CHILDREN'S FRIEND AND SERVICE

HEALTH FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT

Effective January 01, 2021

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CHILDREN'S FRIEND AND SERVICE
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HEALTH FLEXIBLE SPENDING ACCOUNT

Children's Friend and Service (the "Employer") hereby sets forth the Children's Friend and Service Health Flexible Spending Account ("Health FSA" or "the Plan"), as in effect January 01, 2021.

ARTICLE I

Purpose

The purpose of this Health FSA is to permit Eligible Employees to elect to make pre-tax contributions to pay for qualified medical expenses incurred by Eligible Employees and their family members. Contributions made under the Plan are not taxable to the employee. The Plan is intended to be a "cafeteria plan" as described in Section 125 of the Internal Revenue Code, as amended, and the regulations thereunder.

ARTICLE II

Definitions

2.1 "Benefits Account" means an account maintained on the books of the Employer for each Participant in accordance with Article IV for the purpose of recording the Participant's contributions to this Health FSA.

2.2 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.3 "Dependent" means an Employee's Spouse (as defined in Section 2.13) and the Employee's child(ren) if under age 27 as of the end of the Employee's taxable year (or such other age as determined by the Plan Administrator and permitted under applicable law).

2.4 "Eligible Employee" means any person as defined in Section 3.1. Non-resident aliens, independent contractors and individuals designated by the Employer as temporary employees shall not be Employees for purposes of this Plan. Leased employees within the meaning of Sections 414(n)(2) and 414(o)(2) of the Code, and employees subject to collective bargaining agreements may be included in the definition of Employee only at the discretion of the Employer.

2.5 "Employer" means Children's Friend and Service, and any entity which succeeds to the business and assumes the obligations of the Employer.

2.6 "Medical Care" means medical care as defined in Code Section 213(d), which includes amounts incurred by the Participant, Spouse or Dependent(s) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or

function of the body; for transportation primarily for and essential to Medical Care; and for health insurance co-pays and deductibles.

However, Medical Care shall not include health insurance premiums; long-term care services as defined in Code Section 7702B(c); or Medical Care expenses that have already been reimbursed, or are eligible to be reimbursed, by insurance or otherwise, among other exclusions. For expenses incurred prior to Jan. 1, 2020, Medical Care shall not include expenses incurred for any medicine or drug (other than insulin) that is not "prescribed" within the meaning of Code Section 106(f).

2.7 "Participant" means an Eligible Employee who has satisfied the requirements of Article III; and whose participation has not terminated in accordance with Article III, Section 3.5.

2.8 "Participating Employer" means any member of the following group including the Employer, if such member adopts this Health FSA with the Employer's authorization as provided in Article XII, Section 12.1 and meets the definition of an Employer as described in Section 2.5: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix A. The Employer shall amend Appendix A as needed, to reflect a Participating Employer's adoption of or withdrawal from this Health FSA, without any need to otherwise amend this Health FSA. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Directors.

2.9 "Period of Coverage" means the Plan Year; provided, however, that with respect to a Participant who commences participation after the beginning of a Plan Year, the initial Period of Coverage shall run from the effective date of the Participant's participation to the end of that Plan Year, and all subsequent Periods of Coverage shall be on the Plan Year basis.

2.10 "Plan Administrator" means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.11 "Plan" means the Children's Friend and Service Health Flexible Spending Account Plan as set forth herein and as amended from time to time.

2.12 "Plan Year" means the twelve consecutive month period ending on December 31.

2.13 "Spouse" means an individual who is treated as a spouse under federal tax law.

ARTICLE III

Eligibility and Participation

3.1 Eligibility Requirements. An Employee is generally eligible to participate in the Plan if he or she meets the requirements of Section 2.5 and is also eligible to enroll in the Employer's group health plan.

