ARCHDIOCESE OF LOS ANGELES
PREMIUM ONLY PLAN

Effective *July 1, 2014*

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INTRODUCTION

Archiocese of Los Angeles ("Employer") established the Employee Benefits Plan Premium Only Plan (the "Plan") as of July 1, 2015, for the benefit of its eligible employees. The Plan has been amended from time to time and is now restated, effective *July 1, 2014*

This document sets forth the provisions that constitute the Plan. It is intended to help you understand your benefits. Please read it carefully. Technical terms are capitalized and described in Section 1 (Definitions). The purpose of the Plan is to provide eligible employees the option of electing certain benefits. Employee contributions for coverage under the benefit options are made through voluntary pre-tax salary reductions. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code") and is intended to be interpreted in a manner consistent with the requirements of the Code.

The purpose of the Plan is to allow eligible employees to pay their share of premiums under the benefit plan on a pre-tax salary contribution basis. The tax implications of this Plan, however, are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although this document may anticipate certain tax consequences as being likely, the Employer does not represent or warrant to any participant that any particular tax consequence will result from participation in this Plan.

By participating in the Plan, each participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Employer. This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited groups under Code § 125.

SECTION 1—DEFINITIONS

1.01 "Annual Open Enrollment Period" means a period prior to each Plan Year designated by the Plan Administrator during which you are provided appropriate enrollment forms and the opportunity to make or alter your benefit elections under the Plan.

1.02 "Change in Status" means any of the following events (as well as any other events included under subsequent changes to Internal Revenue Code Section 125 or accompanying regulations that the Employer, in its sole discretion, decides to recognize on a uniform and consistent basis):

a) Legal Marital Status: A change in the Participant's legal marital status, including marriage, death of a spouse, divorce, or annulment;

b) Number of Eligible Dependents: Events that change the Participant's number of eligible children dependents, including birth, death, adoption, a

child being Placed for Adoption, and receiving legal guardianship;

c) Change in Employment Status: Any change in the Participant's employment status, or the employment status of the Participant's eligible dependents, that affects benefit eligibility under this Plan or a benefit plan of the eligible dependent, such as: termination or commencement of employment, a change in worksite, switching from salaried to hourly-paid or vice-versa, incurring a reduction or increase in hours of employment (e.g., going from part-time to full-time), or any other similar change which makes the person become or cease to be eligible for benefits under such plans.

d) Dependent Eligibility Requirements: An event that causes a previously eligible dependent child to satisfy or cease to satisfy the dependent eligibility requirements of the Plan or a benefit plan of the dependent child, such as due to attaining a specified age;

e) Change in Residence: A change in the Covered Person's place of residence; and

f) Other Events: Any other event that the Plan Administrator determines will permit a change or revocation of an election, or commencement of participation under applicable law and consistent with governing tax guidance.

1.03 "Code" means the Internal Revenue Code of 1986, as amended.

1.04 "Compensation" means wages, salary and other remuneration paid to a Participant but does not include any amounts contributed to an Employer retirement plan or any other fringe benefits or medical benefits provided to you by your Employer.

1.05 "Covered Person" is an Employee or eligible dependent who is enrolled in coverage under this Plan.

1.06 "Dependent" means your dependents as defined by the Health Plan or by documents governing other benefit options as applicable.

1.07 "Employee" means a person who is a regular employee of the Employer on the Employer's W-2 payroll. It does not include any person classified by the Employer as a leased employee, contract worker, independent contractor, or temporary employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer.

1.08 "Employer" means *The Archdiocese of Los Angeles*.

1.09 "Health Plan" means the health plan options currently offered by the Employer which are purchased with contributions made through this Plan.

1.10 "Participant" means an Employee who has met the requirements for eligibility and is participating in the Plan.

1.11 "Placed for Adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final. The Participant must have assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.12 "Plan" means the Healthcare Benefits Premium Only Plan.

1.13 "Plan Administrator" means the Archdiocese of Los Angeles.

1.14 "Plan Year" means the twelve-month period beginning each 1st of July and ending each 30th of June.

SECTION 2—ELIGIBILITY

2.01 Employee Eligibility. As an Employee, you are eligible to participate in the Plan when you are eligible to participate in pre-tax benefits under current terms of the plans or policies then offered by the Employer.

2.02 Termination of Participation. You and any eligible dependents will cease to participate in the Plan or a particular benefit option of the Plan as of the earliest of the following:

a) the last day of the month in which your employment terminates;
b) the last day of the month in which your election to participate expires;
c) the day this Plan terminates; or
d) the day a particular benefit option terminates or is no longer offered under the Plan.

