Bank of the West Group Health and Welfare Plan

Bank of the West Flexible Benefits Plan

Summary Plan Description

January 1, 2017

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INTRODUCTION

Bank of the West Group Health and Welfare Plan

In this booklet and in the booklets provided by the Insurers of benefits provided under the Bank of the West Group Health and Welfare Plan (the "Group Health and Welfare Plan"), you will find described the health and welfare benefits provided for you by Bank of the West through the Group Health and Welfare Plan. The Group Health and Welfare Plan provides benefits through the component plans listed in Appendix A to the Plan Information section of this booklet, the terms of which are incorporated into this booklet by reference.

Bank of the West Flexible Benefits Plan

This booklet also contains a summary of the principal features of the Bank of the West Flexible Benefits Plan (the "Flexible Benefits Plan"). The Flexible Benefits Plan gives you the opportunity to pay your share of premiums for medical, dental, vision, disability, accident and group-term life insurance coverage (employee only coverage) under plans sponsored by Bank of the West, and out-of-pocket health and dependent care expenses not covered by such plans, using pre-tax dollars. The component plans of the Flexible Benefits Plan are listed in Appendix B to the Plan Information section of this booklet, the terms of which are incorporated into this booklet by reference.

By participating in the Flexible Benefits Plan, you are receiving in benefits a portion of what would otherwise be your wages. This reduces the amount of taxable compensation you receive and, therefore, reduces your taxes.

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Note that for the plans described in this booklet, the plan documents themselves are the controlling documents that set forth the rights of Participants. In the event of a conflict between the summary in this booklet and the plan documents, the plan documents will control. The Group Health and Welfare Plan and the Flexible Benefits Plan are subject to the continuing approval of the Internal Revenue Service.

Bank of the West is referred to as "the Bank" in this booklet. The Bank is the Plan Administrator of the plans described in this booklet.

All individuals actively employed by the Bank shall be referred to as "Employees" in this booklet. Employees who are covered under the Flexible Benefits Plan and the Group Health and Welfare Plan are also referred to as "Participants". When provisions in this booklet apply to all the plans described in this booklet (the Group Health and Welfare Plan and the Flexible Benefits Plan), the plans will be referred to individually and collectively as the "Plan" or "Plans," as applicable.

ELIGIBILITY AND PARTICIPATION

Q&A 1. Am I Eligible To Participate In The Plans?

You are eligible to participate in the Plans if the Bank has classified you as a regular full time or part time employee (an Employee regularly scheduled to work at least 20 hours a week). You are not eligible to participate if you are a temporary employee, an intern, a flex employee, a consultant, an independent contractor or an individual not treated as a common-law employee for purposes of income and employment tax withholding. If, during any period of time, the Bank has not treated you as a common-law employee for tax purposes, you are not eligible to participate for that period of time even if you are later retroactively determined to have been a common-law employee during all or any portion of that period of time.

Eligibility to participate in any of the component plans described in Appendix A and Appendix B to the Plan Information section of this booklet, and the benefits provided under such component plans, is described in the plan documents that govern the applicable component plan. The eligibility rules applicable to you and your dependents may differ from one component plan to another.

Appendix A to the Plan Information section of this booklet lists the component plans included in the Group Health and Welfare Plan, and Appendix B to the Plan Information section lists the component plans included in the Flexible Benefits Plan. For more information regarding eligibility and benefits provided under a particular component plan, please contact the Benefits Administration Unit.

Q&A 2. When Am I Eligible To Participate In The Plans?

Participation is effective as of the first day of the month coinciding with or following the date you complete one month of employment with the Bank, provided the Plan Administrator has received your properly completed enrollment/election forms. Notwithstanding the foregoing, the Bank may provide for certain automatic enrollments as described in Q&A 3 below in accordance with procedures established by the Bank.

Q&A 3. How Do I Enroll?

