Summary Plan Description

& Plan Document

For

The Natomas Basin Conservancy

(Effective MM/YYYY)

INTRODUCTION 1
DISCLAIMERS 2
GENERAL PLAN INFORMATION 4
MEDICAL PLAN COVERAGE 5
Special Enrollment Rights 6
Women's Health and Cancer Rights Act of 1998 7
HEALTH PREMIUM REIMBURSEMENT PLAN 8
DENTAL AND VISION REIMBURSEMENT PROGRAM 12
LONG TERM DISABILITY INSURANCE 14
Eligibility 14
Notice Of Claim 15
Benefit Payments 15
Duration Of Coverage 15
RETIREMENT BENEFITS 17
GENERAL CLAIMS AND APPEALS PROCEDURES 18
Claims under the Unum Long-Term Disability Policy 18
Claims for Medical Benefits under the Medical Plan 18
Claims for Medical Plan Eligibility; Eligibility and Benefit Claims under the 18
HRA Plan Dental & Vision Reimbursement Program, or SEP-IRA Retirement Plan 18
Filing a Claim 19
Notification of Adverse Benefit Determination 19
Appealing an Adverse Benefit Determination 20
Cal-COBRA RIGHTS AND COVERAGE 23
YOUR RIGHTS UNDER ERISA 25
Continue Group Health Plan Coverage 25
Prudent Actions by Plan Fiduciaries 25
Enforce Your Rights 26
Assistance with Your Questions 26
APPENDIX A – HEALTH PREMIUM REIMBURSEMENT PLAN DOCUMENT 27
APPENDIX B – UNUM LONG TERM POLICY 36
APPENDIX C – CLAIM FORM – HRA PLAN, DENTAL AND VISION REIMBURSEMENT PROGRAM 37

INTRODUCTION

The Natomas Basin Conservancy ("The Conservancy") is proud to offer its employees a collection of employee benefits (the "Plan") which include:

- Medical Plan Coverage
- Health Premium Reimbursement Plan
- Dental and Vision Reimbursement Plan
- Long-term Disability Coverage (underwritten by UNUM)
- Simplified Employee Retirement – Individual Retirement Account Plan

This Plan is established and operated in accordance with the Employee Retirement Security Act of 1974 ("ERISA"). As a participant in this Plan, you have certain rights available, as described in the "ERISA Rights" section.

This booklet contains the official rules by which the Plan will be operated. There may be circumstances in which this booklet does not describe all of the provisions of the Plan or all of the possible situations that may occur.

Your rights to benefits under the Plan are determined solely by the provisions of this document, in combination with any other formal documents referenced below. IF THERE IS ANY CONFLICT BETWEEN THIS PLAN DOCUMENT, AND ANY OTHER DOCUMENTS REFERENCED IN THIS DOCUMENT, THE TERMS OF THIS PLAN DOCUMENT WILL GOVERN. The benefits discussed in this document are provided on behalf of The Conservancy through the assistance of a Claim Administrator. You may request a copy of this Claim Document, and any of the documents referenced below, by contacting the Claim Administrator:

Chief Financial Officer
(916) 649-3331

This booklet contains important information about your Plan benefits, including information about instances in which your Plan benefits may be lost, reduced or otherwise denied. You should review this entire booklet and contact the Claim Administrator if you have any questions about the Plan's provisions.

If you believe you are entitled to a benefit that you have not received or if you disagree with any determination made by the Claim Administrator regarding your benefit (such as the amount of your benefit or how it is calculated), you may submit a claim for benefits under the Plan.

However, the period for submitting a claim for benefits is limited. If you fail to make a timely claim for benefits or you fail to timely appeal a claim, you may lose your right to those benefits.

For important information regarding the process for submitting a claim for benefits and the deadlines for submitting such a claim, see the "Claims and Appeals Procedure" section of this booklet.

DISCLAIMERS

No person can make any statements of any kind that alter or amend the terms of the Plan. Accordingly, you should not consider the Plan to have been amended based on written or oral statements made by any employee, officer, director, or representative of The Conservancy including the Claim Administrator, or any of its affiliates or related organizations.

This Plan Document does not constitute a promise or guarantee of employment with The Conservancy and will be updated periodically to reflect all of the current rules and any amendments or changes in benefits made available to you under the Plan.

The Claim Administrator has complete and final discretionary authority to determine all questions regarding an employee's participation and benefits and to interpret and construe the provisions of this Plan document, including any uncertain terms. When deciding claims, the Claim Administrator is using its full discretionary authority to determine facts, interpret the Plan, and resolve any questions. Decisions made by the Claim Administrator will be given full deference by any court of law, and the Claim Administrator's decision on review will be final and binding on all parties.

DEFINITIONS

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

Committee. The Compensation and Governance Committee of the Board of Directors.

Benefits. The reimbursement benefits for Medicare and Medigap premium expenses described in the HRA Plan.

Board of Directors. The Board of Directors of The Natomas Basin Conservancy.

Cal-COBRA. Section 1366.20 et. seq. of the California Health and Safety Code (the “California Continuation Benefits Replacement Act”).

Claims Administrator. The Chief Financial Officer of The Natomas Basin Conservancy.

Code. The Internal Revenue Code of 1986, as amended.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

HRA Account. The recordkeeping account established in your name by the Employer on the basis of which your eligible Medicare and Medigap premium expenses will be paid or reimbursed.

HSA. This means a Health Savings Account offered in conjunction with group health plan coverage.

Participant. An eligible Employee who has become and not ceased to be a Participant in the Plan.

Plan Administrator and Employer. The Conservancy.

Plan Year. The 12-month period ending on December 31.

Spouse. An individual who is treated as a spouse for federal tax purposes.

GENERAL PLAN INFORMATION

Name of Plan:	Natomas Basin Conservancy Employee Benefits Plan
Sponsoring Employer:	Natomas Basin Conservancy
Plan Administrator:	Natomas Basin Conservancy 2150 River Plaza Dr., Ste. 460 Sacramento, CA 95833
Claims Administrator:	Chief Financial Officer

Plan Administrator's Telephone Number: (916) 649-3331

Plan Administrator's Employer Identification Number (EIN): 68-0344388

Plan Number: 502

Plan Year: January 1 through December 31

Agent for Service of Process:	Service may be made on the Administrator at the address listed above.

MEDICAL PLAN COVERAGE

The Natomas Basin Conservancy ("The Conservancy") offers group medical coverage to employees who are hired to work, on average, thirty (30) hours per week over the course of each month. Coverage is provided through a group health service contract with Blue Shield of California (although The Conservancy reserves the right to select another, or any other group health plan at any time).

The benefits offered under Blue Shield of California are structured as a Preferred Provider Organization (PPO) arrangement whereby the Employee, and/or any eligible Dependents may choose to see any hospital or physician to provide covered services provided at hospitals or providers located within, or outside of California. The total cost of services received from the hospital or physician, and the out-of-pocket costs payable by the Employee or Dependent(s), will vary depending on whether the hospital or physician is listed as a Participating Provider (also known as "in-network" provider), or a Non-Participating Provider (also known as an "out-of-network" provider). For a complete list of Participating Providers, please visit:

https://www.blueshieldca.com/fad/homeCoverage is available to the Employee, plus any one or more of the following qualifying Dependents:

- A Spouse who is legally married to the Employee, and who is not legally separated from the Employee.

- A child who is the child of, adopted by, or in legal guardianship of the Employee, Spouse, or Domestic Partner, and who is not covered as an Employee. A child includes any stepchild, child placed for adoption, foster child, or any other child for whom the Employee or Spouse has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than twenty-six (26) years of age. A child does not include any children of a Dependent child (grandchildren of the Employee, Spouse, or Domestic Partner), unless the Employee, Spouse has adopted or is the legal guardian of the grandchild.

- A dependent ceases to be a child at the end of the calendar year in which: (a) the individual turns age twenty-six (26), (b) the date the child ceases to be a foster child of the Employee, if earlier than age twenty-six (26), or (c) the date legal guardianship expires or is otherwise terminated by the court.

The Conservancy pays a portion of the monthly health plan premium, with employees paying the remaining portion of the monthly premium through a pre-tax payroll deduction. The amount each Employee must contribute to the total premium cost may be adjusted annually at the discretion of The Conservancy. In addition, the Employee and enrolled Dependents will be liable for any out-of-pocket costs, which are described in a Summary of Benefits and Coverage document provided annually during The Conservancy's open enrollment process.

This medical coverage is structured as a "High Deductible Health Plan" or HDHP Plan, which means the Employee can simultaneously enroll in a tax-qualified Health Savings Account (HSA). The Conservancy will make a contribution to the Employee's HSA account up to the

annual limit for HSA contributions for an Employee-only coverage. The Employee may contribute additional funds to the HSA account via pre-tax payroll deduction up to the maximum annual contribution limit for family coverage, plus any additional amounts that any Employee, who is fifty-five (55) years or older, may make to an HSA account as "catch-up contributions" (as defined in the Internal Revenue Code). An HSA account will be established and funded by the Conservancy, for each Employee and any eligible Dependents, through Optum. For questions related to an Optum HSA account, please visit www.openenrollment123.com for further information regarding how your HSA account is administered by Optum. You may also contact Optum at hsagroup@optumbank.com or by phone at (966) 988-2006 (7 AM to 6 PM CST).

Contributions are used to offset or reimburse out-of-pocket costs that otherwise apply to any services received under the terms of the medical plan coverage.

Employees are eligible to enroll in the PPO Plan on the first day of the month following the month in which the employee first begins working for The Conservancy. Eligibility for this coverage will end upon the first day of the month following the month in which the employee resigns, is terminated, becomes eligible for Medicare or Medicaid coverage.

In the event coverage is terminated, the Employee and/or Dependents affected by such termination may be eligible to remain enrolled in coverage for up to thirty-six (36) months, under a program called "Cal-COBRA," which is described in more detail, below.

The Conservancy will determine each Employee and Dependent's eligibility to enroll in coverage. Thereafter, the medical plan will determine the benefits each Employee and/or Dependent may receive. Any denial of eligibility by The Conservancy may be appealed using the procedures described in this document. Any denial of coverage for medical services must be appealed directly to Blue Shield of California using the claims and appeals procedures described in the Evidence of Coverage Statement that is provided to each Employee and/or Dependent after initial enrollment. To request a copy of the Evidence of Coverage Statement, please contact:

Blue Shield of California

(888) 319-5999

P.O. Box 272540 Chico, CA 95927-2540

Special Enrollment Rights

If you are declining enrollment for yourself or your Dependents (including your Spouse) because you are eligible for other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in the group health plan offered by The Conservancy, but only if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within the first thirty (30) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Claims Administrator at the information provided at the beginning of this summary.

Women's Health and Cancer Rights Act of 1998

Enrollees in the group health plan offered by The Conservancy have certain rights to the extent the group health plan provides mastectomy-related benefits. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: (a) All stages of reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. See the Summary of Benefits and Coverage statement provided annually, during open enrollment, for information on the applicable deductibles and coinsurance amounts. If you would like more information on WHCRA benefits, call the Claims Administrator at the phone number provided at the beginning of this Summary.

Introduction

The Conservancy is pleased to provide the Natomas Basin Conservancy Health Premium Reimbursement Plan (the "HRA Plan") for eligible Employees. Under federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA." This summary plan description ("SPD") describes the basic features of the HRA Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the HRA Plan and a brief description of your rights as a Participant. See Appendix A for a complete copy of all the rules associated with this benefit. If there is a conflict between the official, complete HRA Plan document and this SPD, the official HRA Plan document attached as Appendix A, will control. Definitions of capitalized terms used in this SPD are contained in Part V.