2.03 Family and Medical Leave Act (FMLA). If you qualify for an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), you may continue to participate in the Plan for the duration of the leave if you pay any required contributions toward the cost of the coverage. The Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by the Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, the Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If you were covered under the Plan when your FMLA leave began and do not continue to participate during the leave, your coverage will be reinstated on the

date you return to work as long as you make any necessary contributions within 31 days of the date you return.

If you do not return to work after the approved leave or if you have given the Employer notice of intent not to return to work, coverage under the Health Plan may be continued under CONTINUATION OF COVERAGE effective as of the date you notify the Employer and provided you properly elect CONTINUATION OF COVERAGE coverage (see the Health Plan for details on CONTINUATION OF COVERAGE). You will be responsible for contributions during the CONTINUATION OF COVERAGE continuation period, if elected. Coverage continued during an FMLA leave will not be counted toward the maximum CONTINUATION OF COVERAGE continuation period.

It is the intent of the Plan to comply with all existing FMLA regulations. If for some reason the information presented in the Plan differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

To the extent an Employee qualifies for another type of leave other than FMLA and the IRS does not disallow similar treatment of contributions, similar rules will apply.

2.03 Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and your Contributions due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the election change rules will apply.

2.04 Active Military Duty. Employees going into military service that results in 30 or fewer days of unpaid leave will maintain their participation in the Health Plan options of the Plan as if they were still working. Employees going into military service that results in unpaid leave of more than 30 days may elect to continue these health coverage options of the Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service:

(a) The maximum period of coverage of a person under such an election shall be determined by then-applicable federal law.

(b) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan.

(c) Whether or not a person elects continuation coverage under USERRA, coverage will be reinstated upon the first day the Employee returns to employment with the Employer if the Employee is released under honorable conditions and returns to employment:

1) within fourteen (14) days of completing military service for a leave of 31 to 180 days; or

2) within 90 days of completing military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an illness or injury determined by the Veterans Administration to be service connected will be allowed).

(d) If health coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

For complete information regarding an Employee's rights under USERRA, contact the Employer. It is the intent of the Plan to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of the USERRA, the Plan reserves the right to administer the Plan in accordance with such actual regulations.

SECTION 3—OPTIONAL BENEFITS

3.01 Election of Benefits. If eligible, you may elect any, all or none of the benefits then made available. As part of electing any of the benefits, you must execute an agreement to reduce your taxable income by completing and signing election forms provided by the Employer.

3.02 Election Procedure. The Employer will establish an Annual Open Enrollment Period, during which you must complete and return the provided election form(s).

3.03 New Participants. If you become eligible during the Plan Year, you must execute the applicable election process and deliver them to your location administrator within 31 days after becoming eligible. Your election is applicable after the 1st full pay period in the month in which you are effective.

3.06 Absence of Election. Once you elect pre-tax payment for Health Plan coverage, your failure to complete a new election form for a subsequent Plan Year will be treated as an election to continue to participate on the same basis as the prior Plan Year.

3.07 Changing Your Elections. Please choose your benefit elections carefully, because in most cases your choices will remain in effect until the end of the Plan Year. You usually will not be able to change them. This rule is a requirement of federal tax law. There are several exceptions to this rule. Subject to the limitations described in each applicable subsection below, you may change your benefit elections during the year under the following limited circumstances.

(a) *Change in Status.* If you experience a Change in Status, any resulting benefit election changes must be made within 31 days of the Change in Status and must be "consistent" with the Change in Status. This "consistency" requirement means: a) the Change in Status must result in you or your dependent gaining or losing eligibility under the Plan or another group plan; and b) the election change must correspond with that gain or loss of eligibility; IRS standards for Changes in Status and consistency will control.

(b) *Special Enrollment Rights.* You may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided under HIPAA, including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP). Any new election must be made within 31 days of the special enrollment event, with the exception that a special right based on the SCHIP provision must be made within 60 days of that event (or longer if permitted by the Plan and communicated to participants.) Any new election shall be effective as of the first day of month coinciding with or next following the date the completed election is received by the employer. Special enrollments in the event of birth, adoption, or placement for adoption will be effective back to the date of the birth, adoption or placement for adoption, as long as timely notice is given to the employer. When exercising a special enrollment right you have the right to enroll in any available benefit package.

(c) *Certain Judgments, Decrees, or Orders.* If a judgment, decree, or order resulting from a divorce, legal separation or annulment results in a change in legal custody of, or the required provision of health coverage for, your Dependent child(ren), you may make a corresponding change in your health benefit elections (the payment of Health Plan coverage) within 31 days of receiving the judgment, decree or order. If the Health Plan is required to enroll a child pursuant to a QMCSO or medical support order as defined, qualified, and determined by federal law, the Plan will add coverage for that child and for you, if you are not already enrolled in the Plan.

