thus, to the extent that your salary is reduced to pay your share of the cost of group medical, dental or vision coverage, to reimburse you for health care or dependent care expenses, or to contribute to your HSA, you will not be taxed on the income. Of course, to the extent that you elect or are deemed to have elected to receive your entire salary or wages as compensation, these amounts will be fully taxable to you. Other benefits may be provided on an after-tax basis, but in general, these benefits will be offered outside of the cafeteria plan.

While the Company intends that the payments made for cafeteria plan benefits under the Plan will be tax-free, the Company does not guarantee that this will, in fact, be the case. The Company has not requested the Internal Revenue Service to rule on whether the payments under the Plan are tax-free and the Company does not intend to ask for such a ruling. Therefore, it is possible that the Internal Revenue Service could successfully claim at some later date that you owe taxes on the money paid for benefits under the Plan. If that should happen, you (and not the Company) will be responsible for paying that tax.

The operation of cafeteria benefits plans is subject to certain non-discrimination rules established in the Internal Revenue Code. Under those rules, only a certain amount can be contributed on behalf of highly-compensated or key employees of the Company. The Company reserves the right to change the elections of highly-compensated or key employees to ensure that the Plan satisfies any non-discrimination rules that may be in place. You will be notified if your election is so affected.

CLAIMS PROCEDURES

Claims under the Health Care Reimbursement Account Plan

If you have a claim for benefits under the Health Care Reimbursement Account Plan, you may file a claim in writing with the Plan Administrator. If your claim is wholly or partially denied, the Plan Administrator will notify you of its decision in writing. Such notification will be written in a manner calculated to be understood by you 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 for you to perfect your claim and an explanation of why this material or information is necessary and (iv) information as to the steps to be taken if you wish to submit a request for review. Such notification will be given to you within thirty (30) days after the claim is received by the Plan Administrator (or within forty-five (45) 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 you within the initial thirty (30) day period). If the claim is denied based on an internal rule, guideline, protocol, or other similar provision, in addition to the notice provisions described in this section, the Plan Administrator's notice will provide that a copy of such rule, guideline, protocol or other similar provision is available upon request and free of charge. You may obtain reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and may request, in writing, a list of medical experts consulted.

Within one hundred eighty (180) days after the date on which you receive a written notice of a denied claim for benefits under the Health Care Reimbursement Account Plan, you (or your duly-authorized representative) may (i) file a written request with the Plan Administrator for a review of your denied claim and of pertinent documents and (ii) submit written issues and comments to the Plan Administrator. The review will take into account any such comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will be conducted by a Plan fiduciary different from the fiduciary who originally denied the claim. This fiduciary cannot be a subordinate of the fiduciary who originally denied the claim. If the original denial of the claim was based on a medical judgment, the reviewing fiduciary will consult with an appropriate health care professional who was not consulted on the original claim and who is not subordinate to someone who was. The Plan Administrator will notify you of its decision in writing. Such notification will be written in a manner calculated to be understood by you 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.

All Other Claims

This section will apply to all claims under the Plan except claims under the Group Benefit Plan that include their own claims procedures, claims under the Health Care Reimbursement Account Plan, claims under your Health Savings Account, or claims that are subject to an insurer's or third party administrator's claims procedures.

Notwithstanding the foregoing, if no other claims procedure under a Group Benefit Plan applies, this claims procedure shall apply. If you believe you are being denied any rights or benefits under the Plan, you may file a claim in writing with the Plan Administrator. If any such claim is wholly or partially denied, the Plan Administrator will notify you of its decision in writing. Such notification will be written in a manner calculated to be understood by you 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 for you 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 you wish 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 you within the initial ninety (90) day period).

Within sixty (60) days after the date on which you receive a written notice of a denied claim, you (or your duly-authorized representative) may (i) file a written request with the Plan Administrator for a review of your denied claim and of pertinent documents, and (ii) submit written issues and comments to the Plan Administrator. The Plan Administrator will notify you of its decision in writing. Such notification will be written in a manner calculated to be understood by you 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 you within the initial sixty (60) day period).

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

Claims for benefits under an HSA must be submitted to the trustee or custodian of the HSA.

Claims Generally

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 you want to seek further review of the Plan Administrator's decision in court, you must first exhaust the administrative reviews and appeals procedures under the Plan before bringing a lawsuit in state or federal court. If you decide to bring a lawsuit, you must do so in federal court in Sioux Falls, South Dakota within one (1) year after you exhaust the administrative reviews and appeals procedures under the Plan.