The HRA Plan is not to be construed as giving you any rights against the HRA Plan except those expressly described in this document. The HRA Plan is not a contract of employment between you and the Employer.

General Information About the Plan

I-1. What is the purpose of the HRA Plan?

The purpose of the HRA Plan is to reimburse Participants, up to certain limits, for their Medicare and Medicare Supplement Insurance policy (also known as Medigap) premium expenses. Reimbursements for premium expenses paid by the HRA Plan generally are excludable from taxable income.

I-2. When did the HRA Plan take effect?

The HRA Plan became effective October 1, 2017.

I-3. Who can become a participant in the HRA Plan?

If you are an Employee of the Employer and are enrolled in Medicare, you are an eligible Employee and may become a Participant in the HRA Plan provided, that, if the HRA Plan covers two or more active employees of the Employer, then an Employee must be enrolled in Medicare Part B or D to participate in the HRA Plan.

I-4. What Benefits are offered through the HRA Plan?

Once you become a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medicare and Medigap premium expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind.

The maximum annual amount that may be credited during that Plan Year to the HRA Account of a Participant in the HRA Plan is equal to the cost of Medicare and Medigap premiums

for the Participant for the Plan Year. For each calendar month that you are a Participant, your HRA Account will be credited with a pro rata portion of the maximum annual amount, so long as you are an eligible Employee on the first day of that month. Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medicare and Medigap premium expenses incurred by you.

After the end of the Plan Year, the unused amount (if any) in your HRA Account will be forfeited and revert to the Employer.

No Benefit payable at any time under the HRA Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

If it is later determined that you received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan. If you do not refund the overpayment or erroneous payment, the HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay to the extent permitted by law.

I-5. How will the HRA Plan work?

The HRA Plan will reimburse you for eligible Medicare and Medigap premium expenses. The following procedure should be followed:

- You must submit a claim to the Administrator and provide any additional information requested by the Administrator;
- A request for payment must relate to Medicare or Medigap premium expenses incurred by you during the time you were a Participant under this Plan; and
- A request for payment must be submitted within sixty (60) days following the date the Medicare or Medigap premium expense was incurred.

Claims must be submitted in writing. The Administrator may require that Participants submit claims on a form provided by the Administrator. The claim must set forth:

- The nature and date of the Medicare or Medigap premium expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party showing that the expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Administrator may request.

I-6. Are there any limitations on Benefits available from the HRA Plan?

Only Medicare and Medigap premium expenses are covered by the HRA Plan.

I-7. How do I become a Participant?

If you meet the eligibility requirements described in Section I-3, you will become a Participant in the HRA Plan on the date you submit a properly completed enrollment form, or the first day of the later month indicated on your enrollment form, in accordance with procedures established by the Employer, but only if you are an eligible Employee on that day.

I-8. What if I cease to be an eligible Employee?

If you cease to be an eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for, and elect Cal-COBRA continuation coverage as described below. In either case, you will be reimbursed for any Medicare and Medigap premium expenses incurred prior to the date your participation terminates provided that you comply with the reimbursement request procedures required under the HRA Plan (see Section I-5 for more information on the reimbursement request process).

I-9. What is Cal-COBRA continuation coverage? If I have a Cal-COBRA Qualifying Event, can I continue to participate in the HRA Plan?

Cal-COBRA is a California law that gives certain employees, Spouses, and Dependent children of employees the right to temporary continuation of their health care coverage under a small employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under Cal-COBRA to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of Cal-COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits; or
- Your Dependent child ceasing to qualify as a Dependent.

The Cal-COBRA continuation coverage runs for a period of thirty-six (36) months following the date that regular coverage ended.

I-10. Will I have any administrative costs under the HRA Plan?

Generally, no. The Employer is currently bearing the entire cost of administering the HRA Plan while you are an Employee.

I-11. How long will the HRA Plan remain in effect?

Although the Employer expects to maintain the HRA Plan indefinitely, it has the right to terminate the HRA Plan at any time. The Employer also reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of HRA Account balances under this Plan.

I-12. Are my Benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

Administrative Information

The Claims Administrator administers the HRA Plan and, in cooperation with the Compensation and Governance Committee of the Board of Directors, has the discretionary authority to interpret all HRA Plan provisions and to determine all issues arising under the HRA Plan, including issues of eligibility, coverage, and Benefits. The Claim Administrator's failure to enforce any provision of the HRA Plan shall not affect its right to later enforce that provision or any other provision of the HRA Plan. The Administrator may delegate some of its administrative duties to agents.

The financial records of the HRA Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

Type of Plan: The HRA Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

Type of Administration: The Administrator pays applicable Benefits from the general assets of the Employer.

Funding: The HRA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

DENTAL AND VISION REIMBURSEMENT PROGRAM

The Natomas Basin Conservancy's Dental and Vision Reimbursement Program (Program) is intended to reimburse employees for dental and/or vision expenses for a set amount with annual limits. Reimbursements provided under this program will not be included in the employee's gross taxable salary provided the expense qualifies as a permissible medical expense tax deduction under Section 213(d) of the Internal Revenue Code. Please consult with your own tax professional for more information on permissible, tax-deductible medical expenses.

This Program is a complementary program to the Conservancy's High-Deductible Health Plan with Health Savings Account (HSA). It is not insurance.

The Program works as follows:

- The Conservancy will reimburse eighty percent (80%) of dental and vision care expenses up to five hundred dollars ($500) per calendar year for each eligible employee[1] upon presentation of a valid paid receipt by the Conservancy's eligible employee.[2] The annual five hundred dollars ($500) benefit amount will accumulate, up to a maximum of one thousand five hundred dollars ($1,500). Each annual five hundred dollars ($500) benefit amount will be forfeited if not used within three (3) years from the date it is made available to the Employee.

- Dental services must be performed by a dentist, endodontist, orthodontist, or hygienist licensed by the State of California.

- Vision services must be performed by an optometrist, ophthalmologist, optician, or dispensing optician licensed by the State of California.

- Requests for payment under the Program must be made by the employee him- or herself directly to the Conservancy, and within one year (365 days) of the service provided.

- Requests for payment are made to the employee and will not be paid to the health provider.

An employee's HSA might be used to pay the remaining twenty percent (20%) of expenses, provided sufficient funds are in the employee's HSA account. Please check IRS guidelines on acceptable HSA expenses. Alternatively, the remaining twenty percent (20%) of expenses maybe out-of-pocket if the employee does not have enough funds in their HSA, or for any other reason chooses to not use their HSA for this expense.

[1] "Eligible employee" as defined in the Conservancy's Employee Handbook, Section 400.

[2] For example, if an employee had a cleaning from a dentist that cost $100, on presentation of a valid receipt, the Conservancy would reimburse the Conservancy employee $80 and the Conservancy employee would not be reimbursed for the remaining $20 of the $100 total.

This program may be modified or terminated at any time at the sole discretion of the Conservancy's management or the Compensation and Governance Committee of the Board of Directors.

LONG TERM DISABILITY INSURANCE

Employees are automatically enrolled in a long-term disability insurance policy underwritten by Unum Life Insurance Company of America ("Unum") and is fully paid for by The Conservancy. Complete details about this coverage can be found in the group insurance policy attached as **Appendix B**. Policy details include:

Policyholder's Name:	The Natomas Basin Conservancy
Policy Number:	144773 001
Policy's Original Effective Date:	August 1, 2011

Employees have the option of having the amount paid by The Conservancy, to Unum, be included in the Employee's gross taxable compensation. When Employees elect this option, any benefits paid out under the policy at a later time are not subject to taxes. If Employees do not elect this option, the amount paid will not be included in the Employee's gross taxable compensation and will result in any future benefits becoming subject to applicable taxes.

The long-term disability plan provides financial protection for eligible participants by paying a portion of the participant's salary when the participant is either totally or partially disabled, provided the disability began after the participant enrolled in the long-term disability coverage. Refer to **Appendix B** for additional information describing total and partial disability.

The amount paid under the policy is based on the amount earned before the disability began. In some cases, disability payments can be received, even if the participant works while disabled. The maximum monthly benefit payable under the policy is sixty percent (60%) of monthly pre-disability earnings, up to a maximum monthly benefit of six thousand dollars ($6,000) per month.

Eligibility

Eligible participants include any active employees of the Natomas Basin Conservancy, provided the employee works at least 30 hours per week. Part-time (less than 30 hours per week), temporary and seasonal workers are not eligible for coverage. Coverage will become effective when the participant completes a "waiting period" as follows:

- **Hired on or before August 1, 2011**: No waiting period, coverage is effective immediately upon being hired.

- **Hired on or after August 1, 2011**: Ninety (90) days of continuous, active employment.

Coverage is not available for any disability caused by a pre-existing condition which is any diagnosed condition occurring in the twelve (12) months prior to the effective date of coverage, for which any medical treatment, care or services or prescribed medicines were provided.

To remain eligible for coverage after the commencement of a disability, the participant must be under the regular care of a physician, unless such regular care: (1) will not improve the disabling condition(s), or (2) will not prevent a worsening of the disabling condition(s).

Notice Of Claim

Participants must submit notice of a disability to Unum, **within twenty (20) days after the occurrence or commencement** of any total or partial disability covered by the Unum policy, or as soon thereafter as is reasonably possible. Notice should be provided to Unum Life Insurance Company of America, 655 North Central Avenue, Suite 900, Glendale, CA 91203.

Benefit Payments

Benefits are paid under the policy after the participant completes a one hundred eighty (180)-day "elimination period," which is the period immediately following the onset of the disability. Benefits will commence after Unum approves the participants claim for benefits, provided the elimination period has been completed.

The maximum benefits payable will vary depending on the participant's age at the commencement of the disability. See **Appendix B** for specific information regarding maximum benefit periods. The total benefit payable on a monthly basis will not exceed one hundred percent (100%) of the participant's monthly pre-disability earnings, or six thousand dollars ($6,000) per month, whichever is less.

Once Unum approves a claim for disability, the covered participant must submit evidence of continuing disability at reasonable intervals based on the disabling condition. Failure to submit evidence of an ongoing disability (i.e., physician disability certification, etc.) within forty-five (45) days following any request made by Unum may result in termination and forfeiture of coverage.

The monthly benefit may be reduced if the participant receives any deductible income, including, but not limited to:

- Amounts received under any worker's compensation law or occupational disease law;
- Amounts paid under any applicable state-provided disability benefit; or
- Payments for any disability approved under any governmental retirement system (if applicable), or any other disability retirement provided by the Natomas Basin Conservancy.

Duration Of Coverage

Coverage under the long-term disability policy will end upon the earliest of:

- The date the policy is canceled by the Natomas Basin Conservancy;
- The date a participant loses eligibility to participate in coverage;
- The last day of active employment;
- Upon conclusion of the maximum period of payment;
- When the participant no longer qualifies as having a total or partial disability;

- The date the participant fails to submit to any reasonable request for an examination by a doctor chose by Unum; or
- Date of the participant's death.

For more information on the circumstances under which disability payments may be stopped, refer to the Unum policy enclosed as **Appendix B**.

RETIREMENT BENEFITS

The Conservancy is pleased to offer Employees the ability to participate in a Simplified Employee Pension – Individual Retirement Account Program (SEP-IRA), which provides retirement benefits to the Employee upon attaining eligibility for retirement.

