Clark University
Section 125 Cafeteria Plan
Summary Plan Description

Effective as Amended and Restated 1/1/2023

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INTRODUCTION

Your employer has implemented a Section 125 Cafeteria Plan to enable you to purchase certain benefits on a pre-tax basis.

The benefits may include insurance and other fringe benefits allowable under Section 125 of the Internal Revenue Code. The benefit programs are listed in the Adoption Agreement included as Appendix A to this Plan and are described in separate documentation that you should have received. Once you elect to purchase the benefits on a pre-tax basis, you cannot as a general rule change your election until the next annual enrollment period. However, if you have a *Change in Status Event* as described below, you may be able to make a change in your election. In most cases, you will have 30 days to make a change. However, if the particular benefit that you want to change provides that you have 31 days, this Plan will also provide 31 days. A change due to a *Change in Status Event* must be on account of and must correspond with that *Event*. Please keep in mind that nothing in this Summary Plan Description overrides the terms and conditions of the plan documentation for the benefits that are available through this Section 125 Cafeteria Plan for pre-tax purchase, so you must always follow the terms of those plans.

If there is any difference between information described in this Summary Plan Description and the Plan's formal documentation, the formal documentation will control. The formal documentation is subject to rules, regulations, and interpretations under Section 125 of the Internal Revenue Code, which will ultimately control the interpretation of any matter under the Section 125 Cafeteria Plan.

ELIGIBILITY

The Eligibility provisions of this Plan are described in Section 9 of the Adoption Agreement. Unless otherwise provided in Section 9, each Employee who normally performs services for the Employer of at least 17 hours per week may elect to participate in the Plan as of the beginning of the next following Coverage Period. Any Employee whose employment begins after the beginning of a Coverage Period may begin participation on the first day of the month after completing 0 month(s) of service with the Employer. Notwithstanding the foregoing, your eligibility for benefits offered under this Plan is subject to the terms and conditions of those underlying benefit plans.

Participation

You become a Participant by completing the benefit election form or other enrollment process supplied by the Company wherein you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. The Plan's Entry Date is described in Section 9.b. of the Adoption Agreement.

Annual Enrollment Period

An annual enrollment period will be scheduled by your Employer prior to the beginning of each plan year. At that time you will receive enrollment materials describing options available to you under the Plan. You will be given the opportunity to change your choices made for the previous 12-month period for the coming 12 months. Failure to complete the form or other enrollment process supplied by the Company at the annual enrollment period impact your elections for the following year. Please see Section 12 of the Adoption Agreement for more information. After an election is made, it may not be modified until the next annual enrollment period unless there is a Change in Status or other IRS authorized event that allows an election change.

Electing Less than the Maximum Allowed Benefit

Any portion of your Compensation that you do not choose to apply toward the purchase of the benefits described will be paid to you as regular, taxable Compensation.

Change in Status Events

Rules of the Internal Revenue Code require that generally, you may not change your benefit plan elections until the next annual enrollment period. However, you will be allowed to make a change if the change is a *Change in Status Event* and the *Consistency Rule* is satisfied. Valid *Change in Status Events* include the following:

- Change in Employee's Legal Marital Status (marriage, divorce, annulment, legal separation or death of spouse).

- Change in Number of Dependents (events that change an employee's number of dependents, such as birth, adoption, placement for adoption or death).

- Change in Employment Status of Employee, Spouse or Dependent (any of the following that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, change in worksite, or a change from an eligible to an ineligible employment status or classification).

- Dependent Satisfies (or Ceases to Satisfy) Dependent Eligibility Requirements (events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as due to age, student status, or similar circumstances). Please note that effective March 30, 2010, dependent children include your adult children until the child attains age 26, as required by the new health reform law.

- Change in Residence (a change in the place of residence of the employee, spouse, or dependent).

Other *Change in Status Events* may be allowed if they are acceptable under interpretations of the Internal Revenue Code. If you have questions, please ask your Employer's benefits representative.

