DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

The Plan Sponsor has established and continues to maintain this City of Frankfort Dependent Care Flexible Spending Account (the "*Plan*") for the benefit of its *associates* and their eligible *dependents* as provided in this document.
Benefits under this *Plan* are provided on a self-insured basis, which means that payment for benefits is ultimately the sole financial responsibility of City of Frankfort, the Plan Sponsor. Certain administrative services with respect to the *Plan*, such as claims processing, are provided under a services agreement.

Any changes in the *Plan*, as presented in this *Summary Plan Description*, must be properly adopted by the Plan Sponsor, and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of the *Plan* or promise having the same effect, made by any person will not be binding with respect to the *Plan.*

City of Frankfort   Plan Number: 502
Effective Date: January 1, 2012

Plan Year: : The first Plan Year shall be the period commencing on January 1, 2012 and ending December 31, 2012 all subsequent Plan Years shall be the 12-month period commencing on January 1st and ending on December 31st.

Employer's Federal Tax Identification Number: 61-6001826

PLAN INFORMATION

GENERAL INFORMATION ABOUT THE PLAN

The City of Frankfort (the "*Employer*") has established the City of Frankfort Dependent Care Flexible Spending Account (the "*Plan*"). The *Plan* allows you to use *Pre-tax Contributions* to pay for qualified expenses. The City of Frankfort Dependent Care Flexible Spending Account contains two components:

(i) A Cafeteria *Plan*. The Cafeteria *Plan* allows you to pay your share of certain underlying welfare benefit plans (called "Benefit Plan Options") with *Pre-tax Contributions*.

(ii) The Dependent Care Spending Account ("Dependent Care FSA"). The Dependent Care FSA allows you to elect to use a specified amount of *Pre-tax Contributions* to be used for reimbursement of Employment Related Expenses. The Dependent Care FSA is intended to qualify as a *Code* Section 129 dependent care assistance plan.

Each of these components is summarized in this document. Each summary and the attached Appendices constitute the *Summary Plan Description* for the City of Frankfort Dependent Care Flexible Spending Account. The *SPD* (collectively, the *Summary Plan Description* or "*SPD*") describes the basic features of the Plan(s), how they operate, and how you can get the maximum advantage from them. The *Plan*(s) are also established pursuant to *plan* documents into which the *SPD* has been incorporated. However, if there is a conflict between the official *plan* document and the *SPD*, the *plan* document will govern. Certain words in this Summary are italicized. Italicized words reflect important terms that are specifically defined in Appendix IV of this Summary. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under the *Plan*(s).

Participation in the *Plan*(s) does not give any *Participant* the right to be retained in the employ of his or her *Employer* or any other right not specified in the *Plan*. If you have any questions regarding your rights and responsibilities under the *Plan*(s), you may also contact the *Plan Administrator*.

PLAN CONTACT INFORMATION

If you have any questions about the City of Frankfort Dependent Care Flexible Spending Account, you should contact the Third Party Administrator or the *Plan Administrator*.

The City of Frankfort / Plan Sponsor
315 West Second Street
Frankfort KY 40601
(502) 875-8500

Plan Administrator
Randy Donahue HR Director
315 West Second Street
Frankfort KY 40601
(502) 875-8500

Third Party Administrator / Plan Manager
FEBCO, Inc.
207 Versailles Road
Frankfort, Kentucky 40601
800-489-1539
502-695-9690
febco@febco.com

CAFETERIA PLAN SUMMARY

PARTICIPATION

You are eligible to participate in this *Plan* if you satisfy the below Eligibility Requirements. Those *employees* who actually participate in the Cafeteria *Plan* are called "*Participant*s."

"Employee" shall mean a person, who is regularly employed by City of Frankfort.

Eligibility for coverage under any given Benefit *Plan* Option shall be determined not by this *Plan* but by the terms of that Benefit *Plan* Option. The terms of eligibility of this Cafeteria *Plan* do not override the terms of eligibility of each of the Benefit *Plan* Options. In other words, if you are eligible to participate in this Cafeteria *Plan*, it does not necessarily mean you are eligible to participate in the Benefit *Plan* Options.