To enroll, you must authorize payroll deductions and complete the enrollment/election procedures established by the Bank. The Bank may provide that you will be automatically enrolled in the pre-tax component of the Flexible Benefits Plan to pay premiums for basic coverage (e.g., health or life insurance) unless you affirmatively decline coverage. If there is automatic enrollment, you will receive a notice that describes the process for automatic coverage, the salary reduction amounts necessary to pay for coverage, the procedures for declining automatic coverage and the period for which an election declining coverage will be effective. The Bank also may provide that if you previously enrolled for a benefit option (other than a flexible spending account), your enrollment in that benefit option will be carried over into subsequent Plan Years unless you revoke your enrollment in that option. You will be notified if the selection of benefit options will carry over into subsequent Plan Years.

Q&A 4. When Does Participation Cease?

Except as otherwise described in this booklet, you will cease to participate in a Plan upon the earliest of the following dates:

1. The date upon which such Plan terminates.
2. The last day of the period for which you have made required contributions.
3. The date you are no longer eligible to participate in such Plan.
4. The last day of the month following the date your employment terminates.
5. The date you no longer participate in any of the Plan's component plans.

Coverage for your dependents will end when your coverage ends. A dependent will also cease to participate upon the date on which he or she ceases to qualify as a dependent as defined in the booklets provided for the component plan(s) providing coverage.

Please refer to the section of this booklet entitled "Continuation Coverage Rights Under COBRA" (Q&A 39 through Q&A 53) for information on your right to continuation group health plan coverage under COBRA.

Please refer to the section of this booklet entitled "Leaves of Absence" (Q&A 32 through Q&A 36) for information regarding participation during your absence from work because of a leave of absence approved by the Bank. More information regarding the Bank's leave of absence policies (and how such leave will affect your benefits) is available from the Plan Administrator.

PRE-TAX PREMIUMS UNDER THE FLEXIBLE BENEFITS PLAN

Q&A 5. How Does The Pre-Tax Premium Component Of The Flexible Benefits Plan Work?

If you are eligible to participate (see Q&A 1 and Q&A 2), the Bank will allow you to pay for your share of the cost of coverage for yourself and your dependents on a pre-tax basis. Your premiums are paid by payroll deduction before any payroll taxes are taken out, thereby enabling you to pay those premiums on a tax-free basis. Depending on the benefits you select, some of your payroll deductions covering your contributions or premiums for certain plans may be made on an after-tax basis. For example, contributions or premiums you pay for a domestic partner who is covered by a Bank-sponsored health plan will generally be made on an after-tax basis (see Q&A 68 entitled "How Are Benefits for Domestic Partners Paid" for further information about domestic partner benefits).

Q&A 6. Do I Receive Benefit Credits?

The Bank may provide you with benefit credits that you can use to pay for the cost of coverage under the Bank's plans. The Bank has discretionary authority to determine the amount of benefit credits to be allocated each Plan Year and such amount may be zero for any Plan Year. You will be notified of the amount of available benefit credits and the rules governing the use of such credits.

Q&A 7. What Benefits May Be Elected Under The Flexible Benefits Plan?

The Flexible Benefits Plan includes the following:

- *Premium Contribution Plan* – permits a Participant to pay his or her share of contributions for medical, dental vision, accident, disability and life insurance plans (employee coverage only), as applicable, with pre-tax dollars.

- *Health Care Flexible Spending Account Plan* – permits a Participant to use pre-tax dollars to pay qualifying medical expenses (described in Q&A 12) that are not otherwise reimbursed by insurance.

- *Dependent Care Flexible Spending Account Plan* – permits a Participant to pay for his or her qualifying dependent care expenses (described in Q&A 14) with pre-tax dollars.

Q&A 8. Does My Participation In The Flexible Benefits Plan Affect Other Benefits?

Because your contributions to the Flexible Benefits Plan are not subject to Social Security taxes now, your Social Security benefits when you are retired (or become disabled) may be slightly less. The reduction in benefits will depend on the length of time between now and when you retire, or become disabled, and whether or not your taxable income exceeds the Social Security maximum wage level. You may wish to consult your personal tax advisor to determine any Social Security benefit reduction for your particular circumstances.