If you experience a *Change in Status Event* and desire to make a change, you must make the change no later than 30 days following the *Event*. However, if the benefit you wish to change allows 31 days to make changes, this Plan will also allow 31 days.

Consistency Rule

A change must be "on account of and correspond with" a Change in Status Event. To meet this requirement, the change that you wish to make must be on account of and correspond with a *Change in Status Event* that affects eligibility for coverage under an employer's plan. The determination of whether a requested change is "on account of and consistent with" a *Change in Status Event* will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service. If you have questions, please ask your Employer's benefits representative.

Other Events That May Allow Election Changes

- HIPAA Special Enrollment Rights. If you, your Spouse and/or a Dependent are entitled to special enrollment rights under the provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996, as amended) for a group health plan, you may change your election to correspond with the special enrollment right. Your special enrollment right may also include the termination of Medicaid or CHIP coverage or eligibility for employment assistance under Medicaid or CHIP coverage. CHIP coverage refers to a state child health plan under Title XXI of the Social Security Act. Please refer to the group health plan description for an explanation of special enrollment rights.

- Judgment, Decree, or Order. If a judgment, decree, or order (collectively called "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under the Employee Retirement Income Security Act) requires an employee to cover a child or children under a group health plan, the employee may change his or her election to cover the child(ren). Likewise, if the order requires another individual to provide coverage for the child and coverage is, in fact, provided, then the employee may change his or her election to drop coverage for the child(ren).

- Medicare and Medicaid. If an employee, spouse, or dependent becomes entitled to Medicare or Medicaid (other than coverage only for pediatric vaccines), the employee may make a change in election to cancel or reduce any group health coverage available through this Plan for the individual. Likewise, if the employee, spouse, or dependent loses eligibility for

coverage under Medicare or Medicaid (other than coverage only for pediatric vaccines), the employee may make a change in election to commence or increase any group health coverage available through this Plan for the individual.

- Cost Changes. If the cost of qualified benefits increases or decreases during the plan year, your election may be automatically adjusted, if the Company in its discretion chooses to change your cost. If the cost significantly increases, you will be permitted to make an election change to increase your payment or to revoke your election and, in lieu thereof, to receive on a prospective basis coverage under another benefit option similar coverage. You may also be permitted to revoke your election and drop coverage if no other option providing similar coverage is available. See your benefits representative for additional information.

- Significant Coverage Change/Curtailment. If the coverage under a benefit is significantly changed or curtailed, you may revoke your election and make a new election on a prospective basis for coverage under another option that provides similar coverage. If the coverage is lost altogether, you may drop your election if no similar coverage is available.

- Addition or Improvement of Benefit Option. If during the plan year the Plan adds or significantly improves a benefit option, you may elect the newly added or improved option.

- Change in Coverage of Spouse or Dependent Under Other Employer's Plan. If there is a change in your, your spouse's, or your dependent's coverage of a qualified benefit under another employer's plan, you may be allowed to change your election under the Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

- Reduction of Hours or Enrollment in Qualified Health Plan. If elected in Section 17 of the Adoption Agreement, you may be able to revoke your election for coverage under a Qualified Health Plan in order to enroll in alternative coverage.

The Plan Administrator, in its discretion, has the authority to interpret all rules that are applicable to the Section 125 Cafeteria Plan. Further, the Plan Administrator may modify your election(s) downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

TAX ADVANTAGES

The cash compensation (wages) you receive from your Employer is taxable. However, when you allocate a portion of your compensation on a pre-tax basis to be used for payment of your benefits, your taxable income is reduced by the amount you have allocated to benefits. This allocation results in a reduction of federal and, in most cases, state income taxes.

Social Security/Other Benefits May Be Affected

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in your Social Security benefits which may be based on taxable compensation. Although this reduction usually is quite small, it could occur if your compensation falls below the annual Social Security taxable wage base as revised each year. The resulting decrease in your taxable compensation could impact other benefits which may be available through your employer.