You may be *required* to pay for any Benefit *Plan* Option coverage that you elect with *Pre-tax Contributions*. When you elect to participate both in a Benefit *Plan* Option and this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that *Plan Year* is deducted from each paycheck after your election date. If you have chosen to use *Pre-tax Contributions* (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

ENROLLMENT

The purpose of the Cafeteria Plan is to allow eligible *employees* to pay for certain benefit plans (Benefit Plan Options) with pre-tax dollars ("*Pre-tax Contributions*"). Each *employee* of the *Employer* (or an Affiliated Employer) who

(i) Satisfies the Cafeteria Plan Eligibility Requirements and

(ii) Is also eligible to participate in any of the Benefit Plan Options will be eligible to participate in this Cafeteria Plan.

If you have satisfied the Cafeteria Plan's eligibility requirements, you may become a *Participant*. You may enroll during the year if you previously elected not to participate and you experience a change described below that allows you to become a *participant* during the year. If that occurs, you must complete an election change form during the Election Change Period. The Cafeteria Plan has three election periods:

(i) The "Initial Election Period," (Upon Hire)

(ii) The "Annual Election Period," (Open Enrollment) and

(iii) The "Election Change Period", which is the period following the date you have a *Qualifying Event*.

The following is a summary of the Initial Election Period and the Annual Election Period.

The Initial Election Period

Upon satisfying the Dependent Care FSA Eligibility Requirements, you are eligible to enroll in the City of Frankfort Dependent Care Flexible Spending Account. The election that you make during the Initial Election Period is effective for the remainder of the *Plan Year* and generally cannot be changed during the *Plan Year* unless you have a qualifying event.

The Annual Election Period

The Cafeteria Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next *Plan Year*. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next *Plan Year* and cannot be changed during the entire *Plan Year* unless you have a *Qualifying Event* described below.

ELECTION CHANGES

If you experience a Qualifying Event as described in the Cafeteria Plan Summary, you may make the permitted election changes if you complete and submit an election change form within thirty-five (35) days after the date of the event, unless the event is for birth of a newborn, or adoption or placement for adoption, in which you have sixty (60) days from the date of birth, adoption or placement for adoption to submit an election change form.

Generally, you cannot change your election under this Cafeteria Plan during the *Plan Year*. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Cafeteria Plan or under all of the Benefit Plan Options that you have chosen.

Second, you may voluntarily change your election during the *Plan Year* if you satisfy the following conditions (prescribed by federal law):

(i) You experience a "*Qualifying Event*" that affects your eligibility under this Cafeteria Plan and/or a Benefit Plan Option; and

(ii) You complete and submit a written Election Change Form within the Election Change period.

Qualifying Events are recognized by this Cafeteria Plan. Please contact your employer for additional information concerning this Plan's Qualifying Events. If coverage under a Benefit Plan Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end.

See Section 26 C.F.R. § 1.125 – 4 and Prop. Treas. Reg 1.125-2(a).

LEAVE OF ABSENCE

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence:

The specific election changes that you can make under this Cafeteria Plan following a leave of absence are:

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the *Employer* will continue to maintain your Benefit Plan Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA.

(b)Your *Employer* may elect to continue all health coverage for *Participant*s while they are on paid leave (provided *Participant*s on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with *Pre-tax Contributions* if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave,

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with *Pre-tax Contributions* from your pre-leave *compensation* by making a special election to that effect before the date such *compensation* would normally be made available to you. However, pre-payments of *Pre-tax Contributions* may not be utilized to fund coverage during the next *Plan Year*.

(iii) By other arrangements agreed upon between you and the *Plan Administrator* (for example, the *Plan Administrator* may fund coverage during the leave and withhold amounts from your *compensation* upon your return from leave).

The payment options provided by the *Employer* will be established in accordance with *Code* Section 125, FMLA and the *Employer*'s internal policies and procedures regarding leaves of absence and will be applied uniformly to all *Participant*s. Alternatively, the *Employer* may require all *Participant*s to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. Your employer will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Cafeteria Plan and the Benefit Plan Option upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing health coverage may be automatically reinstated provided that coverage for *Employees* on non-FMLA leave is automatically reinstated upon return from leave.

(e) The *Employer* may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the *Employer*.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Cafeteria Plan for Benefit Plan Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plan Options are treated with respect to *Participant*s commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Cafeteria Plan or a Benefit Plan Option offered under this Cafeteria Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by *after-tax contributions* while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Cafeteria Plan or a Benefit Plan Option, the election change rules described herein will apply. The *Plan Administrator* will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason.

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;

(ii) The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan;

(iii) The date that you terminate employment with the *Employer*; or

(iv) The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of *employees* of which you are a member.