GENERAL PROVISIONS

Plan Administration

The general administration of the Plan and the duty to carry out its provisions is vested in the Company's Employee Benefits Administration Committee (EBAC). The EBAC will perform such duties on behalf of the Company, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the Company, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation, the EBAC will have the final authority to administer the Plan.

Powers and Duties of the Plan Administrator

The EBAC will have the authority to control and manage the operation and administration of the Plan. This will include all rights and powers necessary or convenient to carry out its functions as Plan Administrator. Without limiting that general authority, the EBAC will have the express authority and discretion to:

1. construe and interpret the provisions of the Plan, decide all questions of eligibility, and determine the amount, manner, and time of payment of any benefits under this Plan;

2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the Plan;

3. prepare and distribute information to you explaining the Plan;

4. receive from you and any other parties the necessary information for the proper administration of the Plan;

5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Plan;

6. provide a full and fair review to any claimant whose claim for benefits has been denied in whole or in part; and

7. retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the Plan.

Actions of the Plan Administrator

The EBAC may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

The EBAC or the Company may contract with agents to assist in the handling of claims under the Plan and/or to provide advice and assistance in the general administration of the Plan. Such agent(s) may also be given the authority to make payments of benefits under the Plan on behalf of and subject to the authority of the EBAC. Such agent(s) may also be given the authority and discretion to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the EBAC.

Type of Plan Administration

Insured claims are administered by the selected insurance carriers. Uninsured claims for benefits are processed by contract administrators. Enrollment (for all benefits) and eligibility and appeals of uninsured benefits are administered by the Plan Administrator.

Funding

This Plan and the component plans are funded by contributions from the Company and/or Eligible Employees. Your contribution towards the cost of coverage under the Plan will be determined by the Company each year and communicated to you prior to the effective date of any change in the cost of coverage. Benefits are paid from the Company's general assets or, in the case of insured benefits, a licensed insurance company. Some of the benefits are funded using a trust account under Internal Revenue Code Section 401(h) or a Voluntary Employee Beneficiary Association described in Internal Revenue Code Section 501(c)(9).

Collective Bargaining Unit

If you are employed and represented by a collective bargaining unit, you will be eligible to participate in the Plan only to the extent that your participation is specifically provided for in a collective bargaining agreement that is negotiated with the Company. You may obtain a copy of the applicable collective bargaining agreement or view it at certain locations. Contact the Plan Administrator to request a copy or a viewing of the applicable collective bargaining agreement.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from the Plan will be governed by the laws of the state of Delaware.

Termination or Changes to the Plan

The Company reserves the right at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Internal Revenue Code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the Plan, including any component plan. The Plan Administrator will communicate any adopted changes to the Eligible Employees to the extent required by law. If the Plan is

terminated, the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to termination.

ERISA RIGHTS

Certain component plans, such as the Health Care Reimbursement Account Plan, are subject to the Employee Retirement Income Security Act of 1974 (ERISA). Other component plans, such as the Dependent Care Reimbursement Account Plan, are not. If you are a participant in an ERISA covered plan, you are entitled to certain rights and protection under ERISA. ERISA provides that all Plan participants will be entitled to:

Receive Information about your Plan and Benefits

1. Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, 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. The Plan Administrator is required by law to furnish each participant with a copy of the Plan's summary annual report (SAR).

Continue Medical Coverage

Continue medical 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 for the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting all administrative remedies under the Plan. In addition, if you should disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after first exhausting all administrative remedies under the Plan. If it should happen that the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue Northwest, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADMINISTRATIVE INFORMATION

Plan Name	NorthWestern Energy Employee Benefit Plan (formerly known as the NorthWestern Energy Flexible Compensation Plan)
Plan Type	A welfare plan under ERISA providing group medical, dental, vision, life insurance, accidental death and dismemberment, disability, employee assistance, and health care reimbursement benefits. The Plan also provides dependent care reimbursement benefits, HSA contribution benefits, and pre-tax premium benefits that are not subject to ERISA.
Plan Number	530
Plan Year	January 1 through December 31
Plan Funding	The Plan's benefits are funded by Plan participants and the Company.
Plan Sponsor	NorthWestern Corporation d/b/a NorthWestern Energy 3010 W. 69th St Sioux Falls, SD 57108
Employer Identification Number	46-0172280
Plan Administrator and Named Fiduciary	Employee Benefits Administration Committee NorthWestern Corporation d/b/a NorthWestern Energy 11 E Park St Butte, MT 59701-1711 (406) 497-4610
Agent for Service of Legal Process	Employee Benefits Administration Committee NorthWestern Corporation d/b/a NorthWestern Energy 11 E Park St Butte, MT 59701-1711 (406) 497-4610
Privacy Officer	Director, Compensation and Benefits NorthWestern Energy 11 E Park St Butte, MT 59701-1711 Phone: (406) 497-4610

