NorthWestern Energy

Vision Care Plan

SUMMARY PLAN DESCRIPTION

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As in effect on January 1, 2025

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INTRODUCTION

The NorthWestern Energy (Company) Vision Care Plan (Plan) provides benefits for routine eye care services and materials such as eye glasses and contact lens. 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.

The Company has contracted with the Vision Service Plan Insurance Company (VSP) to provide the benefits under the Plan and to serve as the Plan's Supervisor for claims administration and billing. You will receive optimum coverage under the Plan if your benefits are received from a VSP network provider. Information regarding VSP, including their website to access and find a network provider, can be found on page 23.

This summary plan description (SPD) has been prepared to provide you with a general description of the Plan including:

- 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.

Detailed terms and provisions regarding the benefits under the Plan are outlined in the agreement between the Company and VSP (Agreement). The Plan is a component plan of the Company's Employee Benefit Plan. Detailed terms and provisions regarding eligibility and participation in the Plan are outlined in the Employee Benefit Plan. If there are any inconsistencies between this SPD and the Agreement or Employee Benefit Plan, the Agreement or Employee Benefit Plan, as applicable, will govern in all cases. You can request a copy of the Agreement or Employee Benefit Plan 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 is also available on the Company's intranet site.

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

DEFINITIONS

ADMINISTRATIVE FEE	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.
BENEFIT AUTHORIZATION	Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.
COMPANY	NorthWestern Energy, who has contracted with VSP for coverage under this Plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
COPAYMENTS	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets the Plan's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this Plan.
ELIGIBLE DEPENDENT	Any legal dependent of an Enrollee of the Company who meets the Plan's eligibility criteria, as defined herein.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or former employee of the Company who meets the Plan's eligibility criteria, as defined herein.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
MEMBER DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials and who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
NON-MEMBER PROVIDER	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Plan.

PREMIUMS The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

PRIVACY OFFICER The person designated by the Company to develop, implement and oversee the Company's compliance with the data privacy and security rules and provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SCHEDULE OF BENEFITS The document, included in this summary as Exhibit A, Exhibit B or Exhibit C that lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this Plan.

VSP The Vision Service Plan Insurance Company that the Company has contracted with to provide the benefits under the Plan and claims administration and billing services for the Plan.

ELIGIBILITY FOR COVERAGE

An Eligible Enrollee can elect coverage under this Plan as either an Enrollee or a Dependent. An eligible Dependent cannot be covered under this Plan by more than one Enrollee.

Coverage under this Plan for an eligible retiree and his or her eligible Dependents is offered as alternative coverage to COBRA continuation coverage. Upon termination of employment, an eligible retiree and his or her eligible Dependents may elect either COBRA continuation coverage or retiree coverage under this Plan. An eligible retiree and his or her eligible Dependents who elect this alternative coverage will waive their rights to COBRA continuation coverage under this Plan based on the retiree's termination of employment. The waiver of COBRA election rights will not be fully effective until the COBRA election period expires under this Plan. By waiving COBRA continuation coverage based on the retiree's termination of employment, the retiree and/or his or her Dependents are not waiving rights to COBRA continuation coverage that arise for qualifying events other than termination of employment.

If a retiree and/or his or her Dependents elect COBRA continuation coverage instead of alternative retiree coverage under this Plan, alternative retiree coverage under this Plan may not be elected at another time (i.e. when such COBRA continuation coverage has been exhausted). Further, as stated in the "Plan Amendment/Termination" section, coverage for a retiree and his or her Dependents under this Plan may be amended or terminated at any time. In such event, a retiree and/or his or her Dependents will not be entitled to elect the COBRA continuation coverage they waived under this Plan based on the retiree's termination of employment.

Eligible Enrollee

An Eligible Enrollee includes:

1. An active regular full-time or part-time or seasonal full-time or part-time employee.

2. A former employee who is eligible for and receiving benefits under the Company's Long Term Disability plan.

2. A retiree under the age of sixty-five (65), provided that he or she was participating in the Plan on the last day of active service prior to retirement and he or she meets the following conditions, as applicable:

    a. If the retiree terminated employment on or before December 31, 2010, he or she was at least age fifty (50) with five (5) or more years of service at termination; or

    b. If the retiree terminated employment after December 31, 2010, he or she was at least age fifty-five (55) with twenty (20) or more years of service at termination.