If your employment with the City of Frankfort is terminated during the *Plan Year* or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will automatically cease. You will not be able to make any more *Pre-tax Contributions* under the Cafeteria Plan. If you are rehired or again become eligible less than 11 days of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the *Plan Year* (unless you are allowed to change your election in accordance with the terms of the Plan).

TAX ADVANTAGES

You save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Cafeteria Plan participation will reduce the amount of your taxable *compensation*. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable *compensation*. Participating in the Plan can actually increase your take home pay.

DEPENDENT CARE FSA ELIGIBILITY REQUIREMENTS

PARTICIPATION

Each *employee* who satisfies the Dependent Care FSA Eligibility requirements is eligible to participate on the Dependent Care FSA Eligibility Date. "Employee" shall mean a person, who is regularly employed by City of Frankfort. If you have otherwise satisfied the Dependent Care FSA's Eligibility requirements, you become a *participant* in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Dependent Care FSA will be effective on the date that you make the election or your Dependent Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next *Plan Year*, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.
You may also become a participant if you experience a Qualifying Event that permits you to enroll midyear.

ENROLLMENT

If you elect to participate in the Dependent Care FSA, the *Employer* will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the *Plan Year*. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the *Employer*'s general assets.

During the enrollment period, you will specify the amount of Dependent Care Reimbursement you wish to pay for with *Pre-tax Contributions*. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution. You may elect any annual reimbursement amount subject to the maximum annual Dependent Care Reimbursement Amount allowed for the plan.

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue *Code*. The minimum annual amount for the City of Frankfort Dependent Care Flexible Spending Account is $120 per *Plan Year*.

• married and file a joint return	$5,000 per *Plan Year*
• married but your *Spouse* maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA	$2,500 per *Plan Year*
• single head of household	$5,000 per *Plan Year*

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the *Plan Year* cannot exceed the lesser of your earned income (as defined in *Code* Section 32) or your *spouse*'s earned income.

Your *Spouse* will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your *Spouse* is

(i) physically or mentally incapable of caring for himself or herself, or

(ii) a full-time *student* (as defined by *Code* Section 21).

TAX ADVANTAGES

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregate Dependent Care Reimbursement (under this Dependent Care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit. The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax *Code*. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

ELECTION CHANGES

You can change your election under the Dependent Care FSA in the following situations:

(i) For any reason during the Annual Election Period. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) Following a Qualifying Event. You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Qualifying Event.

Qualifying events are governed by 26 C.F.R. § 1.125-4 and Prop. Treas. Reg 1.125-2.

LEAVE OF ABSENCE

Refer to the Cafeteria Plan Summary or contact your Employer to determine what, if any, specific changes you can make during a leave of absence.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms acceptable to the Plan Sponsor

1. If your completed enrollment forms are signed by you within thirty (30) days after *your* hire date, *your* coverage is effective on the first of the following month. Your coverage may be effective at a later date as determined by the Plan Sponsor.
2. If your completed enrollment forms are signed by *you* more than thirty (30 days after *your* hire date) you are a *late applicant* and you will not be eligible for coverage under this Plan until the next annual open enrollment period or until you experience a permitted *qualifying event*. *Your* coverage is effective as determined by the Plan Sponsor.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;

(ii) The last day of the *Plan Year* unless you make an election during the Annual Election Period;

(iii) The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;

(iv) The date that you terminate employment; or

(v) The date that the Plan is terminated or you or the class of eligible *employees* of which you are a member are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the *Plan Year*, you may submit for reimbursement Eligible Employment Related Expenses incurred prior to your termination date up to the amount of your Dependent Care Account.

ELIGIBLE CLAIMS EXPENSE

Eligible Expenses must be incurred ***during*** the *Plan Year*. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective or for any expenses incurred after the termination date.

You may be reimbursed for dependent care expenses ("Eligible Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.
2. Each individual for whom you incur the expense is a "Qualifying Individual."

A Qualifying Individual is:

(i) An individual age 12 or under who

(a) Has the same principal place of abode as you,

(b) Does not provide over half of his/her own support and

(c) Is your “child” (son, daughter, grandchildren, step children, brother, sister, niece and nephew).

