PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

MADA INSURANCE TRUST

VISION PLAN

EFFECTIVE: JANUARY 1, 2012

NOTICE

This policy is issued by a self - funded multiple employer welfare arrangement. A self – funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self - funded multiple employer welfare arrangement.

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INTRODUCTION

This document is a description of MADA Insurance Trust (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

COBRA Continuation Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

- All Active Employees of the Employer.
- All Active Owners of the Employer

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least thirty (30) hours per week and is on the regular payroll of the Employer for that work; or

(2) is a Full-Time, Active Owner of the Employer. An Owner is considered to be Full-Time if he or she normally works at least thirty (30) hours per week and is on the regular payroll of the Employer for that work and owns at least 30% of the dealership; or

(3) is in a class eligible for coverage; and

(4) completes the employment Waiting Period of one (1) calendar month as an Active Employee or Active Owner.

Coverage will begin the first day of the calendar month following or coinciding with the completion of all Eligibility Requirements, Active Employee Requirement and Enrollment Requirements as stated under this Plan.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Note: In the event the covered Employee transfers from one participating Employer to another participating Employer under this Plan, the employment Waiting Period will be waived to the extent the employment Waiting Period was met prior to the covered Employee's transfer. This provision will only be applicable if the transfer occurs within thirty (30) days of either the transfer date or the terminated Employee's rehire date.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered **Employee's Spouse and children** from birth to the limiting age of twenty-six (26) years. When the child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term **"Spouse"** shall mean a person of the opposite sex recognized as the covered Employee's husband or wife, including common-law marriage. The Plan Administrator may require documentation proving a legal marital relationship.

The term **"children"** shall include natural children, adopted children, children placed with a covered Employee in anticipation of adoption and step-children.

If a covered Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

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

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who reaches the **limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; foster children; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Employer may share the cost of Employee coverage under this Plan with the covered Employees.

The covered Employees may be required to pay the entire cost for coverage for their Dependents.

The level of any required Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. If Dependent coverage is desired, the covered Employee will be required to enroll for Dependent coverage as well.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as specified in the Open Enrollment section.

(3) **Open Enrollment -** Each year there is an annual open enrollment period designated by the Plan Administrator during which Covered Employees may change their benefit elections under the Plan, and Employees and their Dependents, who are Late Enrollees, will be able to enroll in the Plan. The Pre-Existing Condition Limitation will apply to Late Enrollees enrolling during the open enrollment period.

Benefit choices for Late Enrollees made during the open enrollment period will become effective **January 1st.** *Plan Participants will receive detailed information regarding open enrollment from the Employer.*

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EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action; or

(4) As otherwise specified in the Eligibility section under this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Continuation During Periods of Employer-Certified Disability or Medical Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability or a medical leave of absence and will be subject to pre-approval by the participating Employer.

This continuance will end as follows:

For disability leave only: the end of ninety (90) days following the date on which the person last worked as an Active Employee.

For medical leave of absence: the end of ninety (90) days following the date on which the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-existing Conditions limitations will not be issued unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within thirty (30) days from the date of termination will be credited for time towards the satisfaction of any applicable employment Waiting Period and Pre-Existing Conditions prior to the initial date of termination.

A terminated Employee who is rehired after thirty (30) days from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

However, if the Employee is returning to work and continues his COBRA continuation coverage until he again becomes eligible for coverage as an Employee, any Pre-Existing Conditions Limitations provision will apply only to the extent it was in effect on the last day of COBRA coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of

service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Montana National Guard Members. Participants performing State active duty as a Montana National Guard member may elect to continue Plan coverage subject to the terms of the Montana Military Service Employment Rights Act (MMSERA) under the following circumstances:

(1) The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person's absence for State active duty begins, and ending:

(a) The next regularly scheduled day of employment following travel time plus 8 hours, if State active duty is 30 days or less; or

(b) The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or

(c) The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Participant's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State active duty.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.)

(3) The last day of the calendar month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.)

(4) The last day of the calendar month in which the Dependent ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.)

(5) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be

terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action; or

(6) As otherwise specified in the Eligibility section under this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

SCHEDULE OF BENEFITS

VISION CARE BENEFITS

Eye exam – limited to one exam per Calendar Year:

Calendar Year maximum..... $60

Frame-type lenses – limited to one pair per Calendar Year:

Single Vision Lenses

Calendar Year maximum..... $50

Bi-focal (Single) Lenses

Calendar Year maximum..... $72

Bi-focal (Double) Lenses

Calendar Year maximum..... $136

Tri-focal Lenses

Calendar Year maximum..... $92

Lenticular (including Aspheric)

Calendar Year maximum..... $320

Frames – limited to one pair per Calendar Year:

Calendar Year Maximum $92

Contact Lenses – in lieu of frames and lenses:

Calendar Year Maximum $98

Contact Lenses – if the Covered Person's visual acuity cannot be made 20/70 or better with spectacle lenses, but can be made better than 20/70 with contact lenses:

Calendar Year Maximum $320

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.

