ROMAN CATHOLIC ARCHDIOCESE OF BOSTON
SECTION 125 CAFETERIA PLAN WITH FLEXIBLE SPENDING ACCOUNTS

Amended and Restated, Effective January 1, 2020

Section 125 Cafeteria Plan

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Article 1. *Introduction.*

1.1. Purpose of Plan. This Plan document amends and restates the Roman Catholic Archdiocese of Boston Section 125 Cafeteria Plan, effective January 1, 2014. The purpose of this Plan is to provide Participants with a choice between cash and Optional Benefit Coverages.

1.2. Cafeteria plan status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.

1.3. Employee status. All Participants in this Plan shall be Employees.

Article 2. *Definitions.*

Wherever used in this Plan, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

2.1. "Administrator" means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2. "Benefit-Eligible Employee" means an Employee of a Participating Employer who meets the eligibility requirements in Schedule A. An individual who does not meet the eligibility requirements in Schedule A shall not be eligible to participate in the Plan under any circumstances. Determination of whether an Employee is a Benefit-Eligible Employee shall be made under the normal personnel policies, classifications and practices of the Employer.

2.3. "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any regulations thereunder and any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.4. "Coverage Period" means the Plan Year, except as otherwise provided in Schedule A.

2.5. "Effective Date" of this restatement means January 1, 2014.

2.6. "Employee" means any individual who (a) is employed in the service of the Employer, and (b) is in a legal employer-employee relationship with the Employer for federal withholding tax purposes. Employee shall not include an individual who is self-employed in accordance with Code section 401(c).

2.7. "Employer" means Roman Catholic Archdiocese of Boston ("RCAB") and any successor to all or a major portion of its assets or business, by merger or otherwise, that assumes the obligations of the Employer under the Plan. To the extent approved by RCAB, affiliates of RCAB may adopt this Plan for their employees in accordance with such terms and limitations as RCAB may from time to time require, in which case employees of such affiliate(s) shall be deemed to be Employees hereunder and those who meet the eligibility requirements of Schedule A shall be deemed to be Benefit-Eligible Employees. Employers (including RCAB) whose Employees are Participants under the Plan are referred to as "Participating Employers." Participating Employers under this Plan shall not be Participating Employers under any other Cafeteria Benefit Plan sponsored by RCAB.

2.8. "Key Employee" means any person who is a key employee, as defined in section 416(i)(1) of the Code, with respect to the Employer.

2.9. "Optional Benefit Coverages" means the coverages (if any) available to a Participant under the plans of the Employer set forth in Schedules A and B.

2.10. "Participant" means any individual who participates in the Plan in accordance with Article 3.

2.11. "Plan" means this Section 125 Cafeteria Plan as set forth herein, together with any and all Schedules, amendments and supplements hereto.

2.12. "Plan Year" means the period set forth as the Plan Year in Schedule A.

Article 3. *Participation.*

3.1. Commencement of participation. Each Benefit-Eligible Employee will become a Participant in this Plan when he or she becomes a Benefit-Eligible Employee, subject to his or her completion of any applicable waiting period referred to in the attached Schedule A.

3.2. Cessation of participation. A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which he or she ceases to be a Benefit-Eligible Employee.

3.3. Reinstatement of former Participant. A former Participant who meets the requirements for a Benefit-Eligible Employee will become a Participant again if and when he or she becomes a Benefit-Eligible Employee, subject to the completion of any applicable waiting period.

Article 4. *Optional Benefit Coverages.*

4.1. Coverage options. Each Participant may choose under this Plan to receive his or her full compensation in cash or to have all or a portion of such compensation applied by the Employer toward the cost of the Optional Benefit Coverages available to the Participant. Notwithstanding anything herein to the contrary, Optional Benefit Coverages shall be limited to those coverages and benefits (if any) that are available to the Participant under the plans identified in Schedules A and B.