3.2 Eligible Classification. An Employee shall not be an Eligible Employee while he or she is a member of a classification of Employees which the Plan Administrator has designated as not currently eligible to participate in the Plan. The Plan Administrator may at any time and from time to time remove any one or more Employees or group(s) or class(es) of Employees from eligibility for participation in this Plan, provided that in no event shall any such removal reduce the amount theretofore credited to the Benefits Account of any Participant.

3.3 Determination of Eligibility by Plan Administrator. The determination of an Employee's eligibility to become and continue as a Participant in the Plan shall be made by the Plan Administrator from the Employer's or Participating Employer's records, and the Plan Administrator's determination shall be binding and conclusive upon all persons.

3.4 Enrollment. An Eligible Employee must annually complete any Enrollment Form required by the Plan Administrator to enroll in the Health FSA, and to elect the amount of pre-tax contributions for the Period of Coverage. Such Enrollment Form must be completed, executed, and returned to the Plan Administrator by the applicable deadline. Such coverage will be effective as soon as administratively possible after the completed Enrollment Form is received.

3.5 Termination of Participation. A Participant will cease to be a Participant in this FSA upon the earlier of the termination of the FSA or the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility may continue beyond such date under generally applicable criteria determined in the sole discretion of the Plan Administrator. Reimbursements from the FSA after termination of participation will be made pursuant to Section 6.7 (relating to a run-out period for submitting claims incurred prior to termination).

ARTICLE IV

Accounts and Funding

4.1 Accounts. All amounts credited to a Participant's Benefits Account shall remain the property of the Employer until paid out pursuant to the Plan. In no event shall any interest or other income be allocated to a Benefits Account. The Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The Benefits Account will merely be a recordkeeping account with the purpose of tracking contributions and available reimbursement amounts. In no event shall benefits be provided other than for reimbursement for eligible Medical Care expenses.

4.2 Funding. A Participant may elect a specific amount to be contributed via salary reduction, subject to the contribution limits described in Section 4.3, to pay for qualified Medical Care expenses incurred by the Participant and the Participant's Spouse and Dependents.

The Employer may, at its sole discretion, contribute to a Participant's Benefits Account, subject to applicable limits prescribed by law. Any Employer contributions shall be calculated for each Plan Year in a uniform and nondiscriminatory way. Any amounts credited by the Employer may vary from year to year. However, the maximum benefit payable to any Participant cannot exceed two times the Participant's salary reduction election under the Plan for the year (or, if greater, cannot exceed $500 plus the amount of the Participant's salary reduction election). Unused carryover amounts as described in Section 4.4 are not taken into account for this purpose.

4.3 Contribution Limits. The amount of a Participant's salary reduction contributions for a Plan Year shall not exceed any applicable limits prescribed by law (including the limit in Code Section 125(i), to the extent it is effective for the Plan Year). In addition, the Plan Administrator may impose additional contribution limits beyond those prescribed by law. Unused carryover amounts as described in Section 4.4 are not taken into account for purposes of these limits.

4.4 Unused Funds Remaining at End of Plan Year. A Plan Participant may carry over unused Benefits Account funds to the next Plan Year, up to the carry-over limit in effect for the Plan Year. Any funds in excess of the maximum carryover amount will be forfeited in accordance with the requirements of the Code.

ARTICLE V

Claims Procedure

5.1 Expense Reimbursement Procedure. Reimbursement of Medical Care expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Medical Care expenses from his or her account, a Participant must submit a written application not later than 30 days following the end of the Plan Year in which such Medical Care expenses were incurred or billed to the Participant, in accordance with such rules, practices and procedures as the Plan Administrator may specify, in its discretion, for the reimbursement of Medical Care expenses from the Participant's account, including rules that do not invalidate an application that is submitted later than 30 days following the end of the Plan Year provided the application is filed as soon as reasonably possible.

