MISSION VALLEY POWER

HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

January 1, 2014

ABOUT THIS SUMMARY PLAN DESCRIPTION

The terms of these benefit changes shall begin on May 1, 2014.

Your employer hereby establishes this Health Reimbursement Arrangement (HRA). This HRA is integrated with and is part of your Employer's health plan. The Mission Valley Power (MVP) Health Reimbursement Arrangement (the "Plan") provides eligible employees of MVP and any subsidiary or division designated by MVP as a participating employer with reimbursements of qualifying medical expenses. Currently, MVP is the only employer participating in the Plan.

You are encouraged to read this Summary Plan Description (SPD) carefully. If you have any questions about the benefits provided under the Plan, you should contact your employer.

ELIGIBILITY AND PARTICIPATION

Eligible Employees

You are eligible for the Plan if you are a full time permanent, bargaining unit employee enrolled in your Employer's health plan option that relates to this HRA. After ten years of continuous service with MVP, to the extent required by federal law, employees leaving MVP employment shall be allowed to take their HRA account with them (portability) . Except as provided by law, employees leaving prior to ten years of service shall have no rights to take with them or access their HRA account balance after leaving MVP.

Eligible Employees will be automatically enrolled in the HRA on the date you are eligible for your Employer's Health Plan that relates to this HRA.

Ineligible Persons

You are not eligible to participate in the Plan if you don't meet the eligibility requirements stated above.

Return from Military Service

If an employee returns to active employment in a position as an eligible employee following active military duty, any minimum age and service requirements and any waiting period applicable to new eligible employees will not apply. All benefits provided by the Plan will be restored to their status as of the eligible employee's last day worked provided the employee applies for reinstatement within the time period required by the Uniform Services Employment and Reemployment Rights Act (USERRA). Plan coverage will be effective on the date the employee returns to active employment in a position as an eligible employee.

Spouse and Dependent Coverage

As a Plan participant you can receive reimbursement for eligible claims for your eligible spouse, your eligible children (e.g. biological, adopted, step and foster children) up to his or her 26th birthday, any dependent child for whom you are the legal guardian and any other eligible individual who qualifies as your Federal income tax dependent. In addition, you can receive reimbursement for eligible claims for a child who is covered by a qualified medical child support order (QMCSO) under ERISA Section 609.

Commencement of Participation

Your coverage will be effective on the date you satisfy the eligibility requirements described above.

Leaves of Absence

If you are on a leave of absence, your participation in the Plan will continue during the leave period to the extent coverage under your Employer's Health Plan that relates to this HRA continues.

Rescission of Coverage

The Plan shall not rescind coverage for a participant or qualifying dependent, unless the participant or dependent performs an act, practice, or omission that constitutes fraud or unless the participant or dependent makes an intentional misrepresentation of a material fact with respect to the Plan. If coverage may be rescinded under the foregoing provisions, the participant or dependent shall be provided with at least 30 days advance written notice of such rescission. A rescission is subject to the claims procedures.

A rescission of Plan coverage is a cancellation or discontinuance of such coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission (and not subject to the rescission of coverage rules) if:

- The cancellation or discontinuance of coverage has only prospective effect;
- The cancellation or discontinuance of coverage results from a participant's termination of employment from an Employer; or
- The cancellation or discontinuance of coverage of a dependent results from such dependent's failing to satisfy the applicable eligibility requirements to be a dependent.

BENEFITS

Reimbursements

The Plan allows you to be reimbursed for Qualifying Medical Expenses. Qualifying Medical Expenses include the following, as determined by the Claims Administrator (unless excluded below):

- Any expense that qualifies as a medical expense under Section 213(d) of the Internal Revenue Code for yourself and your eligible spouse and dependents; and
- "Eligible" medical expenses, including but not limited to deductible or co-insurance requirements under the health plan, that qualify as medical expense under Sectin 213(d) of the Internal Revenue Code but are not paid by MVP's health plan.
- Any premiums (or premium equivalents) for retiree health insurance or retiree health coverage that is paid for by you after-tax.