An Eligible Enrollee does not include:

1. Employees covered by a collective bargaining agreement that does not provide for participation in the Plan.

2. Employees in a classification of temporary or limited.

3. Leased Employees, Independent Contractors or Nonresident Aliens (as defined in the Company's Employee Benefit Plan).

Eligible Dependent

An Eligible Dependent includes:

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

   An eligible Dependent does not include:

   a. A retiree's spouse who is age sixty-five (65) or older; or

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

2. Children who are:

   a. A natural child; step-child; legally adopted child or a child placed with the Enrollee for adoption prior to reaching age 19; and

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

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

Change in Status Events

You are permitted to change or revoke your elections under this Plan outside of open enrollment if you experience one of the following events:

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

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 including a termination or commencement of employment, a strike or lockout, 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 constitute 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 this Plan; or

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

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

Any change or revocation of an election under this Plan as a result of one of the above events must be consistent with the event. For example, if, as a result of marriage, you gain eligibility for other vision coverage under your Spouse’s employer benefit plan, revocation of your coverage under this Plan would be consistent with that Change in Status Event (marriage).

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

Effective Date of Coverage

If elected, coverage under the Plan for you and your eligible dependents will become effective on:

1. The 1st day of the month following your hire date (for new hires); or
2. Your retirement date (for retirees); or
3. The effective date of an event that creates a special enrollment right (see “Change of Status Events”); or
4. The start of the next Plan Year if elected during an annual open enrollment period.

PREMIUMS

The Company is responsible for payments to VSP of the periodic charges for coverage under this Plan. Enrollees will be notified of their share of the charges, if any, by the Company. The entire cost of the program is paid to VSP by the Company.

PROCEDURES FOR USING THE PLAN

1. When you want to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from the Plan Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one that does.

2. If you are eligible and elect coverage for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

   Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the Schedule of Benefits, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, a Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the Schedule of Benefits indicates such coverage). No prior approval from VSP is required for a Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the Schedule of Benefits, a Covered Person is not covered by VSP for medical services and should contact a physician under the Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest enrollment information furnished to VSP by the Company and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for a Covered Person by the Company under this Plan. When a Covered Person requests services under this Plan, the Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if the Covered Person is eligible for new services based upon the Covered Person's Plan's level of coverage. Please refer to the Schedule of Benefits for coverage options provided to Covered Persons under the Plan.

BENEFITS AND COVERAGES

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you want to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you under the Plan may be different. Refer to the Schedule of Benefits to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

4. Contact lenses: Unless otherwise indicated on the Schedule of Benefits, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

   Necessary contact lenses, together with professional services, will be provided as indicated on the Schedule of Benefits.

   When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials as shown on the Schedule of Benefits. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the Schedule of Benefits, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

6. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined in the Schedule of Benefits): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined in the Schedule of Benefits. Consult your Member Doctor for details.

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this summary and on the Schedule of Benefits. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. A Covered Person may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

This vision service Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the Plan allowance
- Contact lenses (except as noted elsewhere herein)

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances indicated on the Schedule of Benefits.
- Services/materials not indicated as covered Plan Benefits on the Schedule of Benefits.

LIABILITY IN EVENT OF NON-PAYMENT

In the event that VSP fails to pay the provider, you shall not be liable to the provider for any sums owed by the Plan other than those not covered by the Plan.

TERMINATION OF COVERAGE

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

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

2. An event described in the "Enrollee Termination" and "Dependent Termination" provisions of this Plan.

By electing coverage under this Plan, an Enrollee and Dependent(s) agree that the Plan Administrator is entitled to collect any premium contributions owed by Enrollee (and Dependent(s)) from the Enrollee (and Dependent(s)) for the entire Plan Year in which the election applies (unless a change or revocation is otherwise permitted).

Enrollee Termination

Enrollee coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage provision:

1. On the last day of the month in which the Enrollee's employment terminates unless the Enrollee is disabled and entitled to receive benefits under the Company's Long Term Disability Plan on that date; or

2. With respect to an Enrollee who is disabled and entitled to receive benefits under the Company's Long Term Disability Plan, the earliest of the following dates:

    a. The first day of the month for which the Enrollee fails to make any required contribution for coverage (no coverage exists for that first day);

    b. On the last day of the month in which the Enrollee is no longer disabled;

    c. On the last day of the month in which the Enrollee is no longer eligible for benefits under the Company's Long Term Disability plan; or

    d. The date the Enrollee becomes eligible for coverage under the Company's Health Benefit Plan for Retirees under Age 65 or the Company's Health Benefit Plan for Retirees Age 65 or Older.

