

**AMENDMENT #10**  
TO THE  
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION  
FOR THE  
MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST (MACOHCT)

Effective April 1, 2009, Montana Association of Counties Health Care Trust (the Plan) is amended as follows:

Within the “**CONTINUATION COVERAGE AFTER TERMINATION**” section, the second paragraph is replaced as follows:

The Plan Administrator is Montana Association of Counties Health Care Trust (MACoHCT), 2717D Skyway Drive, Helena, MT 59602; 1-866-669-6428. The Plan Administrator is responsible for administering COBRA Continuation Coverage.

Within the “**CONTINUATION COVERAGE AFTER TERMINATION**” section, “DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE” and “SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE” subsections are replaced as follows:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration’s disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Montana Association of Counties Health Care Trust (MACoHCT), 2717D Skyway Drive, Helena, MT 59602.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: MACoHCT, 2717D Skyway Drive, Helena, MT 59602. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

**MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST**

BY: \_\_\_\_\_

TITLE: \_\_\_\_\_