4.2. Description of Optional Benefit Coverages. While the election of one or more of the Optional Benefit Coverages may be made under this Plan, the coverages and benefits thereunder will be provided not by this Plan but by the plans identified in Schedules A and B. The types and amounts of benefits available under each plan described in Schedules A and B, the requirements for participating in such plan, and the other terms and conditions of coverage and benefits under such plan are as set forth from time to time in the legal plan documents constituting the plans identified in Schedules A and B, and in any group insurance contracts, and prepaid health plan contracts that constitute (or are incorporated by reference in) certain of those plans. The benefit descriptions in such plans, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.3. Election of Optional Benefit Coverages in Lieu of Cash. A Participant may elect under this Plan, in accordance with the procedures described in Sections 4.4, 4.5 and 4.6, to receive one or more Optional Benefit Coverages to the extent available to the Participant under the applicable plans identified on Schedules A and B.

(a) If a Participant elects coverage for a Coverage Period under a plan identified on Schedule A, and if the Participant is required under such plan to pay a share or all of the cost of such coverage, such share or all of the cost of coverage shall be paid by a reduction in the Participant's regular compensation for the Coverage Period. The balance of the cost of each such coverage, if any, shall be paid by the Employer under this Plan with nonelective Employer contributions.

(b) If a Participant elects coverage for a Coverage Period under a flexible spending account plan identified on Schedule B, the Participant's regular cash compensation for the Coverage Period will be reduced by such amount as the Participant elects (subject to the limitations of such plan(s)) and an amount equal to the reduction in compensation will be credited to the appropriate reimbursement account in accordance with the applicable plan identified on Schedule B.

4.4. Election procedure. Prior to the commencement of each Coverage Period, the Administrator shall provide (or make available) a means of election for each Participant and for each other individual who is expected to become a Participant at the beginning of the applicable Coverage Period. The election shall be effective as of the first day of the pay period of the Coverage Period. Each Participant who desires to elect an Optional Benefit Coverage available for the Coverage Period shall so specify in his or her election. The Participant is deemed to have agreed to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be completed and returned to the Administrator on or before such date as the Administrator shall specify.

4.5. New Participants. Before, or as soon as practicable (but no later than thirty (30) days) after, an individual becomes a Participant under Section 3.1 or 3.3, the Administrator shall provide the means of election described in Section 4.4 to the individual. If the individual desires one or more Optional Benefit Coverages for the balance of the Coverage Period, the individual shall so specify in his or her election. The Participant is deemed to have agreed to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be completed and returned to the Administrator on or before such date as the Administrator shall specify.

4.6. Failure to make election.

(a) A new Participant's failure to make an election under Section 4.4 or 4.5 on or before the due date specified by the Administrator for the Coverage Period in which he or she becomes a Participant shall constitute an election by the Participant to receive his or her full compensation in cash.

(b) Except as otherwise provided in the annual election materials approved by the Administrator, an existing Participant's failure to make an election relating to

coverage under a plan identified as an Optional Benefit Coverage on Schedule A and B on or before the due date specified by the Administrator for any subsequent Coverage Period shall constitute (1) a re-election of the same coverage or coverages, if any, under such plans as were in effect just prior to the end of the preceding Coverage Period (to the extent such coverage remains available as an Optional Benefit Coverage under the Plan), and (2) an agreement to a reduction in the Participant's compensation for the subsequent Coverage Period equal to the Participant's share of the cost of such coverage or coverages.

(c) An existing Participant's failure to make an election under Section 4.4 or 4.5 relating to coverage under a flexible spending account plan identified on Schedule B, on or before the due date specified by the Administrator for any Coverage Period shall constitute an election by the Participant of cash compensation in lieu of such coverage, regardless of any election in effect during the preceding Coverage Period.

4.7. Revocation or change of election by the Participant during the Coverage Period.

(a) Any election made under the Plan (including an election made through inaction under Section 4.6) shall be irrevocable by the Participant during the Coverage Period except as otherwise provided in (b) through (k) below.

(b) With respect to the Optional Benefit Coverages under a plan identified on Schedule A and Schedule B, a Participant may revoke an election for the balance of the Coverage Period and, if desired, file a new election in writing if, under the facts and circumstances, (1) a change in status occurs, and (2) the requested revocation and new election satisfy the consistency requirements in Section 4.8 below. For this purpose, a change in status includes the following events:

(1) Legal marital status. An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, or legal separation or annulment.