(b) The Plan Administrator reserves the right to verify to its satisfaction all claimed Medical Care expenses prior to reimbursement. Each request for reimbursement shall include such substantiation as required by the Plan Administrator, which may include the following information:

(i) the name, Social Security number, and address of the employee;

(ii) the name and date of birth of the person for whom the Medical Care expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant;

(iii) the name and address of the person, organization or other provider to whom the Medical Care expense was or is to be paid;

(iv) a written statement from an independent third party setting forth the type, purpose, date and amount of the Medical Care expense for which reimbursement is requested; and

(v) a statement that the Participant has not been reimbursed and that the Medical Care expense is not reimbursable by insurance or otherwise.

(c) The Plan Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence of obligation to pay Medical Care expenses. The Plan Administrator reserves the right to require the Participant to provide, to the Plan Administrator's satisfaction, further proof of any of the above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement from the Participant's account. The Plan Administrator may require the Participant to provide written authorization to obtain information from any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his or her Dependents are enrolled.

(d) Expenses eligible for coverage under any group medical, HMO, dental, vision care, prescription drug, or other health plans or insurance coverage in which the Participant or his or her Dependents are enrolled must be submitted first to all such plans or insurers in accordance with the rules of those plans or insurers, and be finally adjudicated under those plans or insurers, before submitting the expenses to the Employer for reimbursement under the Plan.

(e) Subject to applicable law, the Plan Administrator may establish such rules as it deems desirable regarding the frequency of reimbursement of Medical Care expenses and the minimum dollar amount that may be requested for reimbursement.

5.2 Claims for Reimbursement.

(a) In General. This Section is intended to comply with Department of Labor Regulations 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 2560.503-1.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator (as defined in Section 2.10 of this plan document). For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for benefits.

(c) Upon the denial of a claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan's control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant's failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim. A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 2590.715-2719.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care service(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iii) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to

submit notice of a "second-level appeal" to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits, to notify the claimant electronically or in writing of the appeal determination.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) External Appeals.

If required by applicable law, when a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures as prescribed in Department of Labor Regulation 2590.715-2719.

ARTICLE VI

Payment of Benefits

6.1 Participant's Medical Care Reimbursement. Benefits shall be debited from time to time under this Article VI from a Participant's Benefits Account to reimburse or pay for qualified Medical Care expenses. For purposes of reimbursement, the Plan Administrator reserves the right to define qualified Medical Care expenses more narrowly, which may be outlined in a separate communication. Each Participant shall be entitled to reimbursement or payment of Medical Care expenses incurred by such Participant, and his or her Spouse and Dependents

Subject to Sections 4.2 and 4.3, the payment or reimbursement shall, at all times during the Period of Coverage, be any amount up to the Participant's maximum benefit under this Health FSA for the Plan Year, less the amount of Medical Care expenses previously paid or reimbursed during the Plan Year with respect to the Participant, and his or her Spouse and Dependents. In the event claims for reimbursement or payment exceed the balance in the Participant's Benefits Account, the Plan shall pay such claims and the account shall be reduced to a negative balance.

6.2 Assignment of Benefits. No benefit payable at any time shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (*e.g.*, through garnishment, attachment, pledge or bankruptcy): this Health FSA, the Plan Administrator, or the Employer.

6.3 Payment to Representative. In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Health FSA, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under this Health FSA remain unpaid, the Plan Administrator may make payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Health FSA and the obligations of the Plan Administrator and the Employer.

6.4 Responsibility for Payment. It is the Participant's responsibility, in all cases, to pay for Medical Care expenses. Any benefit payment made directly to a Participant or the Participant's representative for a Medical Care expense shall completely discharge all liability of this Health FSA, the Plan Administrator, and the Employer with respect to such expense.

6.5 Overpayments. If, for any reason, any benefit is erroneously paid or exceeds the amount payable on account of a Participant's Medical Care expenses, the Participant shall be responsible for refunding the overpayment to the Health FSA. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under this Health FSA, or any other method as the Plan Administrator, in its sole discretion, may require.

