COUNTY OF MISSOULA

FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2013

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TABLE OF CONTENTS

INTRODUCTION 1

ELIGIBILITY FOR PARTICIPATION 1
- Eligible Employee 1
- Date of Participation 1

ELECTIONS 2
- In General 2
- Election Procedures 2
- Modification of Elections 2

BENEFITS 3
- Premium Conversion Account 3
- Health Care Reimbursement Account 3
- Dependent Care Assistance Account 4
- Coordination with Other Plans 5
- Limits on Certain Employees 5

FORFEITURES 5
- Plan Year/Termination 5
- Grace Period 5

CLAIMS 6
- Deadlines 6
- Documentation of Claims 6
- Method and Timing of Payment 6
- Where to Submit Claims 6
- Refunds/Indemnification 6
- Beneficiary 7
- Claim Procedures 7

CONTINUATION RIGHTS 8
- Military Service 8
- COBRA 8
- FMLA 8

MISCELLANEOUS 8
- Loss of Benefit 8
- Amendment and Termination 9
- Administrator Discretion 9
- Taxation 9
- Privacy 9

ADMINISTRATIVE INFORMATION 9

INTRODUCTION

County of Missoula (the "Employer") established the County of Missoula Flexible Benefits Plan (the "Plan") effective July 1, 2002. This Summary Plan Description describes the Plan as amended and restated effective July 1, 2013.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are employed by County of Missoula or any affiliate who has adopted the Plan and reported on the Employer's payroll records as a common law employee. However, you are not an "Eligible Employee" if you are any of the following:

A part-time employee who is expected to work less than 20 hours per week.

Temporary employees as classified on payroll records.

You are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

Date of Participation

You will become a Participant eligible to receive benefits from the Plan following three months from your initial date of employment as an Eligible Employee. However, your date of participation in the Health Flexible Spending Account will be six months from your initial date of employment as an Eligible Employee.

Your participation in making contributions and receiving benefits from the Premium Conversion Account will be subject to the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Employer.

ELECTIONS

In General

When you become eligible to participate in the Plan, you may begin contributing to the Plan. All contributions will be credited to an account established in your behalf. Your pre-tax contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Election Procedures

Within 31 days of your employment as an Eligible Employee, you must complete and return an initial election form that will be provided to you by the Plan Administrator.

After you are first eligible to participate in the Plan you will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you. In order to participate in the Plan for the next Plan Year, you must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you may modify elections at a time other than the beginning of a Plan Year.

If, as of the start of a Plan Year, you have not returned an election form by its due date, you will be deemed to have elected to continue with the same elections as the prior Plan Year for your Premium Conversion Account. You will be treated as having elected not to participate in the Plan with respect to the two Spending Accounts.

Modification of Elections

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A dependent satisfies or ceases to satisfy eligibility requirements.

Change in your place of residence.

Commencement or termination of an adoption proceeding.

Court judgment, decree, or order.

Entitlement to Medicare or Medicaid.

Significant cost or other coverage changes.

You take leave under the Family Medical Leave Act (FMLA)

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts as permitted by applicable law.

BENEFITS

Premium Conversion Account

When you become eligible to participate in the Plan, the Plan will establish a Premium Conversion Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. This account may be used to pay premiums on the contracts listed below:

Employer Group Medical

Employer Dental

Employer Vision

If a contract is offered in conjunction with an Employer-sponsored benefit plan, you will be eligible to make contributions to the Premium Conversion Account only if you are also eligible to participate in the applicable Employer-sponsored plan, it is described above and you are eligible to participate in this Plan.

In the event of a conflict between the terms of this Plan and the terms of a contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account

When you become eligible to participate in the Plan, the Plan will establish a Health Flexible Spending Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and

dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27 through the end of the calendar year. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating in the Plan.

The entire annual amount you elect to contribute for the Plan Year for the Health Flexible Spending Account less any reimbursements already disbursed will be available for reimbursement. The maximum amount you may contribute each year is for Plan Years beginning on or after January 1, 2013, is $2,500.

Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Health Flexible Spending Account. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded). You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Dependent Care Flexible Spending Account

When you become eligible to participate in the Plan, the Plan will establish a Dependent Care Flexible Spending Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify if they allow you to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

Before and after school programs

Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)

Licensed child care center

Nursery school or pre-school

Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you will seek reimbursement will qualify as dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is $5,000 ($2,500 if you are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

You generally must file a Form 2441 to determine whether any part of your Dependent Care Flexible Spending Account is taxable. Please note that participation in the Plan may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee of the Employer, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan. The Plan Administrator will notify you if this circumstance arises.

FORFEITURES

Plan Year/Termination

Any amounts remaining in your account at the end of the Plan Year will be forfeited after all claims are paid. In addition, any balance remaining in your account on the date you terminate employment with the Employer will be forfeited after all claims are paid.

Grace Period

However, the unused balance in your Health Flexible Spending Account that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2-1/2 month period after the end of the Plan Year.

CLAIMS

Deadlines

You must submit claims for reimbursement within 75 days after the end of the grace period for the Health Flexible Spending Account and withing 90 days after the end of the Plan Year for the Dependent Care Flexible Spending Account. However, if you terminate employment you must submit claims for reimbursement within 90 days after your date of termination under both Flexible Spending Accounts.

The unused balance in your Health Flexible Spending Account that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2-1/2 month period after the end of the Plan Year. You must submit claims incurred during the grace period for reimbursement by within 75 days after the end of the grace period.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Employer may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to the Plan Administrator at 200 W. Broadway, Missoula, MT 59802 in a manner directed by the Plan Administrator.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents or a representative of your estate.

Claim Procedures

Claim Procedures for Spending Account Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for Flexible Spending Account benefits by completing and filing a claim with the Plan Administrator. (For claims under contracts you pay for through Premium Conversion Account, refer to materials describing benefits under those contracts.) Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 45 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Plan Administrator will notify the Claimant of the Plan's benefit determination on review within 60

days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant will lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, and (3) a 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 Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits.

MISCELLANEOUS

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Employer may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Employer intends that all benefits provided under the Plan on a pre-tax basis will not be taxable to you under federal tax law. However, the Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is County of Missoula.

   Its address is 200 W. Broadway
   Missoula, MT 59802

   Its telephone number is 406-523-4876

   Its Employer Identification Number is 81-6001397.

2. The Plan Year ends on December 31.

If you have any questions about the Plan, you should contact the Plan Administrator.

COBRA NOTICE

In General.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of the Health Flexible Spending Account coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. 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. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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); or

You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

The parent-employee dies;

The parent-employee's hours of employment are reduced;

The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Administrator at 200 W Broadway, Missoula, MT 59802. The telephone number is 406-523-4876.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. 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.

The COBRA continuation coverage under the Health Flexible Spending Account lasts only until the end of the plan year in which the qualifying event occurs. COBRA continuation coverage may only be elected under this plan if, as of the date of the qualifying event, the maximum benefit available under the plan for the remainder of the plan year is more than the maximum amount that the Plan could require as payment to maintain coverage for the remainder of that plan year.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area 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.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Administrator

Missoula County
200 W Broadway
Missoula, MT 59802

V-3.00