CHANGES TO EMPLOYEE'S STATUS

If your employment status changes, participation in the Plan is affected as follows:

Leave of Absence Under the FMLA

If your employer continues any benefit you have elected under the Plan during an FMLA leave, your participation may continue for as long as you are on paid leave or, if the leave is unpaid, you may pay premiums in a manner approved by the employer. In no event, however, will this provision override the terms of any insurance or other program under which the benefit is provided, nor will it override the substance of any employer policy regarding leaves of absence. You should discuss these issues with the benefits representative. You may be entitled to cease participation while you are on FMLA leave. If you cease participation as evidenced by non-payment of premiums, you will not be considered a participant in the Plan, and you will not receive benefits during the time you were not a participant. If you timely return from FMLA leave, you can elect to be reinstated in the Plan on the same terms as existed prior to your FMLA leave (unless those terms were changed in the meantime for other plan participants).

Non-FMLA Leave of Absence

If the employer's policies provide for a paid leave of absence that is not covered by the FMLA, your participation may continue as provided by those policies, as long as you continue to receive compensation. If your leave of absence is unpaid, you should review your options with the employer's benefits representative. In no event will this provision override the terms of any insurance or other program under which the benefit is provided.

Death

In the event of your death, your participation ceases as of the date of your death.

Change to Ineligible Employment Status

Your participation ceases as of the date of the change in your employment status.

Termination of Employment

Your participation ceases as of the date of your termination.

If the events described above cause a loss of coverage under a group health plan, you may be eligible for Continuation Coverage for group health plans. Continuation coverage, if any, is governed by the terms of the health plan and by laws that apply to group health plans. Continuation coverage is not addressed in this Summary Plan Description.

FLEXIBLE SPENDING ACCOUNTS

This Plan also contains flexible spending account options which may be adopted by your Employer. The following summary describes those options.

Dependent Care Flexible Spending Account Plan

If adopted by your Employer, you may be able to make an election to defer a portion of your compensation into an account that can be used to pay for Dependent Care Expenses incurred during the Plan Year such as preschool, summer day camp, before or after school programs, and child or adult daycare. A Participant who has elected to participate may apply for reimbursement by submitting an application in writing to the Administrator, in such form as the Administrator may prescribe, setting forth: (a) the amount, date and nature of the expense; (b) the name of the person, organization or entity to which the expense was or is to be paid; (c) a statement that the expense (or the portion thereof) has not been reimbursed and is not reimbursable under any other Dependent care plan coverage; and (d) such other information as the Administrator shall from time to time require. You also may be required to substantiate your expense with bills, invoices, receipts, or other documents showing the amounts of such expenses.

Unless otherwise elected by your Employer, the maximum amount you may contribute to your Dependent Care Flexible Spending Account is (1) $2,500 if filing tax returns individually (or $5,000 if filing joint tax return) or (2), your Earned Income for the calendar year, if less than the amount listed in (1).

Note that deferrals in a given Plan Year may only be used for expenses incurred during such Plan Year, unless your Employer elects to adopt a Grace Period. If your Employer elects a Grace

Period, then Dependent Care Expenses incurred during the 2 month and 15-day period immediately following the Plan Year may be reimbursed from any balance remaining under your account at the end of such immediately preceding Plan Year, so long as you apply for reimbursement of such expenses in accordance with the applicable Claims Filing Deadline (identified in Section 11 of the Adoption Agreement).

Health Care Flexible Spending Account Plan

If adopted by your Employer, you may be able to make an election to defer a portion of your compensation into an account that can be used to pay for Qualifying Health Care Expenses incurred during the Plan Year. A Participant who has elected to participate may apply for reimbursement by submitting an application in writing to the Administrator, in such form as the Administrator may prescribe, setting forth: (a) the amount, date and nature of the expense, including the name and relationship of the person incurring the expense; (b) the name of the person, organization or entity to which the expense was or is to be paid; (c) information regarding whether the expense is recoverable under any insurance or other arrangement; and (d) such other information as the Administrator shall from time to time require. You also may be required to substantiate your expense with bills, invoices, receipts, or other documents showing the amounts of such expenses.