3. On the last day of the month in which the Enrollee otherwise ceases to be eligible

for coverage; or

4. The date the Plan is terminated; or

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

6. The date the Enrollee dies; or

7. The date following six (6) months of active military duty; or

8. On the last day of the month in which the Plan receives the Enrollee's election to waive or decline coverage.

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

Dependent Termination

Each Covered Person, whether an Enrollee or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of dependent status due to death, divorce or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA continuation coverage after termination.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage provision:

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

2. On the last day of the month in which the Enrollee's coverage is terminated under this Plan; or

3. On the last day of the month in which the Enrollee ceases to be eligible for Dependent coverage; or

4. The date the Plan is terminated; or

5. The date the Company terminates the Dependent's coverage (including, but not limited to, termination as a result of the Company's unsuccessful attempts to obtain any required premium contributions); or

6. On the last day of the month in which the Enrollee dies; or

7. The date the Dependent enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days.

CONTINUATION OF COVERAGE

COBRA Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, the Plan Administrator shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

Surviving Dependent Continuation

NOTE: These provisions **do not** apply to an Enrollee who is a former employee who is eligible for and receiving benefits under the Company's Long Term Disability plan.

A. In the event that an Enrollee dies on or after January 1, 2005 and prior to January 1, 2024, the surviving spouse of the Enrollee who is covered under this Plan at the time of the Enrollee's death can elect to continue coverage under this Plan without electing COBRA continuation coverage for a period of twenty-four (24) months, until he or she reaches age 65, remarries or becomes eligible under another plan, whichever occurs first. Dependent children can continue coverage under this provision, as long as the surviving spouse is covered under this provision and they remain eligible Dependents. In the event there is no surviving spouse, Dependent children who are covered under this Plan on the date of the Employee's death can continue coverage without electing COBRA continuation coverage until the earliest of the following events:

   1. They cease to be eligible Dependents;

   2. They become eligible for another group plan; or

   3. Another person/agency obtains legal guardianship.

   4. They have been covered under this provision for a period of twenty-four (24) months.

B. For a Montana Enrollee who died prior to January 1, 2005, a surviving spouse can elect to continue coverage under this Plan without electing COBRA continuation coverage until he or she reaches age 65, remarries or becomes eligible under another plan, whichever occurs first. Dependent children can continue coverage under this provision, as long as the surviving spouse is covered under this provision and they remain eligible Dependents.

C. In the event that an Enrollee becomes deceased on or after January 1, 2024, a surviving spouse or dependent child of an Enrollee who is covered under this Plan on the date of the Enrollee's death may elect to continue coverage under this Plan through COBRA Continuation Coverage.

CLAIMS PROCEDURES

If a Covered Person ever has a question or problem, the Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer the Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. A Covered Person also has the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, a resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that a resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. **Initial Determination**: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. **Request for Appeals**: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, the Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The Covered Person or Covered Person's authorized

representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If the Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When the Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. The Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], the Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

PLAN AMENDMENT/TERMINATION

This Plan may be amended or terminated by agreement between the Company and VSP.

If service is being rendered to you as of the termination date of the Plan, such service shall be continued to completion but in no event beyond six (6) months after the termination date of the Plan.

HIPAA 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.

ADMINISTRATIVE INFORMATION

Plan Name	NorthWestern Energy Group Vision Care Plan
Group Number	07107290
Plan Number	508
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 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	Name: Director, Compensation and Benefits Address: NorthWestern Energy 11 E Park Street Butte, MT 59701 Phone: (406) 497-4610
Plan Supervisor (Claims and Billing)	Vision Service Plan Insurance Company (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 (916) 851-5000 or (800) 877-7195 www.vsp.com
Type of Administration	VSP provides claim and billing administrative services. Benefits provided under this Plan are self-insured by NorthWestern Energy.

EXHIBIT A - SCHEDULE OF BENEFITS – STANDARD OPTION

All Employees and Retirees

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons under the Plan are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non -Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non -Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $20.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN AND SCHEDULE: ***SIGNATURE PLAN - STANDARD OPTION $20/$20***

EXAMINATION:	ONCE EVERY CALENDAR YEAR
LENSES:	ONCE EVERY CALENDAR YEAR
FRAMES:	ONCE EVERY OTHER CALENDAR YEAR

PLAN BENEFITS

VISION CARE SERVICES	MEMBER DOCTOR	NON-MEMBER PROVIDER
Eye Examination	Covered in Full*	Up to $ 40.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations once every calendar year.

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR	NON-MEMBER PROVIDER
Lenses		
Single Vision	Covered in Full*	Up to $ 48.00*
Bifocal	Covered in Full*	Up to $ 60.00*
Trifocal	Covered in Full*	Up to $ 75.00*
Lenticular	Covered in Full*	Up to $ 160.00*

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full.

Available once every calendar year.

Frames	Covered up to Plan Allowance*	Up to $ 64.00*

Available once every other calendar year.

