CHILDREN'S FRIEND & SERVICE HEALTH FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

FOREIGN LANGUAGE ASSISTANCE NOTICE

Spanish:

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo su Programa de Beneficio Social. Si encuentra alguna dificultad para entender cualquier parte de este folleto, póngase en contacto con su Administrador(a) del Plan. Para mayor información, por favor póngase en contacto con: 401-276-4388

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HEALTH FLEXIBLE SPENDING ACCOUNT

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SUMMARY PLAN DESCRIPTION

This document, along with any other applicable benefit descriptions, is the summary plan description ("SPD") for the Health Flexible Spending Account ("Health FSA" or "the Plan") of Children's Friend & Service (the "Employer"). This document describes the Health FSA as in effect on January 01, 2023.

The Health FSA permits eligible Employees to elect to make pre-tax contributions to reimburse qualified Medical Care expenses incurred by eligible Employees and their family members.

Because the benefits you receive will be of importance to you and your family, you should retain this SPD as part of your permanent records. However, remember that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the Health FSA.

For additional information, you should contact Wellness Coordinator at 401-276-4388 or refer to the Health FSA plan document. Copies of the document are available from the Plan Administrator on request. If the terms of this SPD conflict with the plan document, the Health FSA plan document shall govern.

GENERAL PLAN INFORMATION

Type of Plan:	Health Flexible Spending Account (FSA)
Plan Number:	501
Plan Year:	The Plan Year is the twelve month period ending December 31.
Plan Sponsor:	Children's Friend & Service (the "Employer") 153 Summer Street Providence, RI 02903 401-276-4300 For a list of Participating Employers, please refer to Appendix A.
Plan Sponsor's Employer Identification Number:	05-0258819
Plan Administrator:	Children's Friend & Service 153 Summer Street Providence, RI 02903 401-276-4300

Agent for Service of Legal Process:	Children's Friend & Service 153 Summer Street Providence, RI 02903 401-276-4300 Service of legal process may also be made upon the Plan Administrator.
Claims Administrator:	Health Equity (866) 382-3510

ELIGIBILITY AND BENEFITS

This Health FSA is offered as a supplement to the Employer's primary group health plan coverage. An Employee is generally eligible to participate in the Health FSA if he or she is eligible to enroll in the Employer's primary group health plan.

The determination of an Employee's eligibility to become and continue as a Participant in the Health FSA shall be made by the Plan Administrator based on the Plan Administrator's records. The Plan Administrator's eligibility determination shall be binding and conclusive. An Employee is eligible to participate in this Health FSA as follows:

Health Care Flexible Spending Account	
Funding Medium	Self-Insured – The benefit is self-insured.
Eligibility	Generally, employees who work an average of 30 hour(s) per week. Spouse Dependent/Child Domestic Partner The above Participants must be eligible to enroll in the Employer's primary group health plan.
Employees Excluded from Coverage	Not Applicable
Waiting Period	An Employee is eligible to participate first of the month following date of hire.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.

Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

A Participant may elect a specific amount to be contributed via salary reduction, subject to applicable contribution limits prescribed by law, to pay for qualified Medical Care expenses incurred during the Plan Year by the Participant and the Participant's Spouse and Dependents, if applicable. For purposes of this Health FSA, the term "Spouse" means an individual who is recognized as a Participant's spouse under federal tax law. It does not include domestic partners. For purposes of this Health FSA, the term "Dependent" means the Participant's child(ren) if under age 27 as of the end of the taxable year.

The Employer may, at its sole discretion, contribute to a Participant's Health FSA Benefits Account, subject to applicable limits.

REIMBURSEMENT RULES

The Health FSA will reimburse you for eligible "Medical Care" expenses, as defined by the Plan Administrator and in accordance with Code Section 213(d). Medical Care expenses may include: payments for medical services rendered by physicians, surgeons, dentists, and other medical practitioners; the costs of equipment, supplies, and diagnostic devices; the amounts you pay for transportation to get medical care; and health insurance co-pays and deductibles.

However, Medical Care expenses do 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 (or later date, as established by the Plan Administrator), Medical Care expenses do not include amounts incurred for any medicine or drug (other than insulin) that is not "prescribed" within the meaning of Code Section 106(f).

The maximum amount of reimbursement from the Health FSA will be available at all times during the Period of Coverage. This means that a Participant's entire Health FSA election will be available from the first day of the Plan Year to reimburse Medical Care expenses incurred during the Period of Coverage.

In general, to receive reimbursement, the expense must be substantiated. This may include providing a bill or receipt which includes the name and address of the service provider, the name and address of the Participant, and the name and date of birth of the person for whom the Medical Care expense was incurred.

Amounts remaining in a Participant's Benefits Account at the end of the Plan Year shall be handled in the following manner:

A Plan Participant may carry over unused Benefit Account funds to the next Plan Year, up to the carry-over limit in effect for the Plan Year. The carry-over limit is equal to 20% of the maximum salary reduction contribution under Code Section 125(i) for that Plan Year, in accordance with IRS Notice 2020-

33. Any funds in excess of the maximum carry-over amount will be forfeited in accordance with the requirements of the Code.

For further details regarding the rules, practices, and procedures for reimbursement, please contact the Plan Administrator.

ENROLLING IN THE PLAN

To enroll in the Health FSA, an eligible Employee must annually complete any Enrollment Form required by the Plan Administrator, and elect the amount of pre-tax contributions for the Period of Coverage. The Enrollment Form must be completed, executed, and returned to the Plan Administrator by the applicable deadline. Coverage will be effective as soon as administratively possible after the completed Enrollment Form is received by the Plan Administrator. The Period of Coverage generally runs from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year and cannot be changed or revoked unless you experience a "Change in Status" Event (described below).