6.6 Coordination with Other Sources. Reimbursement of Medical Care expenses under this Health FSA shall be permitted only to the extent that such Medical Care expenses have not been previously reimbursed and are not reimbursable from another source. To the extent that a Medical Care expense is reimbursable from another source, the other source shall provide reimbursement prior to any reimbursement from this Health FSA.

6.7 Reimbursements After Termination. Except as provided in Section 13.4, a Participant shall not receive reimbursements or payments for Medical Care expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement or payment for any Medical Care expenses incurred during the Period of Coverage prior to termination of participation; provided, however, that the Participant (or the Participant's estate) files a claim within 90 calendar days from the date he or she ceases to be a Participant under Section 3.5.

6.8 Participant's Responsibilities. Each Participant shall be responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Plan Administrator and the Employer shall have no obligation or duty to locate a Participant who does not provide a current address. In the event a Participant becomes entitled to payment under this Health FSA and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of this Health FSA without any consideration to interest payments which may have accrued.

6.9 Missing Person. If, within one year after any amount becomes payable under this Health FSA to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of

the Employer or this Health FSA, provided an appropriate level of care shall have been exercised by the Employer in attempting to make such payment.

ARTICLE VII

Amendment and Termination

7.1 Amendment. The Employer has the right to amend this Health FSA at any time to the extent that it may deem advisable, subject to applicable law. Any amendment shall be at the direction of an authorized officer of the Employer or an authorized designee.

7.2 Termination. The Employer has established this Health FSA with the *bona fide* intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain this Health FSA for any given length of time and may, in its sole and absolute discretion, discontinue or terminate this Health FSA, in whole or in part, at any time, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE VIII

Spendthrift Provision

A Participant's rights to pay for benefits under the Plan with pre-tax compensation shall not be assignable or subject to attachment or receivership, nor shall they pass to any trustee in bankruptcy or be reached or applied by any legal process for the payment of any obligations of the Participant.

ARTICLE IX

Modification or Revocation of Elections

9.1 Limitations. A Participant's pre-tax contribution election, as indicated on his or her Enrollment Form, shall remain in effect for the Period of Coverage unless modified or revoked by a Participant as provided in this Article. A Participant may modify or revoke an election with respect to the current Period of Coverage only in accordance with this Article IX.

9.2 Modification or Revocation of Election. An Eligible Employee may modify or revoke an election during a Plan Year within 30 days after the occurrence of one of the events described in this Section or, if longer, within the period required by applicable law, as follows:

(a) An Eligible Employee may modify or revoke an election during a Period of Coverage if one of the following "change in status events" occurs and the modification or revocation satisfies the consistency requirement of paragraph (b) below:

(i) a change in the Eligible Employee's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(ii) a change in the number of the Eligible Employee's Dependents, including due to the birth, adoption, placement for adoption, or death of a Dependent;

(iii) a change in employment status of the Eligible Employee, his or her Spouse, or a Dependent, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;

(iv) a Dependent satisfies or ceases to satisfy the requirements for coverage under this Plan;

(v) the Eligible Employee, his or her Spouse or Dependent changes his or her place of residence, but only if such change affects the person's eligibility for coverage; or

(vi) Any other event that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

(b) An Eligible Employee's modification or revocation of his or her election during the Plan Year must be consistent with the change in status event, and thus permissible, only if the election change is on account of and corresponds with a change in status event that affects eligibility for coverage under the Plan or under a plan maintained by the Spouse's or Dependent's employer.

(c) If an Eligible Employee, his or her Spouse or Dependent becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act ("Medicare") or Title XIX of the Social Security Act ("Medicaid") (other than coverage only for pediatric vaccines), the Participant may modify or revoke his or her Enrollment Form with respect to group health plan coverage to cancel coverage of the individual who becomes enrolled under Medicare or Medicaid. If the Eligible Employee, his or her Spouse or Dependent loses coverage described in the preceding sentence, the Eligible Employee may file a new Enrollment Form with respect to group health plan coverage in order to begin or increase coverage of that individual who lost coverage under Medicare or Medicaid.