FLEXIBLE SPENDING ACCOUNTS UNDER THE FLEXIBLE BENEFITS PLAN

Q&A 9. How Do Flexible Spending Accounts Work?

If you have satisfied the eligibility requirements (Q&A 1 and Q&A 2), then upon initial eligibility and during open enrollment of each Plan Year you will have the opportunity to establish flexible spending accounts. You must first approximate the amount of eligible expenses you will incur in the upcoming Plan Year, and then decide how much of your salary you want to set aside on a pre-tax basis to pay for those expenses. A new enrollment form must be completed each Plan Year in order to establish a flexible spending account. Enrollment forms as they apply to flexible spending accounts will not be carried over into subsequent Plan Years. Absent a change in status as described in Q&A 24, if you do not establish a flexible spending account during open enrollment or when you are first eligible, you will not be able to establish a flexible spending account until the next Plan Year.

Flexible spending account enrollment is currently done online at www.bankofthewest.essbenefits.com. You should contact the Claims Administrator for the Flexible Benefits Plan for more information regarding enrollment.

Q&A 10. What Flexible Spending Accounts Can I Establish?

You can establish two separate accounts: one for health care expenses and one for dependent care expenses. You may enroll in one or both. When you enroll, you designate how

much money will be used for reimbursement of health care expenses and how much for reimbursement of dependent care expenses. The amounts in your health care flexible spending account can only be used to reimburse eligible health care expenses; likewise, the amount set aside in your dependent care flexible spending account can only be used to reimburse eligible dependent care expenses. Amounts cannot be transferred between flexible spending accounts.

Q&A 11. How Are Flexible Spending Accounts Funded?

The amount you elect to contribute through pre-tax salary reduction to a flexible spending account will, as a general rule, be automatically deducted from your paychecks in equal amounts throughout the Plan Year. The amounts that are credited to a flexible spending account are not subject to payroll taxes.

Q&A 12. What Expenses Are Eligible for Reimbursement From A Health Care Flexible Spending Account?

Amounts set aside in a health care flexible spending account may be used to pay health care expenses for you and your tax dependents (children and others for whom an exemption may be claimed under Section 152 of the tax Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) not reimbursed by any other benefit plans. Your health care flexible spending account may also be used to pay health care expenses incurred for any of your children (within the meaning of Section 152(f)(1) of the tax Code) through the end of the year in which the child reaches age 26, whether or not the child qualifies as your tax dependent.

Please refer to *Attachment 1* for a brief summary of qualifying expenses. This summary is not exhaustive.

Q&A 13. What Is The Annual Maximum I Can Contribute To A Health Care Flexible Spending Account?

The maximum amount that can be set aside in a health care flexible spending account for any Plan Year is $2,550 or such other amount established by the Bank.

Q&A 14. What Expenses Are Eligible For Reimbursement From A Dependent Care Flexible Spending Account?

Expenses must meet all of the following conditions for them to be eligible for reimbursement from a dependent care flexible spending account:

- The expenses must be incurred for services rendered after the date of your election to establish a dependent care flexible spending account and during the Plan Year to which your election applies.

- The expenses must be incurred while you are employed by the Bank. If your employment with the Bank terminates during the Plan Year, you may submit claims for eligible expenses incurred before your employment ended, provided the claims are submitted within the 90-day period following the end of the Plan Year (see Q&A 20 below).

- The expenses must be incurred for a "qualifying person." A "qualifying person" is (a) an eligible dependent age 12 or under who is your qualifying child (under section 152(a)(1) of the tax Code); (b) an eligible dependent who requires full-time care because of physical or mental incapacity (for example, a disabled spouse or parent) and lives with you for more than one-half of the taxable year; or (3) a spouse who is physically or mentally incapable of caring for himself or herself and lives with you for more than one-half of the taxable year.