The maximum amount you may contribute to your Health Care Flexible Spending Account is specified in Section 10 of the Adoption Agreement. That maximum may be adjusted automatically for inflation, to the extent allowable by the Internal Revenue Code.

Note that deferrals in a given Plan Year may only be used for expenses incurred during such Plan Year, unless your Employer elects to adopt a Grace Period. If your Employer elects a Grace Period, then Qualifying Health Care Expenses incurred during the 2 month and 15-day period immediately following the Plan Year may be reimbursed from any balance remaining under your account at the end of such immediately preceding Plan Year, so long as you apply for reimbursement of such expenses in accordance with the applicable Claims Filing Deadline (identified in Section 11 of the Adoption Agreement). Alternatively, your Employer may elect a Plan provision allowing you to carry over up to 20% of the statutory maximum contribution to be used for Qualifying Health Care Expenses incurred during the subsequent year. Note, however, that your Employer cannot elect both a Grace Period and a carryover provision.

MORE IMPORTANT FACTS

Plan Documents

The Plan is fully described in the Employer's Adoption Agreement and the Flores & Associates Flexible Benefits Plan Master Plan Document. This booklet describes the major provisions of the Section 125 Cafeteria Plan in easy-to-understand terms. It is shorter and far less technical than the Plan's legal documents. If there is any conflict or inconsistency between this booklet and the Plan's legal documents, or if this booklet does not cover or only partially covers any

provision in the legal documents, the Plan's legal documents govern. If you have any questions about the Plan or if you would like to examine the Plan's legal documents, contact your Employer or Flores & Associates. It is intended that the Plans will be administered in accordance with all relevant statutory and governmental authority. To the extent that any Plan provision is contrary to any statutory and governmental authority, such authority will govern operation of the Plans.

Plan Sponsor/Plan Administrator

The Plan Administrator has the discretionary authority to administer the Plan in all of its details, including determining eligibility for benefits and construing all terms of the plan. The Plan Administrator has the discretion to determine all questions of fact and/or law that may arise in connection with the administration of the Plan. The Plan Administrator may assign its duties to others.

Sources of Contributions

Employees contribute to the plan through pre-tax dollars that are elected by the employee and authorized by the Section 125 Cafeteria Plan. Employees select the amount of their contributions, up to authorized limits. A minimum contribution may be required. There is no trust fund applicable to the Plan. All payments hereunder involve the Employer's general assets.

Future of the Plan

Your Employer intends to continue the Plan indefinitely. However, it reserves the right to change or to terminate the Plan, or to eliminate any benefit under the Plan, at any time without the consent of any participant or dependent. Your Employer or any authorized officer or representative of your Employer can make changes to or terminate the Plan. You will be notified if any changes are made.

CLAIMS DECISIONS AND APPEALING A DENIED CLAIM

The following information is provided for general information about claims and review procedures for benefit plans that are covered by the Employee Retirement Income Security Act ("ERISA"). It is based upon regulations issued by the U.S. Department of Labor and is not intended to override the claims and review procedures that may be contained in the documentation for any underlying benefit program that may be available for purchase through this Plan with pre-tax dollars. You should always consult the documentation that you have been provided for the benefit that you have elected to purchase under this Plan.

Different timelines for deciding claims, submitting appeals, and deciding appeals apply based upon whether the claim relates to a disability benefit, to a medical benefit, or another type of benefit. The information provided below illustrates the claims and review procedure only for a

medical benefit that is a post-service claim. Again, this is only provided for general information, and you should consult the documentation for your specific benefit plan.

Post-Service Medical Claims Decisions.

Within 30 days after receipt of a claim, the Plan will make reimbursement for expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied. The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process for Post-Service Medical Claims.

In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial within 180 days after receipt of written notice of the denial. Your written request should be sent to the Claims Administrator, which will forward your request for review to the Plan Administrator. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil

action in court as described under "Statement of ERISA Rights" below. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing for a review of the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to pursue your rights under ERISA, including your right to file a lawsuit, as described in the "Statement of ERISA Rights" below.