Qualifying Medical Expenses do not include the following:

- Any expense paid by another health plan (up to the dollar amount paid by the other health plan);
- Any expenses for over the counter medicines or drugs, unless you have a written prescription for such medicine or drug. Contact the Claims Administrator for additional information;
- Any expenses incurred before you begin to participate in the Plan;
- Any medical, dental or vision insurance premium (or premium equivalent) to the extent that you have paid for or could have paid for such premium (or premium equivalent) on a pre-tax basis through a Code Section 125 cafeteria plan;

- Any medical procedure deemed to be cosmetic in nature (i.e., teeth whitening, liposuction, chemical peels)

Please keep in mind the following special rules regarding reimbursement and you Plan HRA Account:

- You must file any claims for eligible expenses by May 31st of the year following the year in which the eligible expense was incurred. Claims filed after May 31st of the year following the year in which the expense was incurred will not be paid. The May 31st deadline may be revised in the future by the Plan Administrator by communicating to Plan participants a different deadline date.
- Eligible expenses incurred for yourself may be reimbursed from the HRA Account. Expenses incurred for your spouse, your child, or other dependent will only be reimbursed if your spouse, child, or other dependent satisfies the provisions to be eligible for the Plan. Expenses for your domestic partner and your partner's children are not eligible for reimbursement from you HRA Account, unless they are considered your tax dependents for federal income tax purposes.

Participants may be provided with a debit card by the Claims Administrator to pay for Qualifying Medical Expenses. Any debit card shall be subject to the debit card's terms of use and any other requirements established by the Claims Administrator for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Claims Administrator shall apply correction procedures as set forth in guidance under Section 125 of the Internal Revenue Code.

Maximum Reimbursements

Any credits to the HRA Account will be reduced by Qualifying Medical Expenses that are properly reimbursed from the Plan participant's HRA Account. HRA Account credits will also be reduced, on a pro rata bases, by the administrative fees paid by MVP to the Claims Administrator for processing claims under the Plan. These fees will be withdrawn from HRA Accounts on a monthly or quarterly basis Plan participants can contact the Company or the Plan Administrator to obtain the current amount of the fees.

Unused amounts from the prior calendar may be carried forward to subsequent calendar years. You may not be reimbursed for an amount of eligible expenses that is greater than your HRA Account balance at the time the reimbursement is to be made.

After your Plan eligibility terminates, no additional amounts will be credited to your HRA Account, with respect to periods after your termination. However, a contribution may be made to you HRA Account after termination of employment if the contribution is required by the applicable collective bargaining agreement.

Reimbursement Requests

During the course of the calendar year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than May 31st following

the year in which the expense is incurred. (The deadline of May 31st may be changed for future years by communicating a different date to you in advance.) The Claims Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the

Claims Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan or form of coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

Employer Contributions Only

Benefits from the HRA are paid by your Employer; employee contributions are neither required nor permitted.. Payments from your HRA account balance may only be used to pay for or reimburse for Eligible Medical Expenses. The HRA account balance may not be used for any other purpose or benefit..

Coordination of Benefits with Flexible Spending Account (FSA)

If you have a FSA, you must fully exhaust that account before submitting HRA claims, or using your HRA benefit card.

Termination of Employment or Participation

Once your Plan participation terminates (such as a termination of employment, retirement or death), you will not receive any additional HRA Account contributions, unless otherwise required by the applicable collective bargaining agreement. However, you do have the ability to spend down your remaining HRA Account balance, provided you have worked continuously for MVP for ten years and to the extent required by Federal law, following your termination, as follows:

- You may continue to submit claims for reimbursement based on the rules and procedures set forth in this SPD until the date your HRA Account balance is exhausted. Once your HRA Account is exhausted, any remaining rights you may have in the Plan will terminate.
- If you die while you are participating in the Plan, your eligible spouse and eligible dependents (at the time of your death) can continue to submit claims for reimbursement until the date the HRA Account balance is exhausted.
- For any month that there is an outstanding balance in your HRA Account, your HRA Account will be charged a monthly administrative fee by the Claims Administrator. This fee will be charged based on the rules and procedures of the Claims Administrator. You may contact the Claims Administrator regarding the current amount of the monthly fee.