Employees are eligible, upon being hired, to participate if they are eighteen (18) years of age, or older. Employees are not eligible to participate if they are a non-resident alien (and do not have U.S. wages, salaries or other compensation from The Conservancy) or the Employee's compensation is less than a certain amount determined annually under the Internal Revenue Code (e.g., $750 for the 2023 tax year).

The Conservancy will make discretionary contributions to an Individual Retirement Account (IRA) established in the name of the eligible Employee, based on a percentage of the Employee's annual compensation. Employees are not permitted to make contributions through any pre-tax salary deduction arrangement. Employer contributions will be made:

- Based on the first three hundred thirty thousand dollars ($330,000) of compensation paid to the Employee for 2024 (with maximum compensation adjusted annually);

- Made in an amount that is the same percentage of compensation for every employee; and

- In an amount not to exceed the lesser of twenty-five percent (25%) of the Employee's compensation, or a fixed amount determined annually under the Internal Revenue Code (e.g., $66,000 for 2023).

Each employee is responsible for opening an IRA account through a third-party IRA provider and submit the account information to the Conservancy.

GENERAL CLAIMS AND APPEALS PROCEDURES

Claims under the Unum Long-Term Disability Policy

All claims for benefits under the long-term disability insurance coverage are handled by Unum using the procedures described in the policy found at **Appendix B**. If any claim for benefits is denied by Unum, participants may file an appeal within one hundred eighty (180) days after receiving the adverse benefit determination from Unum. Appeals must be submitted to the address shown on the adverse benefit determination letter.

Claims for Medical Benefits under the Medical Plan

All claims for benefit under the group medical plan sponsored by the Natomas Basin Conservancy are handled by Blue Shield of California. For more information on filing a medical coverage claim, or appealing any denial of medical benefits, please refer to the Explanation of Benefits document provided by Blue Shield of California. You may also contact the Claim Administrator to request a copy of the Evidence of Coverage statement prepared by Blue Shield of California, which contains additional details on appealing any denial of medical plan benefits.

Claims for Medical Plan Eligibility; Eligibility and Benefit Claims under the HRA Plan Dental & Vision Reimbursement Program, or SEP-IRA Retirement Plan

The following procedures will apply with regard to any claim for eligibility under the group health plan, or the eligibility for and payment of benefits, under the HRA Plan or Dental and Vision Reimbursement Program, only ("Claims"). Other claims for benefits payable under the group health plan and the long-term disability benefit are handled by Blue Shield of California or Unum, respectively, as discussed above.

Claims must be submitted to the Claim Administrator at the following address:

Claims Administrator
c/o The Natomas Basin Conservancy Employee Benefits Plan
2150 River Plaza Drive, Suite 460, Sacramento, CA 95833
(916) 649-3331

In all cases, the Claim Administrator will administer Claims in accordance with Section 503 of ERISA and the regulations issued thereunder.

Filing a Claim

Claims for any benefit under the HRA Plan or Dental & Vision Reimbursement Plan must be submitted to the Claims Administrator within one year of the date the expense was incurred. Claims for benefits under the Plan must be made on a form provided by the Claim Administrator. A copy of this form is attached to this document as Appendix C.

You may authorize a representative to act on your behalf in pursuing a Claim or an appeal of an adverse benefit determination. However, the Plan may establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. References to "you" in these Claims procedures includes your authorized representative where required by law.

You are entitled to notification of the decision on your Claim within thirty (30) days after the Administrator's receipt of the Claim. This thirty (30)-day period may be extended by an additional period of up to fifteen (15) days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your Claim. If the extension is necessary because of your failure to submit the information necessary to decide the Claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least forty-five (45) days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

Notification of Adverse Benefit Determination

If your Claim is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. If your Claim is denied, in whole or in part, you will receive a written or electronic notification of an adverse benefit determination (unless oral notification is permitted by law). The notification will contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an appeal of an adverse benefit determination;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Claims Administrator relied upon in making the adverse determination, or a statement that a copy of the rule, guideline, protocol, or other similar criterion was relied upon and will be provided free of charge to you upon request;

- Information sufficient to identify the Claim involved (including the date of service, the health care provider, the Claim amount (if applicable)); and

- A description of the Plan's standard, if any, that was used in denying the Claim.

Appealing an Adverse Benefit Determination

You can appeal an adverse benefit determination and have your Claim reviewed by submitting a written request to the Claims Administrator. You will have one hundred eighty (180) days from the date you are notified of the denial to appeal your Claim. If you do not file your appeal within this one hundred eighty (180)-day period, you lose your right to appeal. Your appeal will be heard and decided by the Compensation and Governance Committee ("Committee"), which is a committee of the Board of Directors. Your appeal must be in writing, must be provided to the Claims Administrator, and must include the following information:

- Your name and address;

- The fact that you are disputing a denial of a claim or the Claim Administrator's act or omission;

- The date of the notice that the Claim Administrator informed you of the denied Claim; and

- The reason(s), in clear and concise terms, for disputing the denial of the Claim or the Claim Administrator's act or omission.

You should also include any documentation that you have not already provided to the Claim Administrator.

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claims Administrator. When reviewing your appeal, the Committee will take into account all relevant documents, records, comments, and other information that you have provided with regard to the Claim, regardless of whether or not such information was submitted or considered in the initial determination.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information is relevant to a claim for benefits if the document, record, or information:

- Was relied upon in making the benefit determination;

- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether the document, record, or information was relied upon in making the adverse benefit determination;

- Demonstrates compliance with the administrative processes and safeguards that ensure and verify that claim determinations are made in accordance with governing Plan

documents and, where appropriate, the Plan provisions have been applied consistently to similarly-situated claimants; or

- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

If the Committee receives new or additional evidence that it considered, relied upon, or generated in connection with the Claim, other than evidence that you have provided, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claim Administrator's notice of final adverse benefit determination. Similarly, if the Claims Administrator identifies a new or additional reason for denying your Claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Claim Administrator's notice of final adverse benefit determination.

The appeal determination will not afford deference to the initial determination and will be conducted by the Committee, who is a fiduciary of the Plan, and who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the appeal determination will be based on the medical judgment of a health care professional retained by the Committee, the health care professional retained for purposes of the appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

You will be notified of the appeal determination within a reasonable period of time, but not later than the date of the meeting of the Committee or Board of Directors that immediately follows the Claim Administrator's receipt of your appeal, unless you file the appeal less than thirty (30) days before the date of the meeting, in which case the appeal determination will be made no later than the date of the second meeting following the Claim Administrator's receipt of your Claim appeal. This period may be extended one time until the third meeting of the Committee following the Plan's receipt of your appeal if the Claim Administrator determines that special circumstances require an extension of time for processing the Claim. If an extension of time is required, you will be notified in writing prior to the beginning of the extension. The notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination, which will be no later than five (5) days after the date the committee or board makes a determination about your appeal.

If your appeal is denied, the notice that you receive from the Committee will include the following information:

- Information about your Claim, including the date of service, health care provider, Claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;

- The specific reason for the denial upon review;

- A reference to the specific Plan provision(s) on which the denial is based;

- Any denial code (and its corresponding meaning) that was used in denying the Claim;

- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your Claim;

- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

- A statement of your right to bring an external appeal or a civil action under ERISA §502(a) after exhaustion of administrative procedures.

External Review of your appeal is not available under this Plan because eligibility for benefits under the HRA Plan, or the Dental and Vision Reimbursement Program, do not involve a determination of medical necessity.

The claims and review procedures described herein must be utilized and fully exhausted before you may bring a legal action against the Plan. Unless a Benefit Program provides otherwise, any legal action must be filed within ninety (90) days from the date the appeal determination is received.

Cal-COBRA RIGHTS AND COVERAGE

Cal-COBRA applies to group health plan benefits offered by non-governmental employers who employ between two (2) and nineteen (19). It is available to Employees, Spouses and Dependents who lose health care coverage under a group health plan as the result of a Qualifying Event (defined below). When this occurs the Employee, Spouse and Dependents are known as "qualified beneficiaries" and are eligible for Cal-COBRA, unless the individual:

- Becomes covered under another group benefit plan which does not impose any pre-existing condition limitations affecting the individual;
- Becomes eligible for federal COBRA;
- Becomes eligible for Medicare;
- Becomes eligible for Medi-Cal; or
- Fails to notify the health plan of a qualifying event in the time specified by the law (generally within sixty (60) days); or fails to pay their premium on a timely basis.

The employee must be enrolled in an employer's health plan at the time of a Qualifying Event, which includes:

- The death of the covered employee;
- The termination or reduction of hours of the covered employee's employment for other than gross misconduct;
- Their divorce or legal separation from a covered employee;
- Their loss of dependent status by a dependent child; and
- The covered employee becoming eligible for Medicare.

Within fourteen (14) days of notification of a qualifying event, the insurance carrier will send an election form and premium information to the qualified beneficiary. If the qualified beneficiary wishes continued coverage, he/she must notify the insurance carrier in writing within sixty (60) days of the later of:

- The qualifying event; or
- The date the employee is given notice.

The first premium payment must be received by the carrier within forty-five (45) days of the date the qualified beneficiary provides written notice of election. The employee will pay one hundred ten percent (110%) of regular premium for eighteen (18) months; qualified beneficiaries who are totally disabled as determined by the Social Security Administration can continue their

coverage up to an additional eleven (11) months beyond the initial eighteen (18) months by paying one hundred fifty percent (150%) of the premium for the additional eleven (11) months.

The major difference between Cal-COBRA and COBRA is that the insurance carrier (i.e., Blue Shield of California) is responsible for the administration of Cal-COBRA. The employer is responsible for notifying the carrier of the qualifying event and the carrier takes it from there.

Anyone covered under Cal-COBRA has the same benefits as active covered employees. However, California law does not require the Plan to continue your non-medical coverage, like dental or vision care. If active employees have open enrollment periods when they can change from one plan to another, Cal-COBRA enrollees may do the same. If the employer changes the employees from one plan to another, the Cal-COBRA enrollee must be allowed to transfer into the new group along with active covered employees. No restrictions based on pre-existing conditions are allowed.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants must be entitled to:

- Receive Information About Your Plan and Benefits;

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;

- Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies; and

- Receive a summary annual report indicating the total contributions made by the Conservancy to the Employee's SEP-IRA account.

Continue Group Health Plan Coverage

You may have the right to continue health care coverage for yourself, Spouse or 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 this summary plan description and the Evidence of Coverage statement available from Blue Shield of California for more information on your rights to continue group health plan coverage under the Cal-COBRA program, as discussed above.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties on 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or 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 annual report regarding SEP-IRA contributions, from the plan, and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to one hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. (29 C.F.R. § 2520.102-3). If you have a Claim which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Your Questions

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

APPENDIX A – HEALTH PREMIUM REIMBURSEMENT PLAN DOCUMENT

THE NATOMAS BASIN CONSERVANCY hereby establishes the NATOMAS BASIN CONSERVANCY HEALTH PREMIUM REIMBURSEMENT PLAN for the benefit of certain employees described herein effective October 1, 2017 ("Effective Date").

ARTICLE I

PURPOSE

This Plan shall be known as the NATOMAS BASIN CONSERVANCY HEALTH PREMIUM REIMBURSEMENT PLAN. This Plan is a welfare benefit plan established to provide health and welfare benefits for the exclusive benefit of certain employees of the Employer. These benefits are to be provided through group contracts with third party insurers or an arrangement in the nature of a prepaid health care plan that is regulated under federal or state law in a manner similar to the regulation of insurance companies. The Plan is intended as a self-insured health reimbursement arrangement to provide reimbursement of health insurance premiums. The Plan is intended to qualify as an accident and health plan and a group health plan under applicable provisions of the Code, and as a health reimbursement arrangement. It is further intended that the benefits paid to eligible employees be excluded from their gross income pursuant to Section 105(b) of the Code.