Note: There is a special rule for children of divorced parents. If you are divorced, the child is a qualifying individual with respect to you if the child lives with you even if you have permitted the non-custodial parent to take the exemption; or

(ii) A *Spouse* or other tax Dependent (as defined in *Code* Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

NOTE: Effective January 1, 2005, there is an income limitation, in addition to a support requirement (and a residence requirement for certain non-relatives) for all individuals (other than a *spouse*) age 19 and older (or between age 19 and 23 if a full-time *student*) under *Code* Section 152.

Generally, such an individual cannot qualify as a *Code* Section 152 dependent if he/she has gross income in excess of the exemption amount under *Code* Section 151.

3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your *Spouse*, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations. The expense is not paid or payable to a “child” (as defined in *Code* Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your *Spouse* is entitled to a personal tax exemption as a Dependent.

6. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441. You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Qualifying Dependent Care Services" means the following:

Services that both

(1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and

(2) are performed— in the Participant's home; or outside the Participant's home for

(1) the care of a Participant's qualifying child who is under age 13; or

(2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

CLAIMS REIMBURSEMENT

Under this Dependent Care FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

FSA claim is deemed filed when it is received by the Third Party Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. *You* may submit requests for reimbursement of Eligible Dependent Care Expenses at any time prior to the end of the Dependent Care FSA Run Out Period. The FSA Run Out Period for active and terminated *employees* is 90 days after the end of the *plan year*. If it is later determined that you and/or your eligible Dependent(s) received an overpayment or a payment was made in error you will be required to refund the overpayment or erroneous reimbursement to the Dependent Care FSA. If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment; or erroneous payment or if that is not feasible to withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have income tax implications for you. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this Dependent Care FSA.

Traditional Paper Claims

When you incur an Eligible Dependent Care Expense, you file a claim with the Plan's Third Party Administrator by completing and mailing or faxing a Dependent Care Request for Reimbursement Form. Forms can be mailed to PO Box 5010, Frankfort, KY 40601-5010 or faxed to 502-695-9692. You may obtain a Request for Reimbursement Form from FEBCO or print a copy from the FEBCO website at http://febco.com. You must include with your Dependent Care Request for Reimbursement Form a written statement from an independent third party associated with each expense that indicates the following:

(i) The nature of the expense
(ii) The date the expense was incurred; and
(iii) The amount of the expense.

FEBCO will process the claim once it receives the Dependent Care Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Dependent Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Dependent Care Expense, you will receive an email notification of this determination. You must submit all claims for reimbursement for Eligible Dependent Care Expenses during the *Plan Year* in which they were incurred or during the Run Out Period.

DENIED CLAIM

If your claim for benefits is denied, you will have the right to a full and fair review process.

UNCLAIMED DEPENDENT CARE REIMBURSEMENTS

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the *Plan Year* following the *Plan Year* in which the Eligible Expense was incurred shall be forfeited.
You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred and the annual Dependent Care Reimbursement you have elected and paid for. Any amount credited to a Dependent Care Account shall be forfeited by the *Participant* and restored to the *Employer* if it has not been applied to provide the elected reimbursement for any *Plan Year* by the end of the Run Out Period following the end of the *Plan Year* for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Plan is January 1, 2012. It should replace and supersede any other Plan with an earlier date. The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan.
Step 1: *Notice is received from FEBCO*. If your claim is denied, you will receive an email notice from *FEBCO* that your claim is denied as soon as reasonably possible but no later than thirty (30) days after receipt of the claim. For reasons beyond the control of *FEBCO*, *FEBCO* may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the thirty (30) day period. If the reason for the additional time is that you need to provide additional information, you will have forty-five (45) days from the notice of the extension to obtain that information. The time period during which the *FEBCO* must make a decision will be suspended until the earlier of the date that you provide the information or the end of the forty-five (45) day period.
Step 2: *Review your notice carefully*. Once you have received your email notice from *FEBCO*, review it carefully. The notice will contain:

a. The reason(s) for the denial and the Plan provisions on which the denial is based;
b. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision *FEBCO* and you wish to appeal, you must file your appeal no later than one hundred eighty (180) days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.
Step 4: *Notice of Denial is received from FEBCO.* If the claim is again denied, you will be notified by email as soon as possible but no later than thirty (30) days after receipt of the appeal by *FEBCO*.
Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the *FEBCO*.
Step 6: *If you still disagree with FEBCO's decision, file a 2nd Level Appeal with FEBCO.* If you still do not agree with *FEBCO*'s decision and you wish to appeal, you must file a written appeal with the *Plan Administrator* within the time period set forth in the first level appeal denial notice from *FEBCO* . You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the *Plan Administrator* denies your 2nd Level Appeal, you will receive notice within thirty (30) days after the *Plan Administrator* receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

This Plan has adopted qualifying events (i.e. election changes). See 26 C.F.R § 1-125-4 and Prop. Treas. Reg. § 1.125-2(a)(1). Please contact your employer for additional information concerning this Plan's qualifying events.