After ten years of continuous service with MVP, and to the extent required by Federal law, employees leaving MVP employment shall be allowed to take their HRA account with them (portability). Except as provided by law, employees leaving prior to ten years of service shall have no rights to take with them or access their HRA account balance after leaving MVP. An account balance not taken by an employee with more than ten years of continuous employment with MVP, as described above shall revert back to MVP.

Claims and Appeals

When you have a claim to submit for reimbursement, you must:

1. Obtain a claim form from the Claim Administrator;
2. Complete the Employee portion of the form; and
3. Attach copies of all bills from the service provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum tines only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances but no later than the time periods set for below. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient Information on the claim:	
Notification of insufficient information	15 days
Required Response by Participant	45 days

The Claim or Plan Administrator will provide written or electronic notification of any claim denial. The notice will include, among other things, specific information regarding the denial of your claim, a description of any additional review procedures that may be available to you and a description of your rights with respect to the denial.

Appeal Process

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Once an appeal is filed, the Claims Administrator will notify you within 60 days thereafter.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

With respect to those matters that the Plan Administrator and the Claims Administrator have been authorized to handle, each such entity has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., the arbitrary and capricious standard). Benefits under the Plan will be paid only if a plan administrator or Claims Administrator, as applicable, decides in its discretion that you are entitled to them.

Affordable Care Act Provisions

External review may be available once you complete the regular claims and appeal process described above. However, external reviews are limited to only the following types of claims and appeals –

- Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).
- Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission. (Subject to certain exceptions, generally a rescission is a retroactive termination of coverage.)

External review procedures do not apply to any other adverse determination (other than medical judgment and rescissions as set forth above), including eligibility appeals. Contact the Claims Administrator to determine if external review applies to your claim determination.

COBRA COVERAGE

General Explanation of COBRA Rights

You and your dependents have the option to extend your Plan coverage at group rates in certain instances when coverage would otherwise end (or the cost of coverage would increase). This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This section gives you a general description of your rights under COBRA.

COBRA Participation

If one of the circumstances listed in the COBRA continuation chart below causes you or a dependent to lose health coverage, you may continue group health plan coverage for yourself and your dependents if you pay the entire cost of coverage, with an additional 2 percent to cover administrative expenses.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the circumstances outlined in the chart. The maximum continuation period if multiple circumstances should occur during the 18-month COBRA period is a total of 36 months. For example, if you terminate your employment and then die, your dependents' coverage may continue for 36 months, as long as COBRA was elected at termination and in effect at your death.

It is the responsibility of you, your spouse, or your dependent children to contact your employer within 60 days of the event to request an application to continue participation due to your divorce or legal separation or a child no longer qualifying as a dependent. Also, to extend coverage beyond 18 months because of disability, you or your covered dependent must become disabled for Social Security purposes within 60 days of the qualifying event, and notice of the Social Security Administration's determination must be provided both within the initial 18-month period and within 60 days of when the determination is made.

If the disability ceases, notice should be provided within 30 days of the final determination that the disability has ended. You or your dependents must pay the full group rate for continued coverage, with an additional 2 percent for administrative expenses. In addition, if you (or a dependent) are disabled and coverage continues for 29 months, during the 19th through 29th month of COBRA participation, the cost for coverage will be greater than that usually charged for COBRA coverage.

If COBRA is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, coverage and cost will be modified as Mission Valley Power makes regular changes to the programs, and you will be given the opportunity to make a

new election during annual enrollment or when you have a change in family status (if applicable). Any newly eligible dependents you may have may be covered under the same rules that apply to active employees.

You or your eligible dependents have 60 days after you receive a COBRA notice to elect continued participation under COBRA. An election by you or your spouse to continue coverage will apply to all the qualified beneficiaries losing coverage in the same qualifying event, unless the election specifies otherwise. Once you make your election, you will have up to 45 days to pay any make-up premiums you missed and the monthly premium for the current month. COBRA coverage will be effective the day after the qualifying event.

Termination of COBRA

COBRA coverage will terminate before the end of the indicated time period if:

- You or your dependent becomes covered under another group healthcare plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals).
- You or certain of your dependents become entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the date a final determination is made that the individual is no longer disabled.
- All health plans for active employees are terminated by your employer.