ARTICLE II

DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context:

2.1 **Benefits**. "Benefits" shall refer to benefits available to Participants in accordance with Section 4.1 of this Plan.

2.2 **Board of Directors**. "Board of Directors" shall refer collectively to the members of the Board of Directors of the Employer.

2.3 **Claims Administrator.** "Claims Administrator" means any person or entity appointed by the Employer to administer this Plan on its behalf.

2.4 **Code**. "Code" shall mean the Internal Revenue Code of 1986, as may be amended from time to time.

2.5 **Employee**. "Employee" shall refer to an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer

but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; or (d) any self-employed individual. "Employee" shall also refer to any individual who is treated as an employee by a single employer under Sections 414(b), (c), and (m) of the Code. "Employee" shall not include any self-employed individual described in Section 401(c) of the Code.

2.6 **Employer**. "Employer" shall refer to the NATOMAS BASIN CONSERVANCY and any successor of such Employer.

2.7 **ERISA**. "ERISA" means the Employee Retirement Income Security Act of 1974.

2.8 **FMLA**. "FMLA" shall refer to the Family and Medical Leave Act of 1993, as amended.

2.9 **Health Benefit Plan**. "Health Benefit Plan" shall refer to any Medicare plan under Title XVIII of the Social Security Act and any Medicare Supplement Insurance policy.

2.10 **Participant**. "Participant" shall refer to an Employee that has satisfied the eligibility requirements of Section 3.1, is eligible to receive Benefits under this Plan and has submitted an election form to the Claim Administrator in accordance with Section 3.2.

2.11 **Plan**. "Plan" shall mean the NATOMAS BASIN CONSERVANCY HEALTH PREMIUM REIMBURSEMENT PLAN, as may be amended from time to time.

2.12 **Plan Administrator**. "Plan Administrator" means the Employer sponsoring the Plan.

2.13 **Plan Year**. "Plan Year" shall mean the twelve (12) month period beginning on January 1 and ending on December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

2.14 **Reimbursement Amount**. "Reimbursement Amount" shall refer to the reimbursement by the Employer to a Participant for Health Benefit Plan premiums actually paid by the Participant. Such Reimbursement Amount shall only be paid upon the Employer receiving satisfactory substantiation of the Participant's payment of such premiums.

2.15 **Spouse**. "Spouse" means a spouse by legal marriage of the Participant.

2.16 **USERRA**. "USERRA" shall refer to the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

ELIGIBILITY AND ENROLLMENT

3.1 **Eligibility and Participation**. This Plan shall cover all Employees enrolled in Medicare subject to the provisions of Section 3.5. An Employee who is eligible to participate in this Plan pursuant to this Section 3.1 shall be eligible to receive Benefits as of the later of the

Effective Date or the date he or she completes an election form pursuant to Section 3.2, and shall be referred to as a Participant.

3.2 Participation. All eligible Participants shall submit a duly completed election form to the Claim Administrator, in the form provided by the Claim Administrator, to commence Participation in the Plan. Participants shall not be required to submit a subsequent election form prior to each Plan Year.

3.3 Termination of Participation. An Employee will cease to be a Participant when the first of the following occurs:

(a) this Plan terminates; or

(b) the Employee fails to satisfy any requirement necessary to be an eligible Employee, provided that an Employee's participation may continue for purposes of Cal-COBRA coverage, as may be permitted by the Claim Administrator on a uniform and consistent basis under Article VI.

If the Plan terminates, the Employee's loss of Participant status shall occur immediately upon occurrence of the applicable event. If an Employee ceases to be a Participant for any other reason, the Employee's loss of Participant status shall occur at the end of the month in which the applicable event occurs. Any reimbursements from the Plan after termination of participation will be made pursuant to Section 5.5(c).

3.4 FMLA and USERRA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active eligible Employee.

3.5 Integration with Group Health Plan. In the event this Plan covers two or more active Employees of the Employer, such that it is considered a group health plan within the meaning of Section 733(a) of ERISA, the Plan will satisfy following provisions for purposes of integrating this Plan with other group health coverage as required by the regulations at 29 C.F.R. 2590.715-2711(d)(5)(iv):

(a) the Employer shall offer a group health plan (other than this Plan or other account-based plan, and other than one that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(b) Participants in the Plan shall actually be enrolled Medicare Part B or D;

(c) the Plan shall be available only to employees who are enrolled in Medicare Part B or D; and

(d) the Plan shall comply with the forfeiture and waiver provisions of the integration rules set out at Treas. Reg. § 54.9815-2711(d)(2)(i)(E) and Treas. Reg. § 54.9815-2711(d)(2)(ii)(D).

ARTICLE IV
BENEFITS AND CONTRIBUTIONS

4.1 Benefits. Each Participant shall be entitled to a Reimbursement Amount from the Employer to reimburse the Participant for the premium(s) for the Health Benefit Plan in which the Participant enrolls in for the Plan Year.

(a) Substantiation. The Reimbursement Amount is intended for the purpose of reimbursing a Participant for Health Benefit Plan premiums actually paid by the Participant and shall only be paid upon the Employer receiving satisfactory substantiation, determined in the discretion of the Employer, of the Participant's payment of the premiums.

4.2 Establishment of Account. The Claim Administrator will establish and maintain an account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) Crediting of Accounts. A Participant's account will be credited each calendar month during a Plan Year with an amount equal to the monthly premium cost for the Health Benefit Plan in which the Participant is enrolled. No amount shall be credited for a calendar month, however, if the Participant is not still an eligible Employee on the first day of that calendar month.

(b) Debiting of Accounts. A Participant's account will be debited during each Plan Year for any reimbursement of Health Benefit Plan premiums incurred during the Plan Year.

4.3 Employer and Participant Contributions.

(a) Employer Contributions. The Employer shall bear the entire cost of providing the Benefits available under this Plan.

(b) Participant Contributions. There are no Participant contributions permitted to the Plan for Benefits provided under the Plan.

(c) No Funding Under Cafeteria Plan. Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions under a cafeteria plan be treated as Employer contributions to the Plan.

4.4 Funding. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Claim Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or

security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

4.5 Nondiscrimination. Reimbursements to Highly Compensated Individuals, as defined under Code §105(h), may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Claim Administrator in its sole discretion.

ARTICLE V
ADMINISTRATION

5.1 Allocation of Responsibility for Administration.

(a) Claim Administrator. The Claim Administrator shall have only those powers, duties, responsibilities and obligations as are specifically given to the Claim Administrator under the Plan or under any administration agreement between the Claim Administrator and the Employer.

(b) Employer Responsibilities. The Employer shall have the sole responsibility for making the contributions provided for under Article IV and shall have the sole authority to amend or terminate, in whole or in part, the Plan at any time. The Employer shall be the named fiduciary for the Plan for purposes of ERISA Section 402(a).

(c) Administrator's Responsibilities. The Claim Administrator shall have the sole responsibility for the administration of the Plan, as set forth herein. The Claim Administrator warrants that any directions given, information furnished, or action taken by him or her shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. The Claim Administrator shall be responsible for the proper exercise of his, her or its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another employee. Neither the Claim Administrator nor the Employer makes any guarantee to any Participant for any loss or other event because of Participant's participation in the Plan.

(d) Transfer of Duties. The Employer may, at any time, assign all or any portion of the Claim Administrator's duties to a third party.

5.2 Powers and Duties of Claim Administrator.

(a) Powers and Duties Delegated to Claim Administrator. The Claim Administrator shall supervise the administration of the Plan. The Claim Administrator shall be responsible for ensuring that the terms and conditions of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan without discrimination. The Claim Administrator shall have full power to administer the Plan, subject to the applicable requirements of the law and any administration agreement executed by and between the Employer and Claim Administrator. For this purpose, the Claim Administrator's powers shall include the following:

(1) to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any Benefits hereunder;

(2) to prescribe the procedures for Participants to follow in filing applications for Benefits and to prepare forms to be used by Participants;

(3) to prepare and distribute, in such manner as the Claim Administrator determines appropriate, information explaining the Plan;

(4) to receive from the Employer, Participants and other persons, such information as shall be necessary for the proper administration of the Plan;

(5) to furnish to the Employer and Participants, upon request, annual reports detailing the administration of the Plan;

(6) to receive, review and keep on file such records pertaining to the Plan as the Claim Administrator deems convenient and proper;

(7) to allocate his, her or its administrative responsibilities;

(8) to appoint or employ individuals and any other agents the Claim Administrator deems advisable, including legal and actuarial counsel, to assist in the administration of the Plan;

(9) to adopt such rules as the Claim Administrator deems necessary, desirable or appropriate, subject to applicable laws. All rules and decisions of the Claim Administrator shall be uniformly and consistently applied to all Participants in similar circumstances; and

(10) to take all other steps necessary to properly administer the Plan in accordance with its terms and conditions and the requirements of applicable laws.

(b) Powers and Duties Not Delegated to Claim Administrator. The Claim Administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any Benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for Benefits under the Plan, except as may be expressly provided herein. Interpretations of the provisions of the Plan shall not be deemed to be additions, subtractions, or modifications of the Plan.

5.3 Indemnification of Employee Administrator. The Employer agrees to indemnify any Employee serving as Claim Administrator (including any Employee or former Employee who formerly served as Claim Administrator), against any and all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by Board of Directors) occasioned by any act or omission to act in connection with the Plan, if such act or omission is made in good faith pursuant to the provisions of

the Plan and not as a result of the Claim Administrator's gross negligence or willful misconduct.

5.4 Claims Procedure for Insured Benefits. All claims for benefits that are provided through insurance contracts, whether such contracts are between an insurer and the Employer or an insurer and Participant, shall be made by filing a claim for benefits in accordance with the claims procedure set forth under the insurance contract. The Employer does not have the authority or responsibility for processing, reviewing, or paying such claims. All disputes regarding those claims shall be resolved in accordance with the procedures set forth in the separate contract concerning those benefits.

5.5 Reimbursement Procedure.

(a) **Timing**. Within thirty (30) days after receipt by the Claim Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Benefit Plan premiums (if the Claim Administrator approves the claim), or the Claim Administrator will notify the Participant that his or her claim has been denied. The thirty (30)-day time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claim Administrator, including in cases where a reimbursement claim is incomplete. The Claim Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

(b) **Claims Substantiation**. A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Claim Administrator in such form as the Claim Administrator may prescribe, by no later than sixty (60) days following the date the Health Benefit Plan premium expense was incurred, setting forth (i) the nature and date of the expense so incurred; (ii) the amount of the requested reimbursement; and (iii) a statement that such expense has not otherwise been reimbursed and are not reimbursable through any other source. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Claim Administrator may request.

(c) **Reimbursements After Termination; Cal-COBRA**. When a Participant ceases to be a Participant under Section 3.3, the Participant will not be able to receive reimbursements for Health Benefit Plan premium expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Health Benefit Plan premiums incurred during the Plan Year prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim within ninety (90) days following the date on which the expense arose. Notwithstanding any provision to the contrary in this Plan, to the extent required by Section 1366.20 et. seq. of the California Health and Safety Code (the "California Continuation Benefits Replacement Act- or "Cal-COBRA"), the Participant whose coverage terminates under the Plan because of a Cal-COBRA

qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the Plan on the day before the qualifying event for the periods prescribed by Cal-COBRA (subject to all conditions and limitations under Cal-COBRA).