(d) If an Eligible Employee, his or her Spouse or Dependent becomes eligible for continuation coverage as provided in the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and in Section 4980B of the Code, the Participant may modify his or her election to pay for the continuation coverage.

(e) An Eligible Employee who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") may revoke any and all existing elections at the beginning of (or during) the leave.

(f) Any modification or revocation of an election under this Section shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.

ARTICLE X

Plan Administration and Fiduciary Duties

10.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

10.2 Plan Administration.

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of this Health FSA.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of this Health FSA, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Employer made in good faith pursuant to this Health FSA shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary to administer this Health FSA, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in filing claims under this Health FSA;

(ii) To prepare and distribute information explaining this Health FSA to Participants;

(iii) To receive from the Employer and Participants, Spouses, and Dependents such information as shall be necessary or desirable for the proper administration of this Health FSA;

(iv) To keep records of claims and disbursements for claims under this Health FSA, and such other information as may be required by the Code;

(v) To appoint individuals or committees to assist in the administration of this Health FSA and to engage any other agents it deems advisable;

(vi) To accept, modify or reject Employee enrollment under this Health FSA;

(vii) To promulgate Enrollment Forms and claims forms to be used by Participants;

(viii) To prepare and file any reports or returns with respect to this Health FSA required by the Code or any other laws;

(ix) To determine and enforce any limits on benefits elected hereunder;

(x) To correct errors and make equitable adjustments for mistakes made in the administration of this Health FSA; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, or Dependent, in whatever manner the Employer determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant, Spouse, or Dependent.

10.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of this Health FSA, may designate fiduciaries other than those named in the Health FSA, and may appoint one or more claim administrators to process all or a designated portion of claims under this Health FSA in accordance with its terms. The person, persons, entity or entities serving as claim administrator shall serve at the pleasure of the Plan Administrator.

10.4 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Health FSA solely in the interest of each Participant, Spouse, Dependent and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Health FSA. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

10.5 Nondiscrimination Rules. In accordance with the nondiscrimination provisions of Code Section 125, the Plan intends to not discriminate in favor of highly compensated individuals regarding eligibility, participation, contributions or benefits. In addition, highly compensated Participants (Participants who are described in Section 105(h)(5) of the Code) shall be required to include in their gross incomes for federal income tax purposes Health FSA reimbursements that are excess reimbursements as defined in Section 105(h) of the Code if the Plan fails to satisfy the nondiscrimination requirements of Section 105(h) of the Code with respect to eligibility or benefits. The Plan Administrator may take action as necessary to ensure that the Plan does not violate the nondiscrimination provisions of the Code.

ARTICLE XI

Miscellaneous

11.1 Limitation of Rights. Neither the establishment nor the existence of this Health FSA, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer or Plan Administrator except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

11.2 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any Participant from the Employer's general assets, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Health FSA may be made.

11.3 Governing Laws and Jurisdiction and Venue. This Health FSA shall be construed and enforced according to the laws of the state of Rhode Island, to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Health FSA shall be in any court of appropriate jurisdiction in the state of Rhode Island.

11.4 Severability. If any provision of this Health FSA plan document is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of this Health FSA, and this Health FSA shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

11.5 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of this Health FSA, nor in any way shall affect this Health FSA or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

11.6 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of this Health FSA or in any respect affecting or modifying its provisions. Such words in this Health FSA as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

11.7 Expenses. All expenses incurred in establishing and operating this Health FSA, including, without limiting the generality of the foregoing, legal fees, accounting fees, administrative expenses and the like, shall be paid by the Employer.

ARTICLE XII

Participating Employers

12.1 Adoption of the Plan. This Health FSA may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer and meets the definition of a Participating Employer as described in Section 2.8. Such adoption shall be by resolution of the Participating Employer's governing body.

12.2 Administration. As a condition to adopting this Health FSA, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

12.3 Termination of Participation. Each Participating Employer may cease to participate in this Health FSA with respect to its Employees or former Employees by resolution of its governing body.