- An eligible dependent is generally any individual who can be claimed by you as a dependent for federal tax purposes (under section 152 of the tax Code) and may also include a "qualifying relative" (including a member of your household during the taxable year) who would qualify as your tax dependent except that (i) he or she has income that equals or exceed the personal exemption amount; (ii) he or she is married and files a joint return with his or her spouse; or (iii) you (or your spouse, if filing jointly) could be claimed as a tax dependent of another taxpayer. If you are divorced or separated and are the custodial parent, you may be able to treat your child as a qualifying person even if you cannot claim the child as your tax dependent. You should consult your personal tax advisor or IRS Publication 17 "*Your Federal Income Tax*" and Publication 503 "*Child and Dependent Care Expenses*" for further guidance.

- The expenses must be incurred for the care of a dependent (as described above), or for related household services, and must be incurred to enable you (and your spouse, if married) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above grades) do not qualify.

- If the expenses are incurred for services outside your household and such expenses are incurred for the care of a dependent who is age 13 or older, such dependent must regularly spend at least 8 hours per day in your home.

- If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

- The expenses must not be paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent. Other relatives may qualify as a provider.

- You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

For more information, you should contact the Claims Administrator for the Flexible Benefits Plan or refer to its website at **www.flexdirect.adp.com**.

You should also consult your personal tax advisor or IRS Publications 17 "*Your Federal Income Tax*" and 503 "*Child and Dependent Care Expenses*" for further guidance as to what expenses are eligible for reimbursement under a dependent care flexible spending account.

Q&A 15. What Is The Annual Maximum I Can Contribute To A Dependent Care Flexible Spending Account?

The maximum amount that can be contributed to a dependent care flexible spending account for each Plan Year is the lesser of the following amounts:

- $5,000 or, if you are married and are filing separate tax returns, $2,500;
- your earned income; or
- if you are married, your spouse's earned income or deemed earned income.

If your spouse is physically or mentally incapacitated or a full-time student, then your spouse's deemed earned income is based on an amount equal to $250 per month for each dependent, up to a maximum of $500 per month.

Q&A 16. Should I Use The Dependent Care Assistance Tax Credit Or A Dependent Care Flexible Spending Account?

Before establishing a dependent care flexible spending account for a Plan Year, you should determine whether the federal tax credit for dependent care assistance would result in greater tax savings because of your individual circumstances. Generally, the tax credit is available in lieu of a dependent care flexible spending account. The charts contained in *Attachment 2* may assist you in making this determination. Note that the illustrations are for general comparison purposes and do not take into consideration individual withholding tax information, which may offset the savings for both programs. You may want to consult your personal tax advisor for guidance on which program is best for you.

Q&A 17. What Are The Potential Tax Savings Of A Flexible Spending Account?

By using a flexible spending account to pay some of your health care and dependent care expenses, you may have more take home pay. For example, assume you are married, have one child and your spouse is a student with no earned income. You and your spouse file a joint tax return. Your annual income is $75,000. Your estimated health care expenses for a Plan Year are $2,400. Using a health care flexible spending account to pay for those expenses would affect your taxes and net pay as follows.

	WITH AN FSA	WITHOUT AN FSA
Annual Income	$75,000	$75,000
Amount Paid to flexible spending account	($2,400)	0
W-2 Gross Wages	**$72,600**	**$75,000**
Standard Deduction	($12,600)	($12,600)
Exemptions	($12,000)	($12,000)
Taxable Income	**$48,000**	**$50,400**
W-2 Gross Wages	**$72,600**	**$75,000**
Federal Income Tax	($6,278)	($6,638)
FICA	($5,554)	($5,738)
After-Tax Health Care Expenses	$0	($2,400)
Take Home Pay After Taxes and Health Care Expenses	**$60,768**	**$60,224**

Under this example, by using a health care flexible spending account you would pay $360 less in federal income taxes and $184 less in FICA taxes. The corresponding increase in your net pay would be $45 per month.

Q&A 18. How Are Expenses Reimbursed From Flexible Spending Accounts?

To receive reimbursement of eligible expenses from your flexible spending account, you need to complete the reimbursement procedures established by the Claims Administrator for the Flexible Benefits Plan.