(d) **Claims Denied**. If a claim for reimbursement under this Plan is wholly or partially denied, a Participant may appeal such decision to the Board of Directors in accordance with the claims procedure set forth in this Summary Plan Description. An external review process generally does not apply to the type of benefits provided under this HRA Plan, and shall otherwise be provided only when legally required.

ARTICLE VI

AMENDMENT; TERMINATION

6.1 **Amendment**. The Plan may be amended by the Board of Directors at any time and from time to time by a written resolution adopted by a majority of the Board of Directors.

6.2 **Termination**. The Plan may be terminated at any time by the Employer. Termination of the Plan shall be effected by a written resolution adopted by a majority of the Board of Directors.

ARTICLE VII

MISCELLANEOUS

7.1 **Non-Assignability and Facility of Payment**. Benefits payable under the Plan are not in any way subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, transferred or assigned to any person or persons other than the provider or providers of such Benefits. When any person entitled to Benefits under the Plan is under a legal disability or, in the Claim Administrator's opinion, is unable to manage his or her affairs, then, to the extent permitted under the applicable group contract, the Claim Administrator may cause his or her benefit to be paid to his or her legal representative for his or her benefit, or to be applied for his or her benefit in any other manner that the Claim Administrator may determine.

7.2 **Mistake of Fact**. Any misstatement or any other mistake of fact in any notice or other document filed with the Employer or Claim Administrator shall be corrected when it becomes known and proper adjustment made by reason thereof. Neither the Employer nor the Claim Administrator shall be liable in any manner for any determination of fact made in good faith.

7.3 **Source of Payments**. The Employer shall be the sole source of Benefits under the Plan. No Participant shall have any right to, or interest in, any assets of the Employer except as provided from time to time under the Plan, and then only to the extent of the Benefits which are payable under the Plan to such Participant.

7.4 **Status of Benefits**. The Employer believes that this Plan is written in accordance with Section 105 of the Code and that it provides certain benefits to Participants which are free

from Federal income tax under the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

7.5 **Applicable Law**. This Plan, as amended from time to time, shall be administered, construed and enforced according to the laws of the State of California, to the extent not superseded by the Code, ERISA, or any other federal law.

7.6 **Employment Rights**. Employment rights of an employee shall not be deemed to be enlarged or diminished by reason of the establishment of this Plan, nor shall any provisions of this Plan be deemed to confer any right upon any employee to be retained in the service of the Employer.

7.7 **Construction**. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine or neuter gender, and the singular shall be deemed to include the plural, and vice-versa, unless the context clearly indicates to the contrary. The words "hereof," "herein," "hereunder" and other similar compounds of the word "here" shall mean and refer to the entire Plan and not to any particular provision or Section.

APPENDIX B – UNUM LONG TERM POLICY

See attached policy.

GROUP INSURANCE POLICY
NON-PARTICIPATING

POLICYHOLDER: The Natomas Basin Conservancy

POLICY NUMBER: 144773 001

POLICY EFFECTIVE DATE: August 1, 2011

POLICY ANNIVERSARY DATE: August 1

GOVERNING JURISDICTION: California

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under the policy. Unum makes this promise subject to all of the policy's provisions.

The **Policyholder** should read the policy carefully and contact Unum promptly with any questions. The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

SCHEDULE OF BENEFITS LTD-SCHED-1

LONG TERM DISABILITY PLAN LTD-SCHED-1

BENEFITS AT A GLANCE ..... B@G-LTD-1

LONG TERM DISABILITY PLAN ..... B@G-LTD-1

COMPULSORY PROVISIONS CP-1

POLICYHOLDER PROVISIONS EMPLOYER-1

CERTIFICATE SECTION CC.FP-1

GENERAL PROVISIONS EMPLOYEE-1

LONG TERM DISABILITY LTD-BEN-1

BENEFIT INFORMATION LTD-BEN-1

OTHER BENEFIT FEATURES LTD-OTR-1

STATE REQUIREMENTS ..... STATE REQ-1

OTHER SERVICES SERVICES-1

GLOSSARY GLOSSARY-1

SCHEDULE OF BENEFITS

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for **you** by paying a portion of your income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before your **disability** began. In some cases, **you** can receive disability payments even if **you** work while **you** are disabled. Your **disability** must begin while **you** are covered under the long term disability plan.

All terms **bolded** are defined in the **GLOSSARY** section.

You must write your name and the date **you** received this certificate in the space provided so that it becomes your certificate of coverage. The date **you** are eligible for coverage is described in the **GENERAL PROVISIONS** section.

EMPLOYEE NAME:

DATE RECEIVED:

ELIGIBLE GROUP(S):

All Employees in **active employment** in the United States with the **Employer**.

Temporary and seasonal workers are excluded from coverage.

DISABILITY COVERED:

Total Disability and **Partial Disability**

For definition of **disability** refer to "***WHEN ARE YOU TOTALLY DISABLED?***" and "***WHEN ARE YOU PARTIALLY DISABLED?***" in the **BENEFIT INFORMATION** section.

Some disabilities may not be covered or may have limited coverage under this long term disability plan.

MAXIMUM MONTHLY BENEFIT:

60% of **monthly pre-disability earnings** to a maximum benefit of $6,000 per month.

Your payment will be reduced by **benefit reductions** and **disability earnings**. Refer to "***WHAT ARE BENEFIT REDUCTIONS?***" in the **BENEFIT INFORMATION** section for income sources that qualify for **benefit reductions**.

ELIMINATION PERIOD:

180 days

This is the period of **disability** which must be satisfied before **you** are eligible to receive benefits.

MAXIMUM PERIOD OF PAYMENT (for **total disability** and **partial disability** combined):

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

No premium payments are required for your coverage while **you** are receiving payments under this long term disability plan.

TOTAL BENEFIT CAP:

The total benefit payable to **you** on a monthly basis (including all benefits provided under this long term disability plan) will not exceed 100% of your **monthly pre-disability earnings** or your **maximum monthly benefit**.

The above items are only highlights of this long term disability plan. For a full description of your coverage, continue reading your certificate of coverage section.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for **you** by paying a portion of your income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before your **disability** began. In some cases, **you** can receive disability payments even if **you** work while **you** are disabled. Your **disability** must begin while **you** are covered under the long term disability plan.

All terms **bolded** are defined in the **GLOSSARY** section.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: August 1, 2011

POLICY NUMBER: 144773 001

ELIGIBLE GROUP(S):

All Employees in **active employment** in the United States with the **Employer**.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

The **waiting period** is a continuous period of **active employment** which **you** must satisfy before **you** are eligible for coverage.

For **employees** in an eligible group on or before August 1, 2011: None

For **employees** entering an eligible group after August 1, 2011: 90 days of continuous **active employment**

REHIRE:

If your employment ends and **you** are rehired within 12 months, your previous work while in an eligible group will apply toward the **waiting period**. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your **Employer** pays the cost of your coverage.

Your **Employer** includes these contributions in your taxable income.

ELIMINATION PERIOD:

180 days

This is the period of **disability** which must be satisfied before **you** are eligible to receive benefits.

DISABILITY COVERED:

Total Disability and **Partial Disability**

For definition of **disability** refer to "***WHEN ARE YOU TOTALLY DISABLED?***" and "***WHEN ARE YOU PARTIALLY DISABLED?***" in the **BENEFIT INFORMATION** section.

Some disabilities may not be covered or may have limited coverage under this long term disability plan.

MAXIMUM MONTHLY BENEFIT:

60% of **monthly pre-disability earnings** to a maximum benefit of $6,000 per month.

Your payment will be reduced by **benefit reductions** and **disability earnings**. Refer to "***WHAT ARE BENEFIT REDUCTIONS?***" in the **BENEFIT INFORMATION** section for income sources that qualify for **benefit reductions**.

MAXIMUM PERIOD OF PAYMENT (for **total disability** and **partial disability** combined):

Age at Disability	**Maximum Period of Payment**
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

No premium payments are required for your coverage while **you** are receiving payments under this long term disability plan.

TOTAL BENEFIT CAP:

The total benefit payable to **you** on a monthly basis (including all benefits provided under this long term disability plan) will not exceed 100% of your **monthly pre-disability earnings** or your **maximum monthly benefit**.

PRE-EXISTING CONDITION:

Benefits are not payable for any **disability** caused by or resulting from a pre-existing condition, as defined in the policy. To see if your **disability** excludes **you** from receiving benefits due to a pre-existing condition, refer to "***WHAT IS AN EXCLUDED PRE-EXISTING CONDITION?***" in the **BENEFIT INFORMATION** section.

Some disabilities may not be covered or may have limited coverage under this long term disability plan.

The above items are only highlights of this long term disability plan. For a full description of your coverage, continue reading your certificate of coverage section.

COMPULSORY PROVISIONS

Entire Contract

This policy (the application of the **Employer**, if any, and the individual applications, if any, of the **employees**) constitute(s) the entire contract between the parties, and any statement made by the **Employer** or by any **employee** shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the **Employer**, except a fraudulent misstatement, be used at all to void this policy after it has been in force for two years from the date of its issue, nor shall any such statement of any **employee** eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or **disability** (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective.

No change in this policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses

(c) No claim for loss incurred or **disability** (as defined in the policy) commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period

A **grace period** of 31 days will be granted for the payment of premiums accruing after the first premium, during which **grace period** the policy shall continue in force, but the **Employer** shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

Notice of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at Unum Life Insurance Company of America, 655 North Central Avenue, Suite 900, Glendale, CA 91203, or to any authorized agent of the insurer, with information sufficient to identify the insured **employee**, shall be deemed notice to the insurer.

Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the **employee**, later than one year from the time proof is otherwise required.

Evidence of Continuing Disability

Once Unum approves your claim **you** will be asked to provide evidence of continuing **disability** at reasonable intervals based on your condition. Evidence of continuing **disability** means documentation of your condition that is sufficient to allow **us** to determine if **you** are still disabled. Upon request, **you** will be asked to provide evidence of continuing **disability** within 45 days. If evidence is not provided within that period of time, Unum will contact your **physician** in an effort to obtain the necessary documentation. If **you** do not submit evidence of continuing **disability** and Unum is unable to obtain the necessary documentation from your **physician** or from a reasonably requested examination by a **physician** of **our** choice, your payments will end. Upon receipt of evidence of continuing **disability**, benefit payments will resume subject to the terms of the policy. **We** will send **you** a payment for any period for which Unum is liable.

Time of Payment of Claims

Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid (to the insured **employee**) as they accrue and any balance remaining unpaid at termination of the period of liability will be paid (to the insured **employee**) immediately upon receipt of due written proof.

Physical Examinations

The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose **injury** or **sickness** is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Cancellation

The insurer may cancel this policy at any time by written notice delivered to the **Employer**, or mailed to his last address as shown on the records of the insurer, stating when, not less than 31 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the **Employer** may cancel this policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either the insurer or the **Employer**, the insurer shall promptly return on a prorata basis the unearned premium paid, if any, and the **Employer** shall promptly pay on a prorata basis the earned premium which has not been paid. (In computing the prorata premium to be returned by the insurer or to be paid by the **Employer**, any discounts in premium or premium rate actually allowed to the **Employer** because of the longer periods for which premiums, at the time of the cancellation, had been paid or agreed to be paid shall be disregarded, and the prorata return or payment of premium will be computed upon the basis of the insurer's regular and customary premium or premium rate for the coverage of this policy.) Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Illegal Occupation or Commission of a Felony

The insurer shall not be liable for any loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose **injury** or **sickness** is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation.

POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

LONG TERM DISABILITY

The initial premium for each long term disability plan is based on the initial rate(s) shown in the Rate Information Amendment(s).

WAIVER OF PREMIUM

Unum does not require premium payments for an **insured** while he or she is receiving Long Term Disability payments under the policy.

INITIAL RATE GUARANTEE

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THE POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Policyholder** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The **Policyholder** must provide Unum with the following on a regular basis:

- information about **employees**:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on the policy will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an **employee** from receiving coverage;
- affect the amount of an **insured's** coverage; or
- cause an **employee's** coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THE POLICY OR A LONG TERM DISABILITY PLAN UNDER THE POLICY?

This policy or a long term disability plan under this policy can be cancelled:

- by Unum; or
- by the **Policyholder**.

Unum may cancel or offer to modify this policy or a long term disability plan if:

- there is less than 100% participation of those eligible **employees** who pay all or part of their premium for a long term disability plan; or
- there is less than 100% participation of those eligible **employees** for a **Policyholder** paid long term disability plan;
- the **Policyholder** does not promptly provide Unum with information that is reasonably required;
- the **Policyholder** fails to perform any of its obligations that relate to this policy;
- fewer than 2 **employees** are insured under a long term disability plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the **Policyholder**, the **employee**, or both, pays the premiums;
- the **Policyholder** does not promptly report to Unum the names of any **employees** who are added or deleted from the eligible group;
- there is a significant change in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the **Policyholder** and/or its **employees**; or
- the **Policyholder** fails to pay any portion of the premium within the 31 day **grace period**.

If Unum cancels or modifies this policy or a long term disability plan, for reasons other than the **Policyholder's** failure to pay premium, a written notice will be delivered to the **Policyholder** at least 31 days prior to the cancellation date or modification date. The **Policyholder** may cancel this policy or a long term disability plan if the modifications are unacceptable.

If any portion of the premium is not paid during the **grace period**, Unum will either cancel or modify this policy or the long term disability plan automatically at the end of the **grace period**. The **Policyholder** is liable for premium for coverage during the **grace period**. The **Policyholder** must pay Unum all premium due for the full period each long term disability plan is in force. Unum will not cancel the policy or a long term disability plan during a period for which the **Policyholder** has paid premium.

The **Policyholder** may cancel the policy or a long term disability plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the **Policyholder** and Unum agree, the policy or a long term disability plan can be cancelled on an earlier date. If Unum or the **Policyholder** cancels the policy or a long term disability plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a long term disability plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THE POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the **employee's** coverage in accordance with the **Policyholder's** Human Resource policy on family and medical leaves of absence if premium payments continue and the **Policyholder** approved the **employee's** leave in writing.

Coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If the **Policyholder's** Human Resource policy doesn't provide for continuation of an **employee's** coverage during a family and medical **leave of absence**, the **employee's** coverage will be reinstated when he or she returns to **active employment**.

We will not:

- apply a new **waiting period**; or
- apply a new pre-existing conditions exclusion; or
- require **evidence of insurability**.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

NAME/LOCATION (CITY AND STATE)

None

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes **you** as a client.

This is your certificate of coverage as long as **you** are eligible for coverage and **you** become insured. **You** will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If **you** have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist **you** in any way to help **you** understand your benefits.

If the terms and provisions of the certificate of coverage (issued to **you**) are different from the policy (issued to the **Policyholder**), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the **Policyholder's** address.

Policyholder's Name: The Natomas Basin Conservancy
Policy Number: 144773 001
Policyholder's Original Plan Effective Date: August 1, 2011
Long Term Disability Plan: August 1, 2011

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells **you**:

- the coverage for which **you** may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply to your coverage.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If **you** are working for your **Employer** in an eligible group, the date **you** are eligible for coverage is the later of:

- the **Policyholder's** original effective date of coverage; or
- the day after **you** complete your **waiting period**.

WHAT IS AN ELIGIBLE GROUP?

All Employees in **active employment** in the United States with the **Employer**.

Temporary and seasonal workers are excluded from coverage.

WHAT IS YOUR WAITING PERIOD?

The **waiting period** is a continuous period of **active employment** which **you** must satisfy before **you** are eligible for coverage.

For **employees** in an eligible group on or before August 1, 2011: None

For employee**s** entering an eligible group after August 1, 2011: 90 days of continuous **active employment**

REHIRE:

If your employment ends and **you** are rehired within 12 months, your previous work while in an eligible group will apply toward the **waiting period**. All other policy provisions apply.

WHEN DOES YOUR COVERAGE BEGIN?

When your **Employer** pays 100% of the cost of your coverage **you** will be covered at 12:01 a.m. on the date **you** are eligible for coverage.

When **you** and your **Employer** share the cost of your coverage or when **you** pay 100% of the cost yourself, **you** will be covered at 12:01 a.m. on the latest of:

- the date **you** are eligible for coverage, if **you** apply for insurance on or before that date; or
- the date **you** apply for insurance, if **you** apply within 31 days after your eligibility date; or
- the date Unum approves your application, if **evidence of insurability** is required.

Evidence of insurability is required if **you**:

- are a **late applicant**, which means **you** apply for coverage more than 31 days after the date **you** are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An **evidence of insurability** form can be obtained from your **Employer**.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If **you** are absent from work due to **injury**, **sickness**, temporary **layoff** or **leave of absence**, your coverage will begin on the date **you** return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If **you** are on a temporary **layoff**, and if premium is paid, **you** will be covered through the end of the month that immediately follows the month in which your temporary **layoff** begins.

If **you** are on a **leave of absence**, and if premium is paid, **you** will be covered through the end of the month that immediately follows the month in which your **leave of absence** begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** or if **you** are on a covered **layoff** or **leave of absence**. If **you** are not in **active employment** due to **injury** or **sickness**, any increased or additional coverage will begin on the date **you** return to **active employment**.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage(s) under the policy ends on the earliest of:

- the date the policy or your coverage under the policy is cancelled;
- the date **you** no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which **you** made any required contributions; or
- the last day **you** are in **active employment**.

However, coverage will continue:

- while benefits are being paid;
- while **you** are fulfilling the requirements of your **elimination period**, so long as premium is being paid; or
- in accordance with the **layoff** and **leave of absence** provisions of the policy.

Unum will provide coverage for a **payable claim** which occurs while **you** are covered under the policy.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

In addition, submission of false information in connection with the claim form may also constitute a crime under federal laws. Unum will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your **Employer** acts on its own behalf as your agent or as Unum's agent for the limited purpose of individualizing certificates and providing contact information at time of claim. Under no other circumstance will your **Employer** be deemed the agent of Unum.

LONG TERM DISABILITY

BENEFIT INFORMATION

WHEN ARE YOU TOTALLY DISABLED?

For the first 30 months, **you** are **totally disabled** when, as a result of **sickness** or **injury**, **you** are unable to perform with reasonable continuity the **substantial and material acts** necessary to pursue your **usual occupation** in the usual and customary way.

After benefits have been paid for 24 months of **disability you** are **totally disabled** when, as a result of **sickness** or **injury**, **you** are not able to engage with reasonable continuity in any occupation in which **you** could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.

The loss of a professional or occupational license or certification does not, in itself, constitute **disability**.

WHEN ARE YOU PARTIALLY DISABLED?

You are **partially disabled** when **you** are not **totally disabled** and that while actually working in your **usual occupation**, as a result of **sickness** or **injury you** are unable to earn 80% or more of your **indexed monthly pre-disability earnings**.

After benefits have been paid for 24 months **you** are **partially disabled** when **you** are not **totally disabled** and that while actually working in an occupation, as a result of **sickness** or **injury you** are unable to engage with reasonable continuity in that or in any other occupation in which **you** could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.

The loss of a professional or occupational license or certification does not, in itself, constitute **disability**.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your **disability** as continuous if your **disability** stops for 30 days or less during the **elimination period**. The days that **you** are not disabled will not count toward your **elimination period**.

Your **elimination period** is 180 days.

This is the period of **disability** which must be satisfied before **you** are eligible to receive benefits.

HOW WILL UNUM DETERMINE YOUR ELIGIBILITY FOR BENEFITS?

Unum, and not your **Employer** or plan administrator, has the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits for any claim **you** make on the policy. **We** will:

- obtain, with your cooperation and authorization if required by law, only such information that is necessary to evaluate your claim and decide whether to accept or deny your claim for benefits. **We** may obtain this information from your notice of claim, submitted proofs of loss, statements, or other materials provided by **you** or others on your behalf; or, at **our** expense we may obtain necessary information, or have **you** physically examined when and as often as **we** may reasonably require while the claim is pending. In addition, and at your option and at your expense, **you** may provide **us** and **we** will consider any other information, including but not limited to, reports from a **physician** or other expert of your choice. **You** should provide **us** with all information that **you** want **us** to consider regarding your claim;
- consider and interpret the policy and all information obtained by **us** and submitted by **you** that relates to your claim for benefits and make **our** determination of your eligibility for benefits based on that information and in accordance with the policy and applicable laws;
- if **we** approve your claim, review **our** decision to approve your claim for benefits as often as is reasonably necessary to determine your continued eligibility for benefits; and
- if **we** deny your claim, explain in writing to **you** the basis for an adverse determination in accordance with the policy as described in the provision entitled "***WHAT NOTIFICATION WILL YOU RECEIVE IF YOUR CLAIM IS DENIED?***"

In the event **we** deny your claim for benefits, in whole or in part, **you** can appeal the decision to **us**. If **you** choose to appeal **our** decision, the process **you** must follow is set forth in the policy provision entitled "***WHAT RECOURSE DO YOU HAVE IF YOUR CLAIM IS DENIED?***" If **you** do not appeal the decision to **us**, then the decision will be Unum's final decision.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If **you** are working while **you** are disabled, the days **you** are disabled will count toward your **elimination period**.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when **we** approve your claim, providing the **elimination period** has been met. **We** will send **you** a payment monthly for any period for which Unum is liable.

ONCE PAYMENTS BEGIN MUST YOU CONTINUE TO BE UNDER THE REGULAR CARE OF A PHYSICIAN?

You must be under the **regular care** of a **physician** unless **regular care**:

- will not improve your disabling condition(s); or
- will not prevent a worsening of your disabling condition(s).

HOW WILL UNUM CALCULATE YOUR DISABILITY PAYMENT IF YOU ARE TOTALLY DISABLED?

If **you** are **totally disabled** and have an earnings loss of 20% or greater due to the same **disability**, **we** will follow this process to calculate your **monthly payment**.

1. Multiply your **monthly pre-disability earnings** by 60%.
2. The **maximum monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the **maximum monthly benefit**. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your **gross disability payment** any **benefit reductions**. This is your **monthly payment**.
5. Your **monthly payment** will be adjusted by any **disability earnings** as follows:

    a. During the first 12 months of payments, while working, add your monthly **disability earnings** to your **gross disability payment**.

    If the answer from Item 5a is less than or equal to 100% of your **indexed monthly pre-disability earnings**, Unum will not further reduce your **monthly payment**.

    If the answer from Item 5a is more than 100% of your **indexed monthly pre-disability earnings**, Unum will subtract the amount over 100% from your **monthly payment**.

    b. After 12 months of payments, while working, **we** will subtract 50% of your **disability earnings** from your **monthly payment**.