Plan Supervisor for Health Care & Dependent Care Reimbursement Account	Fidelity Investments Fidelity Reimbursement Accounts Services PO Box 2703 Fargo, ND 58108 Fidelity@service.healthaccountservices.com Phone: (833) 299-5089
HSA Custodian	Fidelity Investments PO Box 770001 Cincinnati, OH 45277-0047 www.NetBenefits.com or www.401k.com (800) 544-3716
Plan Supervisor for COBRA Administration	Billing Services PO Box 2617 Omaha, NE 68103-2617 www.cobraandbillingservices.com (833) 874-1600
Trustee	The Northern Trust Company 50 S. LaSalle Street Chicago, IL 60603 www.northerntrust.com (312) 630-6000

APPENDIX I
COMPONENT PLANS AND BENEFIT DOLLARS

The following Component Plans are selected pursuant to Section 3.2 of the Plan, for the Plan Year beginning January 1, 2024.

1. Group Benefit Plan (see additional eligibility requirements applicable to specified Eligible Employees in Appendices):

    Group Medical Plan for Active Employees (see Appendix III)

    Group Medical Plan for Retirees under Age 65 (see Appendix IV)

    Group Medical Plan for Retirees Age 65 or Older (see Appendix V)

    Group Dental Plan for Retirees under Age 65 (see Appendix IV)

    Group Dental Plan for Active Employees (see Appendix III)

    Group Vision Care Plan for Active Employees (see Appendix VI)

    Group Vision Care Plan for Retirees under Age 65 (see Appendix VI)

2. Group Life Insurance Plan (see Appendix VII)

3. Group Long Term Disability Plan (see Appendix VIII)

4. Employee Assistance Program (see Appendix IX)

5. Health Care Reimbursement Account – Minimum of $25 per Plan Year. The maximum amount per Plan Year is established by the Plan Administrator and shall not exceed the amount allowed by the IRS for the year.

6. Dependent Care Reimbursement Account Plan – Up to a maximum of $5,000 ($2,500 if married filing separately) per Plan Year, with a minimum of $25 per Plan Year).

7. Former Eligible Employees electing coverage under the Group Medical Plan for Retirees under Age 65:

    A. For an Eligible Employee in Montana who was at least age 50 with 5 or more years of service and terminated employment prior to November 1, 2009, and who elects to participate in the Group Medical Plan for Retirees Under Age 65, the Company will increase its annual contribution toward the individual's premium cost so that the cost to the former Eligible Employee will not increase by more than 10% in 2010. Beginning in 2011, the Company will increase its annual contribution for these former Eligible Employees by the lesser of the premium increase percentage for that year or 5%. Such contribution will be made between the ages of 55 and 65.

B. For an Eligible Employee in Montana, South Dakota or Nebraska who was at least age 50 with 5 or more years of service and terminated employment on or after November 1, 2009 but no later than December 31, 2010, and who elects to participate in the Group Medical Plan for Retirees Under Age 65, the Company will provide a fixed annual contribution toward the individual's premium cost between the ages of 55 and 65, up to the maximum amounts listed as follows:

- $250 per year of completed service with the Company for single coverage, to a maximum of $6,250 per year
- $580 per year of completed service with the Company for non-single coverage, to a maximum of $14,500 per year

C. For an Eligible Employee in Montana, South Dakota or Nebraska with an adjusted service date, per the Company's records, prior to January 1, 2010, who is at least age 60 with 20 or more years of service and terminates employment after December 31, 2010, and who elects to participate in the Group Medical Plan for Retirees Under Age 65, the Company will provide a fixed annual contribution toward the individual's premium cost between the ages of 60 and 65 as follows:

- $250 per year of completed service with the Company for single coverage, to a maximum of $6,250 per year
- $580 per year of completed service with the Company for non-single coverage, to a maximum of $14,500 per year