For purposes of the health care flexible spending account only, you will be reimbursed for the maximum amount of your claim at any point in the Plan Year (up to the amount you have elected to contribute for that Plan Year), even if your account has not yet been fully funded. For example, assume that you establish a health care flexible spending account of $1,200 for the Plan Year and submit a bill in the amount of $1,200 in the first month of the Plan Year. Even though you have only contributed $100 to your health care flexible spending account, the Plan will reimburse you the *full* $1,200, subject to your $1,200 maximum Plan Year election. Future contributions to your health care flexible spending account will continue to be made as usual for the remainder of the Plan Year.

For purposes of the dependent care flexible spending account, you will only be reimbursed up to your year-to-date contribution balance. For example, assume that you submit a bill in the amount of $300 in the first month of the Plan Year, and you have only contributed $250 to your dependent care flexible spending account. The Plan will reimburse you $250, with the remaining $50 reimbursed when you have contributed an additional $50 to your dependent care flexible spending account.

Q&A 19. When Must Expenses Be Incurred In Order To Be Reimbursed From Flexible Spending Accounts?

For eligible medical care expenses to be reimbursed to you from your health care flexible spending account, or for eligible dependent care expenses to be reimbursed from your dependent care flexible spending account, they must have been incurred during the Plan Year. The Plan Year is the 12-month period beginning on January 1 and ending on December 31. In addition, as discussed below, you may be able to be reimbursed for eligible medical care and dependent care expenses incurred during a "Grace Period" following the end of the Plan Year. The Grace Period will begin on January 1 and end on March 15 following the end of the Plan Year. For example, for the Plan Year ending December 31, 2015, the Grace Period will begin on January 1, 2016 and will end on March 15, 2016.

In order to take advantage of the Grace Period for a flexible benefits account, you must be a participant in the Plan with coverage under the flexible benefits account that is in effect as of the last day of the Plan Year to which the Grace Period relates (December 31) or, in the case of a health care flexible spending account, receiving COBRA coverage as to that account on the last day of that Plan Year.

Different rules apply if you terminate employment during the Plan Year (see Q&A 37 below).

Q&A 20. What Is The Last Day For Submitting Claims For A Plan Year?

You may continue to submit claims for eligible medical care expenses and eligible dependent care expenses incurred in a Plan Year or during the Grace Period through the March 15 immediately following the end of the Plan Year.

For transportation flexible spending accounts, you may continue to submit claims for eligible expenses incurred in a Plan Year during the 90-day period immediately following the end of the Plan Year.

Q&A 21. How Are Grace Period Expenses Administered?

Eligible medical care and dependent care expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan year and then from any amounts that are available to reimburse such expenses during the current Plan year. For example, assume that you did not use $200 of your contributions to the health care flexible spending account by December 31 of the current Plan Year, and further assume that you have elected to contribute $2,400 to the health care flexible spending account for the next Plan Year. If you submit a $500 eligible medical expense that was incurred on January 15 of the new Plan Year, $200 of your claim will be paid out of your unused contributions to the health care flexible spending account for the prior Plan Year, and the remaining $300 will be paid out of the amounts available to reimburse you for eligible medical expenses in the current Plan year. Claims will be paid in the order in which they are approved.

Once paid, a claim will not be reprocessed or otherwise recharacterized so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year. For example, using the same

facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 Grace Period expense, you discover $200 of eligible medical expenses attributable to the prior Plan Year that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain available to reimburse you for prior Plan Year expenses. The Plan will not reprocess the $500 Grace Period expense so as to pay it entirely from the current year contributions. For this reason, if you have coverage under a flexible spending account for both the prior and current years, you may want to consider waiting to submit expenses incurred during the Grace Period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

Q&A 22. Do I Forfeit Unused Amounts In A Flexible Spending Account?

Yes. Each Plan Year begins on January 1 and ends on December 31. The Grace Period applicable to health care flexible spending accounts and dependent care spending accounts for a Plan Year begins on January 1 and ends on March 15. If any amounts remain in your health care flexible spending account or dependent care flexible spending account after the March 15 following the end of the Plan Year, those amounts will be forfeited.