Refer to "***WHAT ARE BENEFIT REDUCTIONS?***" in the **BENEFIT INFORMATION** section for income sources that qualify for **benefit reductions**.

Unum may require **you** to send proof of your monthly **disability earnings** at least quarterly if these records are not available from your **Employer**. **We** will adjust your payment based on your quarterly **disability earnings**.

After the **elimination period**, if **you** are disabled for less than 1 month, **we** will send **you** 1/30 of your payment for each day of **disability**.

HOW WILL UNUM CALCULATE YOUR DISABILITY PAYMENT IF YOU ARE PARTIALLY DISABLED?

If **you** are **partially disabled** and have an earnings loss of 20% or greater due to the same **disability**, **we** will follow this process to calculate your **monthly payment**.

1. Multiply your **monthly pre-disability earnings** by 60%.
2. The **maximum monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the **maximum monthly benefit**. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your **gross disability payment** any **benefit reductions**. This is your **monthly payment**.
5. Your **monthly payment** will be adjusted by any **disability earnings** as follows:

    a. During the first 12 months of payments, while working, add your monthly **disability earnings** to your **gross disability payment**.

If the answer from Item 5a is less than or equal to 100% of your **indexed monthly pre-disability earnings**, Unum will not further reduce your **monthly payment**.

If the answer from Item 5a is more than 100% of your **indexed monthly pre-disability earnings**, Unum will subtract the amount over 100% from your **monthly payment**.

b. After 12 months of payments, while working, **we** will subtract 50% of your **disability earnings** from your **monthly payment**.

Refer to "***WHAT ARE BENEFIT REDUCTIONS?***" in the **BENEFIT INFORMATION** section for income sources that qualify for **benefit reductions**.

Unum may require **you** to send proof of your monthly **disability earnings** at least quarterly if these records are not available from your **Employer**. **We** will adjust your payment based on your quarterly **disability earnings**.

After the **elimination period**, if **you** are disabled for less than 1 month, **we** will send **you** 1/30 of your payment for each day of **disability**.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY PRE-DISABILITY EARNINGS OR MAXIMUM MONTHLY BENEFIT?

The total benefit payable to **you** on a monthly basis (including all benefits provided under this long term disability plan) will not exceed 100% of your **monthly pre-disability earnings** or your **maximum monthly benefit**.

WHAT ARE YOUR MONTHLY PRE-DISABILITY EARNINGS?

"**Monthly Pre-disability Earnings**" means your average gross monthly income as figured:

a. from the income box on your W-2 form which reflects wages, tips and other compensation received from your **Employer** for the calendar year just prior to your date of **disability**; or

b. for the period of your employment with your **Employer** if **you** did not receive a W-2 form prior to your date of **disability**.

Average gross monthly income is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from car, housing or moving allowances, **Employer** contributions to a qualified deferred compensation plan, or income received from sources other than your **Employer**.

WHAT WILL WE USE FOR MONTHLY PRE-DISABILITY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If **you** become disabled while **you** are on a covered **layoff** or **leave of absence**, **we** will use your **monthly pre-disability earnings** from your **Employer** in effect just prior to the date your absence begins.

WHAT HAPPENS IF YOUR DISABILITY EARNINGS FLUCTUATE WHILE YOU ARE DISABLED?

If your **disability earnings** routinely fluctuate widely from month to month, Unum will average your **disability earnings** over the most recent 3 months to determine if your claim should continue. **We** will not use this average to determine your **monthly payment**.

If Unum averages your **disability earnings**, **we** will not terminate your claim unless the average of your **disability earnings** from the last 3 months exceeds 80% of **indexed monthly pre-disability earnings**.

We will not pay **you** for any month during which **disability earnings** exceed the amount allowable under the long term disability plan.

WHAT ARE BENEFIT REDUCTIONS?

Unum will only subtract **benefit reductions** which are paid or to which **you** are entitled, in accordance with the provision "***WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR BENEFIT REDUCTIONS?***", as a result of the same **disability** and inability to work as that claimed under the policy. Unum will subtract from your **gross disability payment** the following **benefit reductions**:

1. The amount that **you** receive or are entitled to receive as a temporary disability benefit under a workers' compensation **law**.

2. The amount that **you** receive or are entitled to receive under an occupational disease **law** or any other **act** or **law** with similar intent, other than workers' compensation.

3. The amount that **you** receive or are entitled to receive as disability income payments under any state compulsory benefit **act** or **law**.

4. The amount that **you** receive as disability income payments under any governmental retirement system as a result of your job with your **Employer**.

5. The amount that **you**, your dependent spouse and children receive or are entitled to receive as disability payments because of your **disability** under:

   - the United States Social Security **Act**.
   - the Canada Pensions **Plan**.
   - the Quebec Pension **Plan**.
   - any similar **plan** or **act**.

6. The amount that **you** receive as disability payments under your **Employer's retirement plan**.

Disability payments under a **retirement plan** will be those benefits which are paid due to **disability** and do not reduce the retirement benefit which would have been paid if the **disability** had not occurred.

We will not reduce your benefit by amounts rolled over or transferred to any eligible **retirement plan**.

7. The amount that **you** receive as disability payments under Title 46, United States Code Section 688 (The Jones **Act**).

If **you** receive a lump sum payment from any **benefit reductions**, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, **we** will use a reasonable one.

WHAT ARE NOT BENEFIT REDUCTIONS?

Unum will not subtract from your **gross disability payment** income **you** receive from, but not limited to, the following:

- 401(k) **plans**
- profit sharing **plans**
- thrift **plans**
- tax sheltered annuities
- stock ownership **plans**
- non-qualified **plans** of deferred compensation
- pension **plans** for partners
- military pension and disability income **plans**
- credit disability insurance
- franchise disability income **plans**
- individual retirement accounts (IRA)
- individual disability income **plans**
- **salary continuation or accumulated sick leave plans**

WHAT IF SUBTRACTING BENEFIT REDUCTIONS RESULTS IN A BENEFIT OF LESS THAN $100 OR 10% OF YOUR GROSS DISABILITY PAYMENT?

The **monthly payment** will be the greater of:

- $100; or
- 10% of your **gross disability payment**.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM BENEFIT REDUCTIONS?

Once Unum has subtracted any **benefit reductions** from your **gross disability payment**, Unum will not further reduce your payment due to a cost of living increase from that source.

MUST YOU APPLY FOR BENEFITS LISTED IN THE BENEFIT REDUCTIONS SECTION?

If **you** are entitled to benefits under Item(s) 1, 2, 3 and 5 in the **benefit reductions** section, **you** have an obligation to apply for those benefits.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR BENEFIT REDUCTIONS?

When **we** have both a reasonable, good faith belief that **you** are entitled to benefits under Item(s) 1, 2, 3 and 5 , in the **benefit reductions** section and **we** have a means of reasonably estimating the amount payable, **we** will reduce your benefits in accordance with the provision "***HOW WILL UNUM CALCULATE YOUR DISABILITY PAYMENT IF YOU ARE TOTALLY OR PARTIALLY DISABLED***?", if:

- **you** have not applied for such benefits; or
- **you** have applied for such benefits but have not pursued your application with reasonable diligence.

Your Long Term Disability payment will NOT be reduced by the estimated amount if **you** apply for the disability payments under Item(s) 1, 2, 3 and 5 , in the **benefit reductions** section and pursue these benefits with reasonable diligence.

If your payment has been reduced by an estimated amount, your payment will be adjusted when **we** receive proof of the amount awarded.

If **you** receive a lump sum payment from any **benefit reduction**, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given.

If no time period is stated, **we** will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send **you** a payment each month up to the **maximum period of payment**. Your **maximum period of payment** for **total disability** and **partial disability** combined is based on your age at **disability** as follows:

Age at Disability	**Maximum Period of Payment**
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

WHEN WILL PAYMENTS STOP?

We will stop sending **you** payments and your claim will end on the earliest of the following:

- the end of the **maximum period of payment**;
- the date **you** are no longer disabled under the terms of the long term disability plan;
- when **you** fail to comply with the **Evidence of Continuing Disability** section;
- the date **you** fail to submit to any reasonable request to be examined by a **physician** of **our** choice without just cause;
- the date the most recent 3 month average of your **disability earnings** exceed 80% of your **monthly pre-disability earnings** if **you** are **totally disabled** or **partially disabled**;
- the date **you** die.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of funds that qualify for **benefit reductions**.

You must reimburse **us** in full. **We** will work with **you** to determine an appropriate method by which the repayment is to be made.

Unum will not recover more money than the amount **we** paid **you**.

WHAT IS THE LIMITED BENEFIT PERIOD FOR MENTAL DISORDERS?

MENTAL DISORDER means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a **disability**. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a **disability**.

Disabilities, due solely to **mental disorders** are limited to a maximum pay period of 24 months.

Unum will continue to send **you** payments beyond the 24 month period if **you** meet one or both of these conditions:

1. If **you** are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send **you** payments during your confinement.

   If **you** are still disabled when **you** are discharged, Unum will send **you** payments for a recovery period of up to 90 days.

   If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that

additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if, after the 24 month period for which **you** have received payments, **you** continue to be disabled and subsequently become confined to a **hospital or institution** for at least 14 days in a row, Unum will send payments during the length of the reconfinement.

Unum will not pay beyond the limited benefit period as indicated above, or the **maximum period of payment**, whichever occurs first.

Unum will not apply the **mental disorder** limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR LONG TERM DISABILITY PLAN?

Your long term disability plan does not cover any disabilities caused by or resulting from your:

- intentionally self-inflicted **injuries**.
- active participation in a riot.
- commission of a felony for which **you** have been convicted.
- war, declared or undeclared, or any act of war.
- excluded pre-existing condition.

The loss of a professional or occupational license or certification does not, in itself, constitute **disability**.

WHAT PRE-EXISTING CONDITIONS ARE EXCLUDED?

You have an excluded pre-existing condition if:

- **you** received medical treatment, care or services for a diagnosed condition, or took prescribed drugs or prescribed medicines for that condition, in the 12 months just prior to your effective date of coverage; and
- the **disability** begins in the first 24 months after your effective date of coverage unless **you** have been treatment free for 12 consecutive months after your effective date of coverage.

No claim for **disability** commencing after 2 years from your effective date of coverage shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to your effective date of coverage.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

If **you** have a **recurrent disability**, Unum will treat your **disability** as part of your prior claim and **you** will not have to complete another **elimination period** if:

- your prior claim ended when **you** returned to work for your **Employer** and your earnings from your **Employer** exceeded 80% of your **monthly pre-disability earnings**;
- **you** were continuously insured under the long term disability plan for the period between your prior claim and your **recurrent disability**; and
- your **recurrent disability** occurs within 6 months of the end of your prior claim.

Your **recurrent disability** will be subject to the same terms of this long term disability plan as your prior claim.

Any **disability** which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions.

If **you** are no longer covered under the policy and **you** receive payments under any other group long term disability plan offered through your current **Employer**, this provision will no longer apply.

WHAT NOTIFICATION WILL YOU RECEIVE IF YOUR CLAIM IS DENIED?

If your claim is denied, in full or in part, Unum will notify **you** in writing. This notification will include:

- the specific reason for the denial;
- the policy provisions on which the denial is based;
- a description of any additional information necessary to complete the claim and an explanation of why that information is necessary; and
- a description of the policy's procedures and applicable time limits for appeal.

WHAT RECOURSE DO YOU HAVE IF YOUR CLAIM IS DENIED?