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding.

STATEMENT OF ERISA RIGHTS

The information provided below applies to benefit programs that are covered by the Employee Retirement Income Security Act ("ERISA"). This information is not intended to replace a similar statement provided in the underlying benefit program that is offered by this Plan, but is provided for your information. This Section 125 Cafeteria Plan is not itself covered by ERISA. However, benefits may be offered under the Plan that are subject to ERISA. If a plan is subject to ERISA, you are entitled to certain rights and protections under that law. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at your 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, if any, 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.

Upon written request to the plan administrator, obtain 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.

COBRA Continuation Coverage

If your Employer and the applicable benefit plan are subject to COBRA, you may have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the applicable summary plan description and the documents governing any health plan for the rules governing these rights.

If your Employer and the applicable benefit plan are subject to HIPPA, you may have the right to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing conditions exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Review the applicable summary plan description and the documents governing any health plan for the rules governing these rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes obligations 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 benefit from a plan covered by ERISA or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 (if one is required) 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 to 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 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 medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the Plan's money (if the Plan is considered to have 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.

Newborns’ and Mothers’ Health Protection Act of 1996

Under ERISA, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

APPENDIX A:

ADOPTION AGREEMENT

(attached)

Clark University
Section 125 Cafeteria Plan

Adoption Agreement
to the
Clark University
FLEXIBLE BENEFITS PLAN

Version
1/1/2023

Clark University
SECTION 125 CAFETERIA PLAN

ADOPTION AGREEMENT

1.	Plan Sponsor/Company	Clark University 950 Main Street Worcester, MA 01610 5087937294 EIN: 04-2111203
2.	Plan Administrator:	HUMAN RESOURCES 950 Main Street Worcester, MA 01610 (___) _____
3.	Registered Agent for Service	Corporate Secretary 950 Main Street Worcester, MA 01610 (___) _____
4.	Effective Date of Plan:	1/1/2023
5.	Restatement Effective Date:	1/1/2023
6.	Plan Year:	1/1/2023 to 12/31/2023
7.	Plan Number:	501

8. Related Employers whose employees may participate in the plan (if applicable, each Related Employer must execute the attached Related Employer Participation Agreement):

_____

_____

_____

_____

_____

9. General Requirements for Eligibility:

a. Age and Service Requirements:

( ) Age: _____
( ) Length of Service: _____
( ) None
( ) Other: _____(attach additional sheets as needed)

b. Plan Entry Date (choose one):

( ) First day of employment
( ) Immediately upon satisfaction of eligibility requirements
( ) On the first day of the month coinciding with or next following satisfaction of eligibility requirements
( ) Other: _____

c. Former Participants (check one):

( ) Former participants must satisfy the waiting period requirements before re-entry into the Plan.
( ) Waiting period waived for re-employed former employees re-employed within the same calendar year of termination.
( ) Not applicable – no waiting period

d. Exclusions – the Plan excludes the following from participation (check all that apply):

( ) None
( ) Employees who are not benefits-eligible according to the Company
( ) Employees who are non-resident aliens and receive no earned income from the Company
( ) Temporary employees
( ) Seasonal or migrant employees
( ) Collectively bargained employees whose terms and conditions of employment are covered by a collective bargaining agreement, the terms of which do not provide for eligibility under this Plan
( ) Leased or outsourced employees
( ) Employees of Related Employers that have not adopted this Plan
( ) Self-employed individuals (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
( ) Other: _____
_____

10. Section 125 Cafeteria Plan Benefits. An employee can pay for the following benefits through the Section 125 Cafeteria Plan (check all that apply):

