Summary Plan Description

& Plan Document

For

The Natomas Basin Conservancy

(Effective 12/06/2023)

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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, 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 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 26, (b) the date the child ceases to be a foster child of the Employee, if earlier than age 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 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 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 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 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 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 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 80% of dental and vision care expenses up to $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 $500 benefit amount will accumulate, up to a maximum of $1,500. Each annual $500 benefit amount will be forfeited if not used within 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 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 20% of expenses, provided sufficient funds are in the employee's HSA account. Please check IRS guidelines on acceptable HSA expenses. Alternatively, the remaining 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.

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.

[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.

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 60% of monthly pre-disability earnings, up to a maximum monthly benefit of $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**: 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 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 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 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 100% of the participant's monthly pre-disability earnings, or $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 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 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 $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 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 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 30 days after the Administrator's receipt of the Claim. This 30-day period may be extended by an additional period of up to 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 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 180 days from the date you are notified of the denial to appeal your Claim. If you do not file your appeal within this 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 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 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 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 2 and 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 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 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 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 45 days of the date the qualified beneficiary provides written notice of election. The employee will pay 110% of regular premium for 18 months; qualified beneficiaries who are totally disabled as determined by the Social Security Administration can continue their coverage up to an additional 11 months beyond the initial 18 months by paying 150% of the premium for the additional 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 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 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 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 30-day time period may be extended for an additional 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 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 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 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.

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**

APPENDIX D – DENTAL AND VISION REIMBURSEMENT PROGRAM REIMBURSEMENT AMOUNTS

Reimbursement amounts for all periods up to December 31, 2023:

The Conservancy will reimburse 80% of dental and vision care expenses up to $500 per calendar year for each eligible employee[3] upon presentation of a valid paid receipt by The Conservancy's eligible employee.[4] The annual $500 benefit amount will accumulate, up to a maximum of $1,500.

Reimbursement amounts for all periods after January 1, 2024:

The Conservancy will reimburse 80% of dental and vision care expenses up to $[TBD] per calendar year for each eligible employee[5] upon presentation of a valid paid receipt by The Conservancy's eligible employee.[6] The annual $[TBD] benefit amount will accumulate, up to a maximum of $[TBD].

[3] "Eligible employee" as defined in The Conservancy's Employee Handbook, Section 400.
[4] 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.
[5] "Eligible employee" as defined in The Conservancy's Employee Handbook, Section 400.
[6] 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.