If any amount remains in your transportation flexible spending account after the 90-day period following the end of the Plan Year, those amounts will be forfeited.

Unused flexible spending account balances cannot be carried forward for use in subsequent Plan Years. You may wish to review the amount of your expenses in prior years or consult a tax advisor prior to establishing a flexible spending account.

ELECTION CHANGES

Q&A 23. Can I Change My Plan Elections?

The tax regulations require that elections under the Plans be irrevocable for the entire Plan Year except in the limited circumstances described below. The Plan Administrator has discretionary authority to determine whether an election change is consistent with the tax regulations, and its determination is conclusive and binding on all persons.

Q&A 24. Can I Change An Election Because Of A Change in Status?

You may revoke an election during the Plan Year on account of a change in status if the revocation of your election and your new election are consistent with the change in status, provided you notify the Plan Administrator in writing or electronically of the change in status within 31 days of such change in accordance with procedures established by the Plan Administrator. A brief summary of the consistency rules is described in Q&A 25. Changes in status include the following:

- *Legal Marital Status:* A change in legal marital status because of marriage, legal separation, annulment, divorce or death.

- *Number of Dependents:* A change in the number of eligible dependents because of the birth, death, adoption, placement for adoption, or placement for foster care of a child.

- *Employment Status:* Events that change an individual's employment status such as termination or start of employment, a strike or lockout, starting or returning from an unpaid leave of absence, or a change in worksite. If the eligibility conditions of a flexible benefits plan or other benefit plan are contingent on a person's employment status (e.g., the individual must be a full-time employee to participate), then a change in that status is a change in employment status.

- *Dependent Change in Eligibility:* An event that causes a dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit, such as attaining a specified age.

- *Residence:* A change in the place of residence or in the place of residence of a spouse or dependent.

Q&A 25. When Is A New Election Consistent With A Change in Status?

Generally, an election change is consistent with a change in status only if the change results in an increase or decrease in the number of dependents who may benefit for coverage under the Plans. An election change relating to a dependent care flexible spending account is consistent with a change in status if the change in status affects dependent care expenses. The following rules apply in determining whether an election change is consistent with a change in status:

- *Losing or Gaining Eligibility under Accident or Health Plans.* In the case of an accident or health plan (e.g., a medical, dental, vision or accidental death & dismemberment insurance plan or a health flexible spending account) special rules apply. If the change in status is a divorce, an annulment or legal separation from a spouse, the death of a spouse or a dependent, or a dependent's ceasing to satisfy the eligibility requirements for coverage, then an election to cancel coverage for any person other than the person involved in the divorce, annulment, or legal separation, the deceased spouse or dependent, or the dependent who ceases to satisfy the eligibility requirements, fails to correspond with the change in status. Only coverage for the affected person may be cancelled. If a change in status involves the employee or his or her spouse or dependent gaining eligibility under another employer's plan because of a change in marital or employment status, an election to cease or decrease coverage for the affected person under this Plan is consistent with that change in status only if coverage for the affected person under the other employer's plan is obtained.

Example: Mike and Amy are married, and they have one child. The Bank allows employees to elect employee-only medical coverage, employee-plus-one-dependent medical coverage, family medical coverage or no medical coverage. During open enrollment, Mike elects family coverage for himself, Amy and his child. During the Plan Year, Mike and Amy divorce, and Amy ceases to be eligible for medical coverage under the Bank's plan. Mike's child continues to be eligible. The divorce is a change in status. An election to cancel family coverage and to elect employee-plus-one-dependent coverage is consistent with that change in status. An election to cancel medical coverage for Mike or his child is not consistent with the change in status.

However, if Amy makes an election to cover the child under her employer's plan, a corresponding change by Mike to elect employee-only coverage under his plan would be consistent with the change in status.

- *Dependent Care Flexible Spending Accounts.* In the case of a dependent care flexible account, an employee may change (or cancel) his or her election if such change is on account of and corresponds with a change in status that affects eligibility for coverage under the dependent care flexible spending account or if the change is on account of and corresponds with a change in status that affects the amount of eligible dependent care expenses.