Effective Dates
Effective dates for the various mid-year election changes are as follows:
Dependent Care Flexible Spending Account (DC FSA)
A Events starting or increasing DC FSA contributions

1. Dependent is newly eligible to begin attending day care = 1st day of 1st month from the employee's signature date.
2 Change in dependent's eligibility status = 1st day of 1st month from the employee's signature date.

B. Events stopping or decreasing DC FSA contributions.

1 Termination of employment = Date of termination of employment.
2 Dependent no longer attends day care = End of the month from the employee's signature date.
3 Change in dependent's eligibility status = End of the month from the employee's signature date.

4. Death = Date of death.

All Qualifying Events must be signed by the employee thirty-five (35) days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which are sixty (60) days. Qualifying Events dealing with loss of other group coverage or gaining other group coverage may be signed by the employee prior to the Qualifying Event date. In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place..

DEFINITIONS

Affiliated Employer - means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).
After-tax Contribution(s) - means amounts withheld from an Employee's Compensation after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan.
Benefit Plan Option - means those Qualified Benefits available to a Participant under this Plan as amended and/or restated from time to time.
Code - means the Internal Revenue Code of 1986, as amended.
Compensation - means the cash wages or salary paid to an Employee by the Employer.
Effective Date - This is the date the Plan was established.
Employee - means a person who is employed by City of Frankfort and is eligible to apply for coverage under the City of Frankfort Dependent Care Flexible Spending Plan.
Employer - means the City of Frankfort and any Affiliated Employer who adopts the Plan pursuant to authorization provided by City of Frankfort . Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.
Highly Compensated Individual - means an individual defined under Code Section 125(e), as amended, as a "highly compensated individual" or a "highly compensated employee."
Key Employee - means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.
Non-elective Contribution(s) - means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion.
The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement, or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. In no event will any Non-elective Contribution be disbursed to a Participant in the form of additional, taxable Compensation.
Participant - means an Employee who becomes a Participant pursuant to this Summary Plan Description.
Plan - means this Cafeteria Plan, as set forth herein.

Plan Administrator - means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.
Plan Year - shall be the period of coverage set forth in this Summary Plan Description.
Pre-tax Contribution(s) - means amounts withheld from an Employee's Compensation before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Package Option afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).
Qualifying Event - means any of the events described in this Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election midyear.
Run Out Period – is the period during which expenses incurred during a Plan Year must be submitted to be eligible for Reimbursement. The Run Out Period for active and terminated employees ends 90 days after the end of the Plan Year.
Spouse - means an individual who is legally married to a Participant (and who is treated as a spouse under the Code).
Summary Plan Description or "SPD" - means the Flexible Benefits Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and as amended from time to time. The SPD and appendices are incorporated hereto by reference.

NOTICE OF PRIVACY PRACTICES (SUMMARY)

THIS NOTICE DESRCIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

This Notice describes the obligations of the Department for Employee Insurance (DEI) and your legal rights regarding your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or Dependent Care operations, or for any other purposes that are permitted or required by law. This is a summary of City of Frankfort 's Notice of Privacy Practices. The City of Frankfort Dependent Care Flexible Spending Plan is a self-funded plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. City of Frankfort is the plan sponsor.
The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a Dependent Care provider, Dependent Care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provisions or Dependent Care to you; or 3) past, present, or future payment for provisions of Dependent Care to you. City of Frankfort does not maintain information regarding your specific medical condition but does maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in the Dependent Care Flexible Spending Plan..
City of Frankfort Responsibilities
We are required by law to: 1) maintain the privacy of your PHI; 2) provide you with certain rights with respect to your PHI; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and 4) follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of Notice and to make new provisions regarding your PHI that we maintain, or as required by law.
How City of Frankfort May Use and Disclose Your Protected Health Information Under the law, we may use or disclose your PHI under certain circumstance without your permission. The following categories represent the different ways that we may use or disclose your protected health information:
1) For Treatment;
2) For Payment;
3) For Dependent Care Operations;
4) To Business Associates;