(7) **Training.** Charges for vision training or subnormal vision aids.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is each participating employer in the MADA Insurance Trust.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Plan means MADA Insurance Trust, which is a benefits plan for certain Employees of MADA Insurance Trust and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1st and ending December 31st.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her **EBMS / MADA Insurance Trust Identification card** to the provider. Participating Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number **(MADA Insurance Trust, Group #0000700)**
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Plan Administrator or the Claims Administrator. Claim forms are also available at http://www.ebms.com.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims. A Claim for benefits is not a Claim that has been previously submitted, denied, appealed, and re-denied upon appeal.

A "Claim" is a Post-Service Claim under the terms of the Plan. A **Post-Service Claim** means a Claim for covered medical services that have already been received by the Plan Participant.

All questions regarding Claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment. The Plan Administrator shall have full responsibility to adjudicate all claims and to provide a full and fair review of the initial claim determination in accordance with the following Claims review procedure.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

For the purposes of this section, **Claimant** means the Plan Participant or the Plan Participant's authorized representative. A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives. A Claimant does not include a healthcare provider simply by virtue of an assignment of benefits.

An Adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and, therefore, cannot be appealed.

Initial Benefit Determination

The Initial Benefit Determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If the Claims Administrator requires an extension due to circumstances beyond the Plan's control, the Claims Administrator will notify the Claimant of the reason for the delay within the initial 30-day period. A benefit determination on the Claim will be made within 15 days of the date the notice of the delay was provided to the Claimant. If additional information is necessary to process the Claim, the Claims Administrator will request the additional information from the Claimant within the initial 30-day period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

(1) Specific reason(s) for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(4) Description of the Plan's Claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an Adverse Benefit Determination on final review.

(5) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(6) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and that a copy will be provided free of charge to the Claimant upon request).

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim, or a statement that such explanation will be provided free of charge, upon request.

(8) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by either an appropriate Plan fiduciary or the Claims Administrator on the Plan's behalf, who is neither the individual who made the Initial Benefit Determination, nor a subordinate of that individual. The review will take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in the Initial Benefit Determination.

If the Adverse Benefit Determination was based in whole or in part upon medical judgment, including determinations on whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary, the Plan Administrator or its designee will consult with a health care professional who has the appropriate training and experience in the applicable field of medicine; was not consulted in the Initial Benefit Determination; and is not the subordinate of the initial decision-maker. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

The Plan Administrator will provide free of charge upon request by the Claimant, reasonable access to and copies of, documents, records, and other information as described in Items 5 through 8 under "Notice of Adverse Benefit Determination".

First Level of Claims Review

The written request for review must be submitted within 180 days of the Claimant's receipt of notice of an Adverse Benefit Determination. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
℅ Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the initial Adverse Benefit Determination within the 180 day period will render that determination final.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal.

Second Level of Claims Review

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant

may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information to:

Plan Administrator
℅ Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final.

The second level of review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal. The determination by the Plan Administrator upon review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law.

If upon review, the Adverse Benefit Determination remains the same and the Claimant still does not agree with the determination, the Claimant has the right to bring an action for benefits under Section 502(a) of ERISA. ***Before filing a lawsuit, the Claimant must exhaust both levels of review as described in this section****.* ***A legal action to obtain benefits must be commenced within one (1) year of the date of the notice of the Plan Administrator's determination on the second level of review****.*

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's Covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) Any automobile insurance, including but not limited to, No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

(7) Any third-party liability insurance, including but not limited to, homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

If the Covered Person, or someone on behalf of the Covered Person, has received any compensation and/or benefits from any third-party source, this compensation and/or benefits shall be primary and shall be coordinated with the benefits that they may be eligible to receive through this Plan before they may receive any benefits from this Plan.

Allowable Charge(s). For a charge to be allowable it must be a Usual, Customary, and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(B) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

The first rule that describes which plan is primary is the rule that applies:

(1) The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

(2) Unless there is a court decree stating otherwise, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. This rule applies beginning the first of the month after the plan is given notice of the court decree.

- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);

- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the spouse of the non-custodial parent.

(3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Member/Employee. The benefits of a benefit plan which covers a person as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Member/Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if rule #1 can be used to determine the order of benefits.

(5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

By enrollment in the Plan, a Covered Person agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Covered Person fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Defined Terms

"Covered Person" means anyone covered under the Plan, including but not limited to minor dependents and deceased Covered Persons. Covered Person shall include the parents, trustee, guardian, heir, personal representative or other representative of a Covered Person, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Covered Person’s rights to Recover or pursue Recovery from a Third Party who is liable to the Covered Person for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses. To the extent the Plan paid benefits on the Covered Person’s behalf, the Covered Person agrees that the Plan has an equitable lien on any Recovery whether or not such Recovery(s) is designated as payment for such expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person, and/or anyone on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party and to which the Plan is entitled for reimbursement of benefits paid by the Plan on the Covered Person’s behalf. The Covered Person shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan’s lien. The Covered Person will reimburse the Plan first, even if the Covered Person has not been fully compensated or “made whole” and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Covered Person pursuing a claim against a Third Party, unless the Plan agrees in writing to such a reduction in its equitable lien, or subject to the terms of a court order.