(2) Number of dependents. An event that changes a Participant's number of dependents (as defined in Code Section 152), including birth, death, adoption or placement for adoption.

(3) Employment Status. An event that changes the employment status of the Participant, the Participant's spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of the Employer.

(4) Requirements For Unmarried Dependents. An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, or any similar circumstance.

(5) Residence. A change in the place of residence of the Participant or his or her spouse or dependent that affects eligibility for an Optional Benefit Coverage under a plan identified in Schedule A.

(6) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Coverage Period under regulations and rulings of the Internal Revenue Service.

(c) In the case of coverage under a medical benefits plan identified in Schedule A, a Participant may revoke an election for the balance of the Coverage Period and file a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) pertaining to HIPAA special enrollment rights, whether or not the change in election is permitted under Section 4.7(b) above.

(d) In the case of a judgment, decree or court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for a Participant's child or for a foster child who is a dependent of the Participant, a Participant may change his or her election (1) in order to provide coverage for the child under a health coverage identified on Schedule A if the court order so requires, or (2) in order to cancel a health coverage identified on Schedule A for the Participant's child if such order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) In the case of a medical coverage identified on Schedule A, a Participant may revoke an election in writing for the balance of the Coverage Period and file a new election in writing in order to cancel or reduce such medical coverage for the Participant and/or for one or more covered dependents of the Participant to the extent that such individual becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election in writing for the balance of the Coverage Period to commence or increase a medical coverage identified on Schedule A.

(f) In the case of an Optional Benefit Coverage identified on Schedule A or a dependent care assistance plan identified on Schedule B, if the Participants' share of the cost of such coverage significantly increases or significantly decreases during the Coverage Period, the Participants may make a corresponding change in election under the Plan for the balance of the Coverage Period, which will include (but not be limited to) the following:

(1) for a significant cost increase, Participants electing such coverage for the Coverage Period may revoke their election and either elect a similar coverage identified on Schedule A or B for the balance of the Coverage Period, or drop such coverage if there is no similar coverage identified on Schedule A or B; or

(2) for a significant cost decrease, Participants may elect to commence participation in the Optional Benefit Coverage with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Coverage Period.

This Section 4.7(f) shall apply to a dependent care assistance plan identified on Schedule B only if the significant cost change is imposed by a dependent care provider who is not a relative of the Participant. No election change may be made as to any medical flexible spending account plan identified in Schedule B on account of a significant cost or coverage change.

(g) In the case of an Optional Benefit Coverage identified on Schedule A, if the Participant or his or her spouse or dependent experience a significant curtailment in coverage during the Coverage Period, the Participant may make a corresponding change in election under the Plan for the balance of the Coverage Period as follows:

(1) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Coverage Period may revoke his or her election and elect a similar coverage identified on Schedule A for the balance of the Coverage Period; or

(2) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Coverage Period may revoke his or her election and either elect a similar coverage identified on Schedule A for the balance of the Coverage Period, or drop such coverage if there is no similar coverage identified on Schedule A.

(h) If during the Coverage Period a new Optional Benefit Coverage becomes available, or an existing Optional Benefit Coverage is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Coverage Period, provided that no such election change may be made as to any medical flexible spending account plan identified in Schedule B. For purposes of this Section 4.7(h), a Participant's change in dependent care provider shall be treated as a change in available coverage.

(i) In the event that a Participant's spouse or dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Coverage Period that is on account of and corresponds with the election change made by the Participant's spouse or dependent, if:

(1) the election change made by the Participant's spouse or dependent under his or her employer's plan satisfies the regulations and rulings under Code section 125; or

(2) the period of coverage under the plan maintained by the employer of the Participant's spouse or dependent does not correspond with the Coverage Period of this Plan.

(j) In the event that a Participant, his or her spouse or dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect health coverages identified on Schedule A for the balance of the Coverage Period for the Participant, his or her spouse or dependent.

