TEMPORARY AMENDMENT
TO THE PLAN DOCUMENT ANO SUMMARY PLAN DESCRIPTION FOR MONTANA AUTO DEALERS ASSOCIATION GROUP BENEFIT TRUST

The Amendment is made Effective **MARCH 1, 2020.**

It is agreed that the following be amended as follows:

SECTION, SCHEDULE OF BENEFITS; MEDICAL BENEFITS SCHEDULE is amended to add the following:

COVID-19 (Novel Coronavirus)* Testing for diagnosis and treatment for COVID-19 when medically necessary and consistent with Centers for Disease Control and Prevention (CDC) guidance.	Covered pursuant to any applicable federal and/or state regulations.

*Subject to all Plan provisions including but not limited to exclusions, eligibility, and limitations set forth herein.

SECTION, ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS; ELIGIBILITY; Eligible Classes of Employees is amended to add the following:

COVID-19 (Novel Coronavirus)
For purposes of addressing the Novel Coronavirus pandemic, Employees who are:
1) on an Employer approved leave of absence;
2) have had his or her hours reduced; or
3) are on an Employer approved furlough;
and were eligible and enrolled in this Plan immediately prior to the Employer approved leave of absence, reduction in hours, or Employer approved furlough, will be considered an Active Employee or Active Owner for purposes of this Plan and its eligibility requirements.

At the discretion of the Employer, an approved leave of absence, reduction in hours, or furlough period may be intermittent and may extend beyond any other medical leave of absence time frames set forth herein so long as it does not extend beyond December 31, 2020.

Note: Any applicable continuation coverage provisions (i.e. COBRA or FMLA) may apply during the duration of this Temporary Amendment as well.

THIS AMENDMENT WILL TERMINATE WHEN THE PERIOD OF AN EMERGENCY OR DISASTER RELATED TO CORONAVIRUS (COVID-19) AS DECLARED BY THE PRESIDENT OF THE UNITED STATES HAS BEEN LIFTED, OR A PUBLIC HEALTH EMERGENCY RELATED TO CORONAVIRUS (COVID-19) AS DECLARED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES HAS BEEN LIFTED, AND/OR AS DETERMINED BY THE PLAN ADMINISTRATOR, WHICHEVER IS LAST.

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

of the Plan Administrator for the above named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and am hereby authorizing its implementation as of the effective date stated above.

Signature: _____

Print Name: _____

Date: _____