Right to Subrogation

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses.

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the

Covered Person may have now or in the future against a Third Party who has or may have caused, contributed, aggravated, and/or been responsible for the Covered Person's Injury, Sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Covered Person further agrees that the Plan is subrogated to any and all claims or rights that the Covered Person may have against any Recovery, including the Covered Person's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Covered Person automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Covered Person agrees to:

1. Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;

2. Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;

3. Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Covered Person's Injury, Sickness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;

4. Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;

5. Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Covered Person's Injury, Sickness, condition, and/or accident;

6. Hold in trust that portion of any Recovery received by the Covered Person or on the Covered Person's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;

7. Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and

8. Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

1. The Plan may require the Covered Person as a condition of paying benefits for the Covered Person's Injury, Sickness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;

2. The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Covered Person;

3. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person;

4. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible; or

5. The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Covered Person or on the Covered Person's behalf.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the

Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedures as deemed necessary and appropriate to administrate the Plan's rights under this section.

Right to Recover Benefits Paid in Error

The Plan has the right to recover any benefits the Plan paid in error to the Covered Person or on behalf of a Covered Person to which the Covered Person is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's allowable charges. The Plan may recover benefits paid in error from the Covered Person, the provider who received a payment from the Plan on the Covered Person's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Covered Person's behalf, or from any other Covered Person enrolled through the same covered Employee.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee (or former Employee), Qualified Beneficiary, or any representative acting on behalf thereof. Coverage will end in certain instances, including, but not limited to, if you or your Dependents fail to make timely payment of premiums. You should check with your Employer to see if COBRA applies to you and your Dependents.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. ***A domestic partner is not a Qualified Beneficiary.***

If you are a Covered Employee (meaning that you are an Employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your Spouse; or
- In certain circumstances, you are no longer eligible for coverage under the Plan.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-Covered Employee dies;

- The parent-Covered Employee's hours of employment are reduced;
- The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

(1) Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former Employee) from his or her Spouse;

(2) Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent child under the terms of the Plan;

(3) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and

(5) Notice that a Qualified Beneficiary, with respect to whom a notice described in (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice?

Any individual who is the Covered Employee (or former Employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice.

The notice must contain the following information:

- Name and address of the Covered Employee or former Employee;
- If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the Covered Employee or former Employee, death of the Covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status);
- In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
- In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former Employee (or in certain circumstances, the Spouse), date of entitlement, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
- In the case of a Qualifying Event that is the death of the Covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's Notice of Award letter;
- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce, legal separation or the SSA's Notice of Award letter by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce, legal separation, or the SSA's Notice of Award letter within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation, or the SSA's Notice of Award letter is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. However, if, pursuant to the Plan, the first Qualifying Event is the Covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of (i) 36 months after the date the Covered Employee became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

If, pursuant to the Plan, the Qualifying Event is the death of the Covered Employee (or former Employee), the Covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

If the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the Covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules. However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator and COBRA Administrator:

Plan Administrator

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

COBRA Administrator

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1 (866) 444-3272 or visit the EBSA website at www.dol.gov/ebsa.

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. MADA Insurance Trust is the benefit plan of MADA Insurance Trust, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by MADA Insurance Trust to be Plan Administrator and serve at the convenience of the Plan Administrator. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, MADA Insurance Trust shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding may be derived from the funds of the Employer and contributions made to the MADA Insurance Trust by the covered Employees.

For Dependent Coverage: Funding may be derived from contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Plan Sponsor or Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUES PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Secretary to the MADA Insurance Trust
Office Manager

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUES PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(c) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(d) Report to the Plan any security incident of which it becomes aware.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from contributions by Employers and covered Employees to the MADA Insurance Trust. The Plan is not insured.

PLAN NAME

MADA Insurance Trust

PLAN NUMBER: 501

TAX ID NUMBER: 81-0380275

PLAN EFFECTIVE DATE: January 1, 2012

PLAN YEAR ENDS: December 31st

PLAN SPONSOR

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

PLAN ADMINISTRATOR

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

NAMED FIDUCIARY

MADA Insurance Trust501 N. Sanders
Helena, Montana 59601

AGENT FOR SERVICE OF LEGAL PROCESS

Smith Law Firm
501 N. Sanders
Helena, Montana 59601

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

Plan Name: MADA Insurance Trust

Plan Option: Vision Plan

Effective Date: January 1, 2012

I, _____, certify that I am the _____
Name Title

of the Plan Sponsor/Administrator for the above named Vision Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the above referenced Plan Document and am hereby authorizing its implementation as of the effective date stated above.

Signature: _____

Print Name: _____

Date: _____