ARTICLE XIII

Special Compliance Provisions

13.1 Use and Disclosure of Protected Health Information. Unless the Plan is self-administered and has fewer than 50 Participants, the Plan shall use protected health information ("PHI") only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in HIPAA Regulation 45 C.F.R. § 164.501.

(a) A Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, a Plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of the Plan.

(b) A Plan shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the Plan documents have been amended to incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required by this Health FSA plan document or as required by law;

(ii) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from a Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(v) report to the Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA's access requirements;

(vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting of disclosures;

(ix) make the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(x) ensure that adequate separation between the Plan and the Employer is established as required by HIPAA; and

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

(c) Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the Plan. If such individuals do not comply with this plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(d) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the

electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (*e.g.*, in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

13.2 Family and Medical Leave Act of 1993 ("FMLA"). A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") may revoke his or her Enrollment Form election at the beginning of or during the leave. However, the Participant shall have the right to reinstate his or her election upon his or her return to work after the FMLA leave period. In addition, the Employer shall have the right to require Participants to resume participation in the Plan at the level previously elected on the Enrollment Form, if it requires Participants on other forms of leave to do so.

If a Participant chooses to continue coverage under the Employer's group health plan during an unpaid leave of absence under FMLA, the Plan Administrator shall select among the following options for required payments during the leave of absence:

(a) Pre-payment by the Participant before the commencement of the leave through pre-tax or after-tax contributions under an Enrollment Form, from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met; provided, however, that pre-payment shall not be the sole option offered to a Participant on FMLA leave;

(b) Payment by the Participant of required payments during the leave on the same schedule as payments would be made if the Participant were not on leave, or under another schedule permitted under federal regulations. The Employer shall not be required to continue group health plan coverage of a Participant who fails to make required payments while on FMLA leave. However, if the Employer chooses to continue such coverage of a Participant who fails to make required payments while on FMLA leave, the Employer is entitled to recover those payments after the Participant returns from FMLA leave by payroll deduction; or

(c) Advancement by the Employer of the Participant's required payments while the Participant is on FMLA leave. The Employer shall be entitled to recover such advanced amounts when the Participant returns from FMLA leave by payroll deduction.

13.3 Military Leave. In no event shall benefits available under this Plan during a period of qualified military leave be less generous than those benefits available during other comparable employer-approved leave periods (*e.g.*, family and medical leave). Notwithstanding any

provision of this Plan to the contrary, contributions and benefits with respect to qualified military service shall be provided in accordance with the Uniform Services Employment and Reemployment Rights Act ("USERRA") and the regulations thereunder.

13.4 COBRA. Notwithstanding any provision in this Plan to the contrary, a Participant, Spouse or Dependent who loses coverage under the Plan due to a qualifying event as defined in the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and Section 4980B of the Code shall be entitled, to the extent required by law, to elect to continue the same coverage he or she had on the day before the qualifying event. Qualified beneficiaries who elect to continue coverage may submit claims for Medical Care expenses incurred after the qualifying event and before the end of such COBRA continuation coverage.

However, limited COBRA coverage may be provided where the maximum COBRA premium equals or exceeds the maximum benefit available under this Health FSA for the year, in accordance with Code Section 4980B.

ARTICLE XIV

Effective Date

This plan document sets forth the terms of this Health FSA as in effect January 01, 2021.

IN WITNESS WHEREOF, the Employer has caused this document to be duly executed in its name and on its behalf as of the date set forth below.

Children's Friend and Service

By: _____
Date: _____

ATTEST:

_____

APPENDIX A

Children's Friend AND SERVICE
HEALTH FLEXIBLE SPENDING ACCOUNT

PARTICIPATING EMPLOYERS

In addition to Children's Friend and Service, the following Participating Employers have adopted this Health FSA pursuant to Article XII, Section 12.1:

There are no other employers participating in this Health FSA.