(k) Any application for a revocation and new election under this Section 4.7 must be made within the time specified by the Administrator following the date of the actual event and shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law. Furthermore, no such revocation and new election will be permitted if the insurance company or vendor administering the applicable Optional Benefit Coverage does not permit an election change in that situation.

(l) Revocation to Purchase a Qualified Health Plan Through an ACA Marketplace. In accordance with, and to the extent permitted by, Notice 2014-55, a Participant may revoke his or her elections (but not any election of flexible spending account coverage) in order to purchase a Qualified Health Plan through an Exchange ("Marketplace") established under the Affordable Care Act, subject to the following conditions:

(1) Conditions for revocation due to reduction in hours of service:

(a) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(b) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage

due to the revocation, in another plan that provides the minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked; or

(2) Conditions for revocation due to enrollment in a Qualified Health Plan:

(a) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(b) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

4.8. Consistency Rules.

(a) A Participant's requested revocation and new election will be consistent with a change in status (1) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's spouse or dependent, and (2) with respect to dependent care assistance, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses as defined in Code Section 21(b)(2)). A change in status that affects eligibility under the Employer's plan shall include a change in status that results in the increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the plan.

4.9. Changes by Administrator. If the Administrator determines, before or during any Coverage Period, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals or to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.10. Adjustment of compensation reductions. If the cost of an Optional Benefit Coverage provided to a Participant under a plan identified in Schedule A increases or decreases during a Coverage Period, including any increase or decrease due to a change in the Participant's salary, a corresponding change shall be made in the compensation reductions of the Participant in an amount reflecting such increase or decrease, as determined by the Administrator. If the cost of dependent care assistance provided to a Participant under a plan identified in Schedule B increases or decreases during a Coverage Period because of cost changes imposed by a dependent care provider who is not a relative of the Participant, a corresponding change may be made in the compensation reduction of the Participant in an amount to be determined by the Administrator.

4.11. Automatic termination of election. Any election made under this Plan (including an election made through inaction under Section 4.6) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a plan identified on Schedule A or Schedule B may continue if and to the extent provided by such plan.

4.12. Maximum elective contributions. The maximum amount of elective contributions under the Plan for any Participant shall be the total cost to the Participant for the Coverage Period of the most expensive Optional Benefit Coverages that any Participant could elect.

4.13. Cessation of required contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under any plan identified on Schedule A or B, in accordance

with the terms of such plan, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.

4.14. Elections via other media. The Administrator may, in its discretion, use any telephonic, electronic or other alternative media form that it deems necessary or appropriate for the election of benefits under the Plan.

4.15. Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more Optional Benefit Coverages under the Plan, and (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any regulations pertaining thereto.

Article 5. *Administration of Plan.*

5.1. Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Administrator, or its authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any plan identified on Schedule A or B shall not be subject to review under this Plan, and the Administrator's authority under this Section 5.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan or policy.

5.2. Examination of records. The Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours; provided, however, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

5.3. Reliance on tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the plans identified on Schedules A and B, or by accountants, counsel or other experts employed or engaged by the Administrator.

5.4. Nondiscriminatory exercise of authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

Article 6. *Amendment and Termination of Plan.*

6.1. Amendment of Plan. The power to amend the Plan, in whole or in part, shall be vested in the Employer, which shall have the sole discretion to make all amendments to the Plan or any of its provisions. Such amendment shall be effected by a written instrument signed by an officer of the Employer, or his or her authorized delegate.

6.2. Termination of Plan. The Employer has established the Plan with the bona fide

intention and expectation that it will be continued indefinitely, but the Employer will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time, without liability, by a written instrument signed by an officer of the Employer, or his or her authorized delegate.

Any affiliate of the Employer that has adopted this Plan for its employees (see Section 2.7) may terminate its participation in the Plan by a written instrument signed by an officer of such affiliate.

Article 7. *Miscellaneous Provisions.*

7.1. Information to be furnished. Participants shall provide the Employer and the Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2. Limitation of rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Administrator, except as provided herein.