COBRA CONTINUATION CHART			
CIRCUMSTANCES	**MAXIMUM CONTINUATION PERIOD**		
	EMPLOYEE	**SPOUSE**	**CHILD**
Employee loses coverage because of reduced work hours	18 months	18 months	18 months
Employee terminates for any reason (except gross misconduct)	18 months	18 months	18 months
Employee or covered dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days of COBRA coverage	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Child no longer qualifies as dependent	N/A	N/A	36 months

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services. If your coverage under the Plan terminates due to your service in the uniformed services, you may elect special continuation coverage under USERRA for yourself and your covered dependents. Please contact your employer for additional information if you think these special rules apply to you.

AMENDMENT AND TERMINATION

The Plan has been established with a bona fide intention and expectation that it shall be continued indefinitely. However, MVP shall not have any obligation whatsoever to maintain or continue the Plan or any level of Plan benefits for any length of time. MVP reserves the right to modify, reduce, suspend, amend or terminate (in whole or in part) this Plan at any time. MVP does not promise any specific level of Plan benefits or Plan coverage.

Benefits for claims occurring after the effective date of a Plan amendment, modification or termination are payable in accordance with the revised Plan documents. All statements in this SPD and all representations by MVP or its personnel are subject to the above right of amendment and termination. The right to modify, reduce, suspend, amend or terminate (in whole or in part) this Plan at any time applies, without limitation, even after an individual's circumstances have changed by retirement, termination or otherwise. Benefits do not become vested at any time.

The rights to amend and terminate this Plan as set forth above shall be limited by and shall be subject to the applicable collective bargaining agreement.

MISCELLANEOUS

Official Plan Information

Your coverage is an employee welfare benefit under the Employee Retirement Income Security Act of 1974 (ERISA), as amended,

The Plan discussed in this SPD is the Mission Valley Power (MVP) Health Reimbursement Arrangement.

The financial and other records are kept on a plan year bases. The plan year ends on each December 31st.

Plan Sponsor and Plan Administrator

The Plan sponsor is:	Mission Valley Power P.O. Box 97 Pablo, MT 59855-0097 TIN: 81-0454523
The Plan Administrators Are:	General Manager and/or Support Services Manager Mission Valley Power P.O. Box 97 Pablo, MT 59855-0097

The Plan Administrators may be contacted by phone or in person.

The Plan Administrator is the "named fiduciary" for the Plan under ERISA and has full discretion to exercise its duties hereunder. The Plan Administrator may adopt rules and procedures as to how the Plan operates and has authority to exercise discretion in performing its duties.

Agent for Service of Legal Process

Legal process may be served on: Mission Valley Power
P.O. Box 97
Pablo, MT 59855-0097

It may also be served on the Plan Administrator.

Third-Party Administrator/Claims Administrator

CompuSys of Utah, Inc. provides certain third-party administration services related to the Plan. Contact information is as follows:

CompuSys of Utah, Inc.
2156 West 2200 South
Salt Lake City, Utah 84119
1-800-628-6562

Plan Funding

Contributions for Plan coverage are made by MVP. Benefits are self-insured and paid out of MVP's general assets on a monthly basis. The Claims Administrator is not responsible for funding or insuring Plan benefits. MVP pays an administrative fee to the Claims Administrator to process claims. This fee shall be deducted on a pro rata basis from each Participant's HRA Account at one or more times during the year. Information on the current amount of the administrative fee can be obtained by contacting the Plan Administrator.

No Guarantee of Employment

Nothing in the Plan or this SPD may or can be interpreted as a guarantee of future employment or continued employment for any duration.

YOUR RIGHTS UNDER ERISA

The following statement is required by federal law. As a participant in the group health plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following rights:

Receive Information About Your Plan and Benefits

You may examine, without charge, at MVP's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts and a copy of the latest annual report (For 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.

You may obtain, upon written request to MVP, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. MVP may make a reasonable charge for the copies.

You will receive a summary of the Plan's annual financial reports. MVP is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue 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 SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights and reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan 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 the plan documents and/or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require Mission Valley Power to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond Frontier's control. 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that plan 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 if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about a plan, you should contact your employer. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your employer, 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, N.W., 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.