(d) *Entitlement to Medicare, Medicaid.* If you or your Dependent become(s) entitled to Medicare, Medicaid or other government-sponsored health program

or if you or your Dependent who has been entitled to Medicare or Medicaid or other government-sponsored health program lose(s) eligibility for such, you may make a corresponding change in your election for health benefits (the payment of Health Plan coverage). You must request applicable election changes within 31 days of your notification of the change.

(e) *Loss of coverage.* If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, if affected, you may revoke your elections of such Benefit, and in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(f) *Loss of coverage under certain other plans.* You may make a prospective election change to add group health coverage for you, your spouse or dependent if there is a loss of group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, as state health benefits risk pool, or a foreign government group health plan.

(g) *Change of coverage due to change under certain other plans.* You may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the other employer permits its participants to make a change; or (2) this cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse;s or Dependent's employer.

In each case, your new benefit election is effective for the first pay period that begins after the Employer receives your election form. Any changes must also be permitted by the Health Plan.

SECTION 5---PLAN ADMINISTRATION

5.01 Plan Administrator. The Plan Administrator is responsible for administration of the Plan and shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including determinations regarding eligibility for benefits, construction of the terms of the Plan, and resolution of possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator or its designee with respect to any matter on which it has the power, duty, and/or authority to act shall be made by it in its sole discretion and shall be conclusive and binding on all persons. In addition, the Plan Administrator may:

a) prescribe forms, rules, policies and procedures for the purpose of administration of the Plan; and

b) appoint such agents, attorneys, accountants, service providers and consultants or other person(s) as it may deem necessary or desirable in connection with the administration of the Plan.

5.02 Plan Must Be Nondiscriminatory. The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate or the receipt of benefits, and is intended to comply in this respect with the requirements of the Code. The Plan Administrator is authorized to take such actions that, in its sole discretion, are necessary to assure such compliance. Such actions may include, without limitation, a modification of the elections for highly compensated employees.

SECTION 6—CLAIMS AND APPEALS PROCEDURE

6.01 Health Plan. The applicable claims and appeals procedures for the Health Plan are set forth in its governing documents.

SECTION 7—RESERVED

SECTION 8—MISCELLANEOUS

8.01 Information. The Plan Administrator may require you to supply such information and sign such documents as are necessary to implement the Plan.

8.02 Applicable Law. The laws of the State of *California)* will determine all questions arising with respect to the provisions of the Plan except to the extent superseded by federal law.

8.03 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan. The Employer will make all payments of benefits under the Plan solely from the assets of the Employer and the Plan Administrator is not liable for payment of benefits in any manner.

8.04 Non-alienation of Benefits. Except as specifically provided under the Health Plan, benefits payable under the Plan are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary,

including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, unless pursuant to court order, prior to actual receipt by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan, is void. The Employer is not in any manner liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

8.05 Employment Not Guaranteed. Nothing contained in the Plan, or any modification or amendment to the Plan, or in the creation of any account, or the payment of any benefit, gives you or your beneficiaries any right to continue employment, any legal or equitable right against the Employer, or Employee of the Employer, or its agents, or against the Plan Administrator, except as expressly provided by the Plan.

SECTION 9—RESERVED

SECTION 10—PLAN INFORMATION

10.01 Employer. The Employer's legal name, address and federal tax identification number are:

The Roman Catholic Archbishop of Los Angeles, a Corporation Sole, on behalf of its group health plan
Telephone: 213-637-7218
EIN: 95-1642382

10.02 Plan Name. The name of the Plan is the Employee Benefits Plan Premium Only Plan.

10.03 Plan Year. The plan year is the twelve-month period beginning 1st of July, and ending 30th of June.

10.04 Type of Plan. The Plan is commonly known as a cafeteria plan.

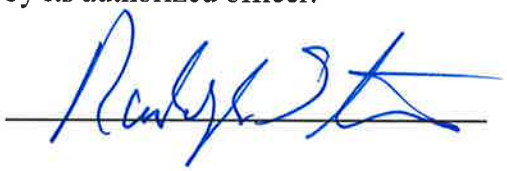
10.05 Type of Administration. The Plan's various benefit options are administered through contracts with carriers and/or third party administrators and, in some instances, by the Employer.

10.06 Plan Funding. The Plan is unfunded. Benefits are provided through component programs.

10.07 Plan Sponsor/Administrator. The Employer is the Plan Sponsor and Plan Administrator.

10.08 Termination and Amendment. The Employer reserves the right to amend the Plan, change the applicable Employee contribution rates, or terminate the Plan at any time.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed effective as of the first day of July, 2015 by its authorized officer.



By [type/print]: Randy Steiner

Title: ADLA Chief Financial Officer