7.3. Employment Not Guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Employer.

IN WITNESS WHEREOF, the Employer has caused this amended and restated Plan to be executed in its name and on its behalf by an officer or a duly authorized delegate as of the Effective Date.

ROMAN CATHOLIC ARCHDIOCESE OF
BOSTON (THE "EMPLOYER" AND "RCAB")

By: Carol Gustavson
(print name)

Title: Plan Administrator

SCHEDULE A

1. "Benefit-Eligible Employees" – With respect to the Optional Benefit Coverages described below and in Schedule B, "Benefit-Eligible Employees" consists of the following Employees:

   All Employees of the Roman Catholic Archdiocese of Boston whose Payroll is administered through an Archdiocesan location and who are eligible under the terms of the Health, Vision, and Dental plans sponsored by the Roman Catholic Archdiocese of Boston are eligible to participate in this Plan(Such Employees shall not be eligible to participate under any other Cafeteria Benefit Plan sponsored by RCAB). Eligible Employees became Participants by completing an election form in accordance with such requirements as the Administrator may establish from time to time.

2. Waiting Period- Any applicable waiting period under the Health, Vision, and Dental Plans described as Optional Benefits Coverages in Section 3 below shall apply under this Plan.

3. Optional Benefit Coverages–For Benefit-Eligible Employees described above, the following Optional Benefits Coverages are available under this Schedule A :

   RCAB Employee Health Benefit Plan Administered by Blue Cross Blue Shield of Massachusetts Health Plan.

   RCAB Employee Vision Plan Insured by VSP.

   RCAB Employee Dental Benefit Plan Administered by Delta Dental.

4. "Plan Year" means the following 12-month period: October 1st to September 30th. The Coverage Period for Health and Dental Benefits is the Plan Year; provided, however, for Optional Benefits described in Schedule B and Vision Plan Benefits, the Coverage Period is January 1st to December 31st.

SCHEDULE B

Other Optional Benefit Coverages - Flexible Spending Account Plans

1. Are any Flexible Spending Account Plans available as Optional Benefit Coverages under the Plan?

■ Yes ☐ No.

If "Yes," which Flexible Spending Account Plans are available as such Optional Benefit Coverages under the Plan?

Medical Flexible Spending Account Plan?

■ Yes ☐ No

Dependent Care Flexible Spending Account?

■ Yes ☐ No

2. The terms of the Medical Flexible Spending Account Plan and Dependent Care Flexible Spending Account Plan are set forth in Exhibit I (attached) to this Schedule B. That Exhibit I is fully incorporated by reference into this Schedule B.

EXHIBIT I

SCHEDULE B

ROMAN CATHOLIC ARCHDIOCESE OF BOSTON

FLEXIBLE SPENDING ACCOUNT PLAN

PLAN SUMMARY

INTRODUCTION

Roman Catholic Archdiocese of Boston (the "Company") established the Archdiocese of Boston Flexible Spending Account Plan (the "Plan") effective January 1, 2009 and restated, effective January 1, 2014.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you meet the eligibility requirements set forth in Schedule A of the Roman Catholic Archdiocese of Boston Section 125 Cafeteria Plan.

Date of Participation

You will become a Participant eligible to receive benefits from the Plan on the first day of the calendar month next following the date you first perform an hour of service as an Eligible Employee.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

ELECTIONS

In General

When you become eligible to participate in the Plan, you may begin contributing to the Plan. All contributions will be credited to an account established in your behalf. Your contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Election Procedures

When you are first eligible to participate in the Plan, you must return a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator.

After you are first eligible to participate in the Plan you will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you. In order to participate in the Plan for the next Plan Year, you must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you may modify elections at a time other than the beginning of a Plan Year.

If as of the start of a Plan Year you have not returned an election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

Modification of Elections

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A dependent satisfies or ceases to satisfy eligibility requirements.

Change in your place of residence.

Commencement or termination of an adoption proceeding.

Court judgment, decree, or order.

Entitlement to Medicare or Medicaid.

Significant cost or other coverage changes.