Example: Mike and Amy are married, and their daughter is 12 years old. Mike elects to reduce his salary by $2,000 during the Plan Year to fund a dependent care flexible spending account and to receive reimbursement of eligible dependent care expenses for his daughter on a tax-favored basis. In the middle of the Plan Year, Mike's daughter turns 13 years old and, as a result, the expenses for her daycare are no longer eligible for reimbursement under Mike's dependent care flexible spending account. This event constitutes a change in status. Mike's election to cancel his dependent care flexible spending account is consistent with this change in status.

- *Life and Disability Plans.* In the case of a group term life or disability plan, an employee who experiences a change in status may elect either to increase or decrease coverage under such plan.

Example: Mike and Amy are married with one child. During open enrollment, Mike elects $10,000 of group-term life insurance. Mike and Amy subsequently divorce during the Plan Year. The divorce constitutes a change in status. Mike's election to increase or to decrease his group-term life insurance coverage is consistent with the change in status.

Q&A 26. Can I Change An Election On Account Of A Special Enrollment Right?

If you, your spouse or dependent are entitled to a special enrollment right under a group health plan subject to HIPAA (defined in Q&A 58), you may change your election prior to the next open enrollment to correspond with the special enrollment right. For example, if you declined enrollment in medical coverage for yourself and/or your eligible dependents because of outside medical coverage, and eligibility for such coverage is subsequently lost because of legal separation, divorce, death, termination of employment, reduction in hours, reaching the lifetime limit on all benefits under a plan, employer contributions cease, or exhaustion of COBRA, you may be able to elect medical coverage for yourself and/or your eligible dependents who lost such coverage provided you properly request enrollment within 31 days of the loss of coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll yourself, your spouse and your newly acquired dependents provided that you properly request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment (other than a new dependent child) will be effective on the first day of the month following the date the Plan Administrator receives your properly filed enrollment application, provided such enrollment application is received within 31 days of the special enrollment event. A special enrollment attributable to the birth, adoption or placement for adoption of a child, will be effective retroactive to the date of such birth, adoption, or placement, provided the Plan Administrator receives your properly filed enrollment application within 31 days of the birth, adoption or placement.

You may also enroll yourself or your eligible dependents for coverage under a group health plan prior to the next open enrollment date under two additional circumstances. If you or your dependents are covered under either a Medicaid plan or a state children's health insurance program (CHIP), and coverage is terminated as a result of loss of eligibility for such coverage, you may be able to elect coverage under a group health plan for yourself and/or your eligible dependents who lost coverage provided you properly request enrollment within 60 days of the loss of coverage. Furthermore, if you or your dependents become eligible under a Medicaid plan or CHIP for premium assistance with respect to coverage under a group health plan, you may be able to elect coverage under the plan for yourself and/or your eligible dependent provided you properly request enrollment within 60 days after the date eligibility for such premium assistance is determined. An election change that corresponds with one of the additional special enrollment events described in this paragraph will be effective on the first day of the month following the date the Plan Administrator receives your properly filed enrollment application, provided such enrollment application is received within 60 days of the special enrollment event.

The special enrollment provisions of HIPAA are not available for the health care flexible spending account plan. However, the particular life event may still qualify as a change in status event (see Q&A 24). For example, marriage is a change in status event that would permit you to make a change in your health care flexible spending account election event.

To request special enrollment or to obtain more information, contact the Claims Administrator for the Flexible Benefits Plan.

Q&A 27. Can I Change An Election Because Of A Judgment, Decree or Order?

If a judgment, decree or order from a divorce, separation, annulment or custody change requires your child (including an eligible foster child) to be covered under an Employer sponsored plan, you may (or you may be required to) change your election under the Plans to provide coverage for such child. If the order requires that another individual (such as your former spouse) cover a child, and such coverage is actually provided to the child, you may change your election to revoke coverage for the child.

Q&A 28. Can I Change An Election Because Of Entitlement To Medicare or Medicaid?