	Benefit Type	**Provider**	**Plan ID Number**
( )	Group Health Benefit Plan		
( )	Group Dental Benefit Plan		
( )	Group Vision Benefit Plan		
( )	Group Life Insurance Plan - Basic Coverage		
( )	Group Life Insurance Plan - Supplemental Coverage		
( )	Group Short Term Disability Insurance Plan		
( )	Group Long Term Disability Insurance Plan		
( )	Accidental Death & Dismemberment Coverage		
( )	Dependent Care Flexible Spending Account Plan Minimum annual benefit– $0.00 Maximum annual benefit– $5,000.00	Flores & Associates, LLC	501
( )	Health Care Flexible Spending Account Plan (General) Minimum annual benefit– $0.00 Maximum annual benefit– $3,050.00	Flores & Associates, LLC	501

( )	Health Savings Account (HSA) If Company offers both HSA and Health Care Flexible Spending Account Plan, check as applicable: ( ) Limited Purpose Vision/Dental[1] ( ) Limited Purpose Preventive Care[2] ( ) Limited Purpose Post-Deductible[3] Maximum annual benefit amount – $3,050.00 Note: An HSA Eligible Individual may not be covered by a General Health Care FSA but may be covered under these options.	

11. Health Care Claims Filing Deadline: 2/29/2024
Dependent Care Claims Filing Deadline: 2/29/2024

12. Failure to File an Enrollment Form:

( ) If at the end of a Plan Year an Employee fails to file an Enrollment Form with the Plan Administrator for the following Plan Year prior to the start of the Plan Year, the Employee waives his or her right to participate in the Plan for the following Plan Year.

( ) If at the end of a Plan Year an Employee fails to file an Enrollment Form with the Plan Administrator for the following Plan Year prior to the start of the Plan Year, the Employee's elections for all benefits except the Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan will continue in the following year on the same basis as the Employee elected in the previous year.

With respect to the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account Plan, if the Employee fails to file an Enrollment Form with the Plan Administrator for the following Plan Year prior to the start of the Plan Year, then the Employee will be deemed to have elected not to participate in such benefits for the following Plan Year.

With respect to the Tobacco Credit and the Spousal Fee (if applicable) for the group medical plan benefit, if the Employee fails to file an Enrollment Form with the Plan Administrator for the following Plan Year prior to the start of the Plan

[1] Reimburses expenses incurred only for vision or dental care.
[2] Reimburses expenses incurred only for preventive care as defined in Code Section 223 and applicable guidance.
[3] Reimburses expenses incurred only after the Code Section 223 minimum annual high deductible health plan deductible has been satisfied.

Year, the Employee will not receive the Tobacco Credit and will be charged the Spousal Fee (if applicable).

( ) If at the end of a Plan Year an Employee fails to file and Enrollment Form with the Plan Administrator for the following Plan Year prior to the start of the Plan Year, the Employee will be deemed to have elected not to participate **only** with respect to the following benefits(s) for the following Plan Year:

_____

_____

_____

13. Family Medical Leave Act (FMLA):

a. If the plan includes a qualifying group health benefit or a health care flexible spending benefit and the Company is subject to FMLA, a Participant may elect to continue coverage during FMLA leave (choose one):

( ) Only with respect to the group health benefit and health care flexible spending benefit
( ) With respect to all Cafeteria Plan benefits
( ) With respect to the following plan benefits: _____

_____

( ) Company is not subject to FMLA (skip to Section 14)

b. Payment Options under FMLA. If the Company is subject to FMLA, the Company elects the following payment options for the Participant's portion of any premium due during the Participant's FMLA leave:

( ) Pre-pay option
( ) Pay-as-you-go option
( ) Catch-up option. This option must be selected if it is the only option available to non-FMLA employees on leaves of absence

( ) Other. _____

Note that if the Company offers either the pre-pay option or the catch-up option, it must also offer the pay-as-you-go option if the Company offers the pay-as-you-go option to non-FMLA employee on leaves of absence.

14. Company Contribution (check one):

( ) The Company will not make any contributions to the Plan on behalf of Employees.