You take leave under the FMLA

BENEFITS

Health Care Reimbursement Account

When you become eligible to participate in the Plan, the Plan will establish a Health Care Reimbursement Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating on the Plan.

The entire annual amount you elect to contribute for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed will be available for reimbursement. Beginning in 2013, the maximum amount you could contribute each year was $2,500.00, which limit is indexed for cost-of-living changes in subsequent Plan Years. As of 2020, the maximum amount you may contribute each year is $2,750. The minimum amount you may contribute each year is $260.00.

Eligible expenses generally include all medical expenses (but not health insurance premiums) that may be deductible on an individual taxpayer's federal income tax return, but you may also seek reimbursement for certain over-the-counter drug expenses incurred after 2019. You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source. An expense is incurred when the service or supply relating to that expense is provided.

Dependent Care Assistance Account

When you become eligible to participate in the Plan, the Plan will establish a Dependent Care Assistance Account in your name. This Account will be credited with your contributions

and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify only if they allow you to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

Before and after school programs

Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)

Licensed child care center

Nursery school or pre-school

Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you will seek reimbursement will qualify as dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source. An expense is incurred when the service relating to that expense is provided.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is $5,000 ($2,500 if you are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

Please note that participation in the Plan may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

FORFEITURES

Plan Year/Termination

Effective with the 2020 Plan Year, if you are a participant in the Health Care FSA as of the last day of the Plan Year and you have enrolled in the Health Care FSA for the subsequent Plan Year, you are eligible to roll over up to $550.00 in unused Health Care FSA funds for use in the subsequent Plan Year. Going forward, the carryover amount will be adjusted for inflation. These funds may be used for IRS eligible expenses incurred in the subsequent Plan Year only.

The carryover amount does not count against the maximum salary reduction election for the subsequent Plan Year.

If you are a Health Care FSA participant but do not elect to participate in the following Plan Year, you are not eligible to roll over unused Health Care FSA funds. Any amounts remaining in your account at the end of the Plan Year (i.e., December 31) will be forfeited after all claims are paid. In addition, any balance remaining in your account on the date you terminate employment will be forfeited after all claims are paid. You may only submit claims for health care expenses incurred before your date of termination. You may continue to submit claims for dependent care expenses incurred during the Plan Year after your date of termination but you will only be reimbursed up to the balance in your Dependent Care Assistance Account on the date of your termination.

CLAIMS

Deadlines

You must submit claims for reimbursement within 90 days after the end of the Plan Year.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than certain amount will be carried forward and aggregated with future claims until the

reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to HealthEquity at 15 W Scenic Pointe Drive, Draper, UT 84020. The telephone number is 877-472-8632 and the website is www.myhealthequity.com

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents or a representative of your estate.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence

that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial. and (5): (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination 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.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was

consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent 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 Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

Claim Procedures for Non-Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent 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 Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States armed forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact your Human Resources Department.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order.

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time. To the extent any provision of the Plan does not comply with Section 125 of the Internal Revenue Code, the Plan shall be automatically amended to so comply and administered in accordance with all such automatic amendments.

Fees

Your account may be charged for some or all of the costs and expenses of operating the Plan.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

The provisions of the RCAB Group Health Plan relating to compliance with HIPAA shall also apply to the Health Care Reimbursement Account to the extent required by HIPAA.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor is the Roman Catholic Archdiocese of Boston.

   Its address is 66 Brooks Drive, Braintree, MA 02184.

   Its telephone number is 617-746-5736.

   Its Employer Identification Number is 04-2106175.

   The Plan Administrator is Roman Catholic Archdiocese of Boston.

   Its address and telephone number is that of the Plan Sponsor listed above.

2. The Plan is an ERISA-exempt church welfare benefit plan that has been designated by the sponsor as its plan number 510. ERISA does not apply to the Plan.

3. The Plan's designated agent for service of legal process is Archdiocese of Boston. Any legal papers should be delivered to the address listed in paragraph 1.

4. The Coverage Period begins on January 1 and the Plan Year ends on December 31.