*Less any applicable Copayment.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

Client charge shall be determined by the then applicable wholesale/retail equivalent conversion factor.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every calendar year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

Necessary

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

	MEMBER DOCTOR	NON-MEMBER PROVIDER
Professional Fees and Materials	Covered in Full*	Up to $ 190.00*

Elective

Professional Fees and Materials	Up to $ 120.00 Elective Contact Lens fitting and evaluation** services are covered in full once every calendar year, after a maximum $60.00 Copayment	Up to $ 120.00

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

*Subject to Copayment, if any.

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

LOW VISION BENEFIT

The Low Vision Benefit is available to Covered Person who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR	NON-MEMBER PROVIDER
Supplementary Testing	Covered in Full	Up to $ 125.00
Complete low vision analysis/diagnosis, which includes comprehensive examination of visual functions including the prescription of corrective eyewear or vision aids where indicated.		
Supplemental Care Aids	75% of cost	75% of cost
Subsequent low vision aids. Copayment for supplemental aids:	25% payable by Covered Person	

Benefit Maximum

The maximum benefit available is $1,000.00 (excluding Copayment) every two (2) years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider their full fee. The Covered Person will be reimbursed in accordance with an

amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the Plan allowance
- Contact lenses (except as noted elsewhere herein)

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

EXHIBIT B - SCHEDULE OF BENEFITS – PREMIER OPTION

All Employees

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons under the Plan are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non -Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non -Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $20.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN AND SCHEDULE: ***SIGNATURE PLAN - PREMIER OPTION $20/$20***

EXAMINATION:	ONCE EVERY CALENDAR YEAR
LENSES:	ONCE EVERY CALENDAR YEAR
FRAMES:	ONCE EVERY CALENDAR YEAR

PLAN BENEFITS

VISION CARE SERVICES	MEMBER DOCTOR	NON-MEMBER PROVIDER
Eye Examination	Covered in Full*	Up to $ 40.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations once every calendar year.

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR	NON-MEMBER PROVIDER
Lenses		
Single Vision	Covered in Full*	Up to $ 48.00*
Bifocal	Covered in Full*	Up to $ 60.00*
Trifocal	Covered in Full*	Up to $ 75.00*
Lenticular	Covered in Full*	Up to $ 160.00*

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full.

Available once every calendar year.

Frames	Covered up to Plan Allowance*	Up to $ 64.00*

Available once every calendar year.

*Less any applicable Copayment.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

Client charge shall be determined by the then applicable wholesale/retail equivalent conversion factor.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary

CONTACT LENSES

Contact lenses are available once every calendar year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

Necessary

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

	MEMBER DOCTOR	NON-MEMBER PROVIDER
Professional Fees and Materials	Covered in Full*	Up to $ 190.00*
Elective		
Professional Fees and Materials	Up to $ 120.00 Elective Contact Lens fitting and evaluation** services are covered in full once every calendar year, after a maximum $60.00 Copayment	Up to $ 120.00

*Subject to Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

EASY OPTIONS

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following Easy Options upgrades:

FRAMES*:** An Additional Allowance of $120.00 once every calendar year*; or***

LENS ENHANCEMENT

Premium and Custom Progressive lenses: Covered in full once every calendar year**; o***r***

Photochromic: Covered in full once every calendar year**; ***or***

Anti-reflective coating: Covered in full once every calendar year**; ***or***

CONTACT LENSES

ELECTIVE: An Additional Allowance of $80.00 once every calendar year**

*Less any applicable Copayment. ** beginning with the first day of the Benefit Period.

LOW VISION BENEFIT

The Low Vision Benefit is available to Covered Person who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR	NON-MEMBER PROVIDER
Supplementary Testing	Covered in Full	Up to $ 125.00

Complete low vision analysis/diagnosis, which includes comprehensive examination of visual functions including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of cost	75% of cost

Subsequent low vision aids
Copayment for supplemental aids: 25% payable by Covered Person

Benefit Maximum
The maximum benefit available is $1,000.00 (excluding Copayment) every two (2) years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider their full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the option unless such option is covered as an EASY OPTIONS upgrade..

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the Plan allowance
- Contact lenses (except as noted elsewhere herein)

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;

- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

EXHIBIT C – SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

All Employees and Retirees

GENERAL

This Exhibit lists additional vision care benefits to which Covered Persons of VSP are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes.

Essential Medical Eye Care benefits are available to a Covered Person only after covered benefits under their group medical plan have been exhausted, or when a Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to a Covered Person's group medical plan. A Covered Person should refer to their group medical plan or summary plan description to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to the Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("COB."). Please refer to the Coordination of Benefits section of the Eligible Enrollee's group medical plan or summary plan description for additional information regarding COB.

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When a Covered Person does not have a group medical plan, or when a VSP Member Doctor does not participate with a Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts VSP preferred provider and makes an appointment.

2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS
VSP MEMBER DOCTORS

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Exhibit as covered Plan Benefits.