Except for the Change in Status Events rule, and, if applicable, periods of FMLA Leave (see below) there is no provision for stopping or starting payroll deduction contributions or changing the amount of deductions at different times throughout the year. A pro-rated amount of your contribution election can be deducted throughout the entire Plan Year.

Once you have enrolled in the Plan, you will not need to complete another election form during the Plan Year to continue participation unless you want to revoke or modify your election due to a Change in Status Event.

In general, if you cease to be a Participant due to termination of employment and are rehired within 30 days, then the election that was in effect prior to your termination of employment shall be reinstated. If you are rehired more than 30 days following termination of employment, then you shall be treated as a new Employee and be permitted to make a new election.

CHANGE IN STATUS EVENTS

As explained above, your election must remain in effect from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year, unless you revoke or change your election due to a Change in Status Event. In accordance with IRS rules, when you experience certain specified changes in your status or your personal circumstances during a Plan Year, you can change your election by increasing or decreasing the amount you have deducted from your salary. Any change you make must be consistent with the Change in Status Event. Examples of a Change in Status Event include the following:

(i) a change in your legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(ii) a change in the number of your children, including the birth, adoption, placement for adoption, or death of a child;

(iii) a change in your employment status or your Spouse's or covered child's change in employment, 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; or

(iv) your child satisfies or ceases to satisfy the requirements for coverage (for example, due to attainment of a specified age).

These are just some examples of Change in Status Events that may entitle you to make a change in your election during a Plan Year. Please consult the Plan Administrator for other circumstances that may be permissible Change in Status Events.

You must inform the Plan Administrator and make the change in your election within 30 days after the event that results in a Change in Status Event. If you do not inform the Plan Administrator of your need to make such a change within that 30-day period, you will then have to wait until the next open enrollment period to make a change in your election.

Please consult the Plan Administrator for additional information or if you have questions about Change in Status Events.

HIPAA PRIVACY ISSUES

With the exception of Health FSAs with fewer than 50 Participants that are self-administered, HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Health FSA's Privacy Notice. If you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Health FSA nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Health FSA has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

HEALTH COVERAGE DURING UNPAID FMLA LEAVE

If your Employer has at least 50 employees employed within 75 miles of your worksite and you take an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (FMLA), you may generally continue to receive the maximum payment or reimbursement amount available under this Health FSA for medical expenses for yourself, and your covered Spouse and Dependents (if applicable), incurred during such leave, if contributions are made for this period of absence in a manner prescribed by the Plan Administrator.

If you do not continue coverage under this Plan during FMLA leave, but you return to work before the expiration of FMLA leave, you will be reinstated in your benefit coverage in this Plan under the same conditions as if the leave had not occurred. However, in this instance, you will not be reimbursed for medical expenses incurred during FMLA leave and credits to your Health FSA Account may be pro-rated based on absence to the extent permitted by law.

Additional family and medical leave or sick leave rights may apply under state law. Please contact the Plan Administrator for further information.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in this Health FSA during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue participation in this Plan. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (*e.g.*, family and medical leave).

COBRA CONTINUATION COVERAGE

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 in 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 at their own expense. 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 under this Health FSA may be provided in certain circumstances.

CLAIMS PROCEDURES

The following claims procedures shall apply specifically to claims made under this Health FSA. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, or other written materials for the Health FSA, the claims procedures in such other policies, contracts, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

BENEFIT DETERMINATIONS

The Health FSA will reimburse claims that are filed for payment of benefits after health care has been received. If your claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to

process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- ☐ The patient's name.
- ☐ The Plan identification number.
- ☐ The date(s) of health care service(s).
- ☐ The provider's name.
- ☐ The reason(s) you believe the claim should be paid.
- ☐ Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEALS DETERMINATIONS

You will be provided with written or electronic notification of the decision on your appeal as follows:

The first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request

must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

External Review

If you exhaust all internal appeals procedures, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

PLAN AMENDMENT OR TERMINATION

The Employer has established the Health FSA with the intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation to maintain the Plan for any given length of time. Subject to applicable law, the Employer may amend or terminate the Plan, in whole or in part, at any time.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Health FSA contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You may lose coverage if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- ☐ You revoke your election to participate;
- ☐ You terminate employment with the Employer;
- ☐ You fail to file benefits claims on a timely basis;
- ☐ You make fraudulent benefits claims;
- ☐ You cease to be an eligible Employee; or
- ☐ The Health FSA terminates.

If you terminate participation in the Plan for any reason, including, without limitation, termination of employment, retirement, reduction of hours, death, disability or leave of absence, you will continue to be entitled to payment or reimbursement of Health FSA benefits for eligible Medical Care expenses incurred during the Period of Coverage prior to the termination of participation, if you file a claim within 90 calendar days from the date you cease to be a Participant.

For further details, please contact the Plan Administrator.

RESPONSIBILITY FOR GOODS/SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

NO GUARANTEE OF EMPLOYMENT

Nothing contained in this document nor the benefit documents gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

STATEMENT OF ERISA RIGHTS

As a Participant in the Health FSA you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- ☐ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- ☐ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- ☐ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Health Plan Coverage

Continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30

days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A
CHILDREN'S FRIEND & SERVICE
HEALTH FLEXIBLE SPENDING ACCOUNT

PARTICIPATING EMPLOYERS

In addition to Children's Friend & Service, the following Participating Employers have adopted the Health FSA:

There are no other employers participating in the Health FSA.