( ) The Company will make the following contribution(s) to the Plan on behalf of Employees:

_____

15. Grace Period (choose one):

( ) Not applicable
( ) The Company **will not** adopt the grace period permitted under IRS Notice 2005-42.
( ) The Company **will** allow a grace period, which will end on 3/15/2024
( ) The grace period **will** apply to the following benefits (check all that apply):

( ) Health Care Flexible Spending Account Plan (General)
( ) Health Care Flexible Spending Account Plan (Limited Purpose/Post-Deductible)
( ) Health Care Flexible Spending Account Plan (Limited Purpose)
( ) Health Care Flexible Spending Account Plan (Post-Deductible)
( ) Dependent Care Flexible Spending Account Plan

16. Health Care Flexible Spending Account Carry-Over:

( ) Not applicable
( ) The Company **will not** allow participants to carry over any unused balance in a health care flexible spending account to a subsequent Plan Year.
( ) The Company **will** allow participants to carry over to a subsequent Plan Year up to 20% of the of the maximum salary reduction contribution under Section 125(i) of the Internal Revenue Code of any unused balance in a health care flexible spending account pursuant to IRS Notice 2013-71 (as updated by IRS Notices 2020-29 and 2020-33).

PLEASE NOTE: If the Company selects a Grace Period for its Health Care Flexible Spending Account, then it cannot also select a Carry-Over.

17. Change in Election in Event of Reduction of Hours or Enrollment in Qualified Health Plan

( ) Employees may revoke their election for coverage under a Qualified Health Plan during the Coverage Period in order to enroll in alternative coverage, subject to the additional restrictions described in the Plan, in the following circumstances (select one or both):

( ) Change in Hours of Service. There is a change in that Employee's status so that the Employee will reasonably be expected to average less than 30 hours of service per week.

( ) Enrollment in a Qualified Health Plan through the Health Insurance Marketplace. The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace.

( ) The Company will not adopt this change in election option.

18. Automatic Adjustment for Inflation

( ) If this box is checked, the maximum salary reduction contributions identified in this Adoption Agreement shall be automatically adjusted, to the extent allowable under the Internal Revenue Code.

( ) If this box is checked, the maximum salary reduction contributions identified in this Adoption Agreement shall not be automatically adjusted for inflation.

19. The terms of this Adoption Agreement are part of the Flores & Associates Flexible Benefits Plan document, which is attached hereto. This Adoption Agreement, when executed by the Company, and the Flores & Associates Flexible Benefits Plan document constitute the Clark University Section 125 Cafeteria Plan. The undersigned Plan Sponsor/Company hereby adopts this Adoption Agreement and in doing so agrees to be bound by all the terms, provisions, conditions and limitations of the Clark University Section 125 Cafeteria Plan, as it may be amended from time to time.

20. The Plan will be construed, enforced and administered and the validity determined in accordance with the laws of the State of MA to the extent not superseded by the Internal Revenue Code, as amended, or any other applicable Federal law.

THIS ADOPTION AGREEMENT is executed this _____ day of _____, 20__, by the Company effective as of the date specified above.

Clark University

By: _____

Title: _____

RELATED EMPLOYER PARTICIPATION AGREEMENT

[*Note: Each participating Related Employer must execute a separate Participation Agreement, the terms of which control as to that Related Employer.*]

Agreement as to Signatory Employer control. The undersigned Related Employer, by executing this Participation Agreement, elects to become a participating Employer in the Plan identified in the foregoing Adoption Agreement. The participating Employer accepts, and agrees to be bound by, all of the elections as made by the Signatory Employer except as otherwise indicated below. *The Participating Employer also hereby consents to the Signatory Employer's sole authority (without further signature or other action by the participating Employer) to amend, to restate or to terminate the Plan, to terminate the Participating Employer's participation in the Plan, and to take certain other actions governing the terms and conditions of this Plan.*

Related Employer: _____

Date: _____

Signed: _____

_____

[*print name/title*]

Participating Employer's EIN: _____

Acceptance by Signatory Employer and Trustee/Custodian.

Signatory Employer: _____

Date: _____

Signed: _____

_____

[*print name/title*]

Participating Employer's EIN: _____