You may appeal to **us** for review within 180 days from the receipt of the claim denial. Requests for appeals must be made in writing and should be sent to the address specified in the claim denial. **You** may request access to all relevant documents and will have the opportunity to submit written comments, documents, or other information in support of your appeal.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that **you** have died, **we** will pay your **eligible survivor** a lump sum benefit equal to 3 months of your **gross disability payment** if, on the date of your death:

- your **disability** had continued for 180 or more consecutive days; and
- **you** were receiving or were entitled to receive payments under the long term disability plan.

If **you** have no **eligible survivors**, payment will be made to your estate.

However, **we** will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if **you** have been diagnosed as terminally ill.

We will pay **you** a lump sum amount equal to 3 months of your **gross disability payment** if:

- **you** have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to 12 months or less; and
- **you** are receiving **monthly payments**.

Your right to exercise this option and receive payment is subject to the following:

- **you** must make this election in writing to Unum; and
- your **physician** must certify in writing that **you** have a terminal illness or condition and your life expectancy has been reduced to 12 months or less.

This benefit is available to **you** on a voluntary basis and will only be payable once.

If **you** elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

STATE REQUIREMENTS

CALIFORNIA
CONTACT NOTICE

GENERAL QUESTIONS: If you have any general questions about your insurance, you may contact the Insurance Company by:

CALLING:
1-800-421-0344 (Customer Information Call Center)

-OR-

WRITING TO:
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

COMPLAINTS: If a complaint arises about your insurance, you may contact the Insurance Company by:

CALLING:
(Compliance Center Complaint Line)
Toll free: 1-800-321-3889, Option 2
Direct: 207-575-7568

-OR-

WRITING TO:
Deborah J. Jewett, Manager, Customer Relations
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE PROVIDE YOUR INSURANCE POLICY NUMBER.

If the Policy or Certificate of Coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street - South Tower
Los Angeles, California 90013
In-State Toll Free Hotline Telephone Number: 1-800-927-4357
Local Telephone Number: 213-897-8921
Office Hours: 8:00 a.m. - 5:00 p.m.

This form is for contact information only, and it is not to be considered a condition for the Policy.

OTHER SERVICES

These services are also available from **us** as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE LONG TERM DISABILITY PLAN?

We do provide **you** and your dependents access to a work life assistance program designed to assist **you** with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your **Employer**.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, **you** must be receiving **monthly payments** from **us**. Unum can provide expert advice regarding your claim and assist **you** with your application or appeal.

Receiving Social Security benefits may enable:

- **you** to receive Medicare after 24 months of disability payments;
- **you** to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist **you** in obtaining Social Security disability benefits by:

- helping **you** find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACTIVE EMPLOYMENT means **you** are working for your **Employer** for earnings that are paid regularly and that **you** are performing the **substantial and material acts** of your **usual occupation**. **You** must be working at least 30 hours per week.

Your work site must be:

- your **Employer's** usual place of business;
- an alternative work site at the direction of your **Employer**, including your home; or
- a location to which your job requires **you** to travel.

Normal vacation is considered **active employment**.

BENEFIT REDUCTIONS means amounts paid to **you** in compensation for the same **disability** for which benefits are claimed under this policy. This income will be subtracted from your **gross disability payment**. Refer to "**WHAT ARE BENEFIT REDUCTIONS?**" in the **BENEFIT INFORMATION** section for income sources that qualify for **benefit reductions**.

DISABILITY means **total disability** or **partial disability** due to **sickness** or **injury**.

DISABILITY EARNINGS means the earnings which **you** receive for work performed while **you** are disabled and working for your **Employer** or earnings received from another employer if **you** became employed after your **disability** began.

ELIGIBLE SURVIVOR means your spouse or **registered domestic partner**, if living; otherwise your children equally.

ELIMINATION PERIOD means a period of **total disability** and/or **partial disability** which must be satisfied before **you** are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in **active employment** with the **Employer**.

EMPLOYER means the **Policyholder**, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if **you** are approved for coverage. **Evidence of Insurability** will be provided at Unum's expense.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made without cancellation or modification of the policy.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts **benefit reductions** and **disability earnings**.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your **disability**.

INDEXED MONTHLY PRE-DISABILITY EARNINGS means your **monthly pre-disability earnings** adjusted on each anniversary of benefit payments by the current annual percentage increase in the Consumer Price Index. Your **indexed monthly pre-disability earnings** may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while **you** are disabled and working.

INJURY means physical harm or damage to the body. **Injury** which occurs before **you** are covered under the policy will be treated as a **sickness**.

INSURED means any person covered under the policy.

LATE APPLICANT means **you** apply for coverage more than 31 days after the date **you** are eligible for coverage.

LAW, PLAN OR ACT means the original enactments of the **law, plan or act** and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means **you** are temporarily absent from **active employment** for a period of time that has been agreed to in advance in writing by your **Employer**.

Your normal vacation time or any period of **disability** is not considered a temporary **layoff** or **leave of absence**.

MAXIMUM MONTHLY BENEFIT means the total benefit amount for which an **employee** is eligible under this long term disability plan subject to the terms of the policy.

MAXIMUM PERIOD OF PAYMENT (for **total disability** and **partial disability** combined) means the longest period of time Unum will make payments to **you**.

MENTAL DISORDER means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a **disability**. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a **disability**.

MONTHLY PRE-DISABILITY EARNINGS means your gross monthly income from your **Employer** as defined in this long term disability plan.

MONTHLY PAYMENT means your payment after any **benefit reductions** have been subtracted from your **gross disability payment**.

PARTIALLY DISABLED means **you** are not **totally disabled** and that while actually working in your **usual occupation**, as a result of **sickness** or **injury you** are unable to earn 80% or more of your **indexed monthly pre-disability earnings**.

After benefits have been paid for 24 months **partially disabled** means **you** are not **totally disabled** and that while actually working in an occupation, as a result of **sickness** or **injury you** are unable to engage with reasonable continuity in that or in

any other occupation in which **you** could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction and is performing tasks that are within the limits of his or her medical license; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

Unum will not recognize **you**, or your spouse, children, parents or siblings as a **physician** for a claim that **you** send to **us**.

POLICYHOLDER means the The Natomas Basin Conservancy, to whom the policy is issued.

RECURRENT DISABILITY means a **disability** which reoccurs after your **disability** ends and is due to the same cause(s) as your prior **disability** for which Unum made a disability payment.

REGISTERED DOMESTIC PARTNER means the person named in your declaration of domestic partnership that has been filed with the Secretary of State of California.

REGULAR CARE means:

- **you** personally visit a **physician** as frequently as is medically required, to effectively manage and treat your disabling condition(s); and
- **you** are receiving appropriate medical treatment and care for your disabling condition(s), which conforms with generally accepted medical standards.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to **you** by your **Employer** of all or part of your **monthly pre-disability earnings**, after **you** become disabled as defined by the policy. This continued payment must be part of an established plan maintained by your **Employer** for the benefit of all **employees** covered under the policy. **Salary continuation or accumulated sick leave** does not include compensation paid to **you** by your **Employer** for work **you** actually perform after your **disability** begins.

SICKNESS means an **illness** or disease.

SUBSTANTIAL AND MATERIAL ACTS means the important tasks, functions and operations generally required by employers from those engaged in your **usual occupation** that cannot be reasonably omitted or modified.

In determining what **substantial and material acts** are necessary to pursue your **usual occupation**, **we** will first look at the specific duties required by your **Employer**. If **you**

are unable to perform one or more of these duties with reasonable continuity, **we** will then determine whether those duties are customarily required of other individuals engaged in your **usual occupation**. If any specific material duties required of **you** by your **Employer** differ from the material duties customarily required of other individuals engaged in your **usual occupation**, then **we** will not consider those duties in determining what **substantial and material acts** are necessary to pursue your **usual occupation**.

TOTAL DISABILITY means, for the first 30 months, that as a result of **sickness** or **injury you** are unable to perform with reasonable continuity the **substantial and material acts** necessary to pursue your **usual occupation** in the usual and customary way.

After benefits have been paid for 24 months of **disability**, **total disability** means that as a result of **sickness** or **injury you** are not able to engage with reasonable continuity in any occupation in which **you** could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.

USUAL OCCUPATION means the **substantial and material acts you** are routinely performing for your **Employer** when your **disability** begins.

WAITING PERIOD means the continuous period of time that **you** must be in **active employment** in an eligible group before **you** are eligible for coverage under the policy.

WE, US and **OUR** means Unum Life Insurance Company of America.

YOU means an **employee** who is eligible for Unum coverage.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

If this policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DELEGATION OF AUTHORITY

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates or entities.

HOW UNUM DETERMINES YOUR ELIGIBILITY FOR BENEFITS

Unum, and not your Employer or Plan Administrator, has the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits for any claim you make on the policy. We will:

- obtain, with your cooperation and authorization if required by law, only such information that is necessary to evaluate your claim and decide whether to accept or deny your claim for benefits. We may obtain this information from your notice of claim, submitted proofs of loss, statements, or other materials provided by you or others on your behalf; or, at our expense we may obtain necessary information, or have you physically examined when and as often as we may reasonably require while the claim is pending. In addition, and at your option and at your expense, you may provide us and we will consider any other information, including but not limited to, reports from a physician or other expert of your choice. You should provide us with all information that you want us to consider regarding your claim;

- consider and interpret the policy and all information obtained by us and submitted by you that relates to your claim for benefits and make our determination of your eligibility for benefits based on that information and in accordance with the policy and applicable laws;
- if we approve your claim, review our decision to approve your claim for benefits as often as is reasonably necessary to determine your continued eligibility for benefits; and
- if we deny your claim, explain in writing to you the basis for an adverse determination in accordance with the policy.

In the event we deny your claim for benefits, in whole or in part, you can appeal the decision to us. If you choose to appeal our decision, the process you must follow is set forth in the policy. If you do not appeal the decision to us, then the decision will be Unum's final decision.

Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information
We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information
We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. *When legally necessary, we ask your permission before sharing NPI about you*. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. *When required by law, we ask your permission before we share NPI for marketing purposes.*

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

Access to Information
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information
If you believe NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

Coverage Decisions
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C467, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.

MK-1883 (10-10)

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, however, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance Guarantee Association
P. O. Box 17319
Beverly Hills, CA 90209-3319

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the life insurance company would owe under a life policy or annuity contract up to
  - $100,000 in cash surrender values,
  - $100,000 in present value of annuities, or
  - $250,000 in life insurance death benefits.
- A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for insurance policies to which the Act applies.

APPENDIX C – CLAIM FORM – HRA PLAN, DENTAL AND VISION REIMBURSEMENT PROGRAM

NATOMAS BASIN CONSERVANCY EMPLOYEE BENEFITS PLAN

HRA ACCOUNT – REIMBURSEMENT REQUEST

Employee/Dependent Contact Information

Employee Name

Phone

Address

E-mail

City, ST Zip

Dependent Name
(Provide only if expense is submitted on behalf of an eligible Dependent)

Itemized Expenses

HRA eligibility and allowable expenses are determined by the Plan. See the Summary Plan Description for more information. Ensure all receipts are attached to this form when submitted.

Date of Service	Provider / Merchant	Amount
		$
		$
		$
		$
		$
		$

I certify that I have not already been paid for these expenses from my HRA Plan or any other source. I have submitted the above information in good faith and it is correct to the best of my knowledge. I understand that reimbursement is not a guarantee. The services or expenses for which I am requesting reimbursement must be incurred during my period of participation. Services or expenses incurred after participation ends are not eligible for reimbursement even if there was a balance remaining in my account.

Signature **Date**