D. Effective as of May 1, 2017, for an Eligible Employee hired under the terms of the September 26, 2013 Purchase and Sale Agreement between the Company and PPL Montana with an adjusted service date, per the Company's records, prior to July 1, 2013, who is represented under a collective bargaining agreement between the Company and the Local 44 of the International Brotherhood of Electrical Workers, AFL-CIO, and who is at least age 60 with 20 or more years of service at termination of employment and who elects to participate in the Group Medical Plan for Retirees Under Age 65, the Company will provide a fixed annual contribution towards the individual's premium cost between the ages of 60 and 65 as follows:

Termination of employment on or before February 28, 2021:

- Maximum of $8,218 for single coverage or $16,436 for non-single coverage (not to exceed the premium cost)

Termination of employment on or after March 1, 2021:

- $250 per year of completed service with the Company for single coverage, to a maximum of $6,250 per year

- $580 per year of completed service with the Company for non-single coverage, to a maximum of $14,500 per year

E. Effective January 1, 2010, former Eligible Employees who waive medical coverage will no longer receive a contribution from the Company.

8. Former Eligible Employees electing coverage under the Group Medical Plan for Retirees Age 65 or Older:

   A. For an Eligible Employee in Montana who was at least age 50 with 5 or more years of service and terminated employment prior to January 1, 2011, and who elects to participate in the Group Medical Plan for Retirees Age 65 or Older, the Company will provide a fixed annual contribution toward the individual's premium cost of up to:

      - $36 per year for single coverage;

      - $72 per year for non-single coverage

   B. For an Eligible Employee who terminates employment on or after January 1, 2011, and who elects to participate in the Group Medical Plan for Retirees Age 65 or Older, the Company will not provide a contribution toward the individual's premium cost.

9. Former Eligible Employees electing coverage under the Group Dental Plan for Retirees under Age 65:

   A. For an Eligible Employee in Montana who was at least age 50 with 5 or more years of service and terminated employment prior to November 1, 2009, and who elects to participate in the Group Dental Plan for Retirees Under Age 65, the Company will increase its fixed annual contribution toward the individual's premium cost so that the cost to the former Eligible Employee will not increase by more than 10% in 2010. Beginning in 2011, the Company will increase its annual contribution for these former Eligible Employees by the lesser of the premium increase percentage for that year or 5%. Such contribution will be made between the ages of 55 and 65.

   B. For an Eligible Employee who terminates employment on or after November 1, 2009, and who elects to participate in the Group Dental Plan for Retirees under Age 65, the Company will not provide a contribution toward the individual's premium cost.

   C. Effective January 1, 2010, former Eligible Employees who waive dental coverage will no longer receive a contribution from the Company.

10. Former Eligible Employees under the Group Life Insurance Plan:

A. For an Eligible Employee in Montana who was at least age 50 with 5 or more years of service and terminated employment on or before December 31, 2010, the Company will provide Benefit Dollars sufficient to purchase term life insurance coverage for the former Eligible Employee equal to one times (1x) the individual's annual base salary at termination of employment between the ages of 55 and 65 and term life insurance coverage equal to $5,000 from age 65 to death. Such contribution will only be made if the former Eligible Employee elected coverage equal to one times (1x) his/her annual base salary at termination and, if under the age of 55 at termination, paid 100% of the premium cost for such coverage between the ages of 50 and 55.

B. For an Eligible Employee in Montana, South Dakota or Nebraska with an adjusted service date, per the Company's records, prior to January 1, 2010, who is at least age 60 with 20 or more years of service and terminates employment after December 31, 2010, the Company will provide Benefit Dollars sufficient to purchase term life insurance coverage for the former Eligible Employee equal to one times (1x) the individual's annual base salary at termination of employment between the ages of 60 and 65. Such contribution will only be made if the former Eligible Employee elected coverage equal to one times (1x) his/her annual base salary at termination.

11. Health Savings Account

A. For an Eligible Employee who meets the criteria listed below, the Company will provide a fixed annual contribution into the Eligible Employee's Health Savings Account as follows:

- $750/year for Participants enrolled in single HSA-qualified plan option coverage
- $1,500/year for Participants enrolled in non-single HSA-qualified plan option coverage

To be eligible for a Company contribution , the Eligible Employee must satisfy the following requirements as of the date on which the Company's HSA contribution is issued: (i) be actively employed by a participating employer; (ii) be enrolled in the HSA-qualified plan option under the Group Medical Plan for Active Employees, and (iii) be eligible to contribute to a Health Savings Account.