If you, your spouse or a dependent becomes entitled to Medicare or Medicaid, you may cancel accident or health coverage under the Plans for the person that became entitled, subject to the terms of the accident or health plan. Similarly, if you, your spouse, or a dependent who has been entitled to Medicare or Medicaid loses eligibility for Medicare or Medicaid, you may elect to begin or increase that person's accident or health coverage under the Plans, subject to the terms of the applicable accident or health plan.

Q&A 29. Can I Change An Election Because Of Eligibility For COBRA?

If you, your spouse (but not former spouse) or a dependent becomes eligible for continuation coverage under COBRA, you may change your election in order to pay for such coverage for the remainder of the Plan Year.

Q&A 30. Can I Change An Election Because Of A Change in Cost?

If the Bank notifies you that the cost of your coverage under a benefit option will significantly increase or decrease during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose to increase your contributions, revoke your election and receive coverage under another benefit option that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the benefit option that decreased in cost. For insignificant increases or decreases in the cost of benefit options, however, the Bank may automatically adjust your election contributions to reflect the minor change in cost. Election changes relating to a health care flexible spending account are not permitted on account of a change in cost.

Election changes relating to a dependent care flexible spending account are only permitted on account of a change in cost if such change is imposed by a dependent care provider who is not your relative.

Q&A 31. Can I Change An Election Because Of A Change in Coverage?

If the Bank notifies you that your coverage under a benefit option is significantly curtailed, you may revoke your election and elect coverage under another benefit option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. If a Plan adds or

significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Election changes relating to a health care flexible spending account are not permitted on account of a change in coverage.

Election changes relating to a dependent care flexible spending account are permitted on account of a change in coverage where one dependent care provider is replaced with another provider (even if the provider is related to you), if a dependent child no longer qualifies as a dependent child for purposes of the dependent care flexible spending account (meaning the child is over age 13) or if the provider's hours of service change.

LEAVES OF ABSENCE

Q&A 32. What Happens To My Dependent Care Flexible Spending Account If I Take A Leave of Absence?

Contributions to your dependent care flexible spending account will be suspended during an unpaid leave of absence. You may however, arrange to pre-pay contributions before you go on leave. Contributions will resume upon return to work. If upon return to work a change in status has occurred (see Q&A 24), such as the birth of a child, you may change your election for the dependent care flexible spending account but such a change must be made within 31 days of your return to work by completing the change in status procedures established by the Claims Administrator for the Flexible Benefits Plan. You may <u>not</u> be reimbursed for dependent care expenses incurred while you are on a leave of absence.

You should contact the Plan Administrator for more information regarding the Bank's leave of absence policies and how your benefits may be affected.

Q&A 33. What Happens To My Pre Tax Premium Election Under The Flexible Benefits Plan And/Or My Health Care Flexible Spending Account If I Take A Leave Of Absence?

If you take an unpaid leave of absence approved by the Bank (including a leave protected under the Family and Medical Leave Act (FMLA)), you may continue coverage or revoke an existing election under the Flexible Benefits Plan relating to the pre-tax payment of employee contributions for health coverage or, if applicable, your contributions to a health care flexible spending account. You may elect to be reinstated in the group health plan and the health care flexible spending account upon returning from the leave if coverage under the group health plan or health care flexible spending account terminated by revocation or non-payment of premiums while you were on leave. If you elect to continue premium payments for group health coverage or to continue participation in the health care flexible spending account during a leave, you may pay your contributions during unpaid leave according to the payment options below, subject to the Bank's approval as communicated by the Claims Administrator for the Flexible Benefits Plan:

- **Pre-pay** – Contributions are paid before the leave begins. Payment may be made on a pre-tax basis out of taxable compensation or can be paid on an after-tax basis. Contributions for coverage after the last day of a Plan Year cannot be paid with pre-tax contributions made in the year preceding coverage.

- **Pay-as-you-go** – Contributions are paid on the same schedule as payments made by participants who are not on leave. Payments can be made pre-tax out of taxable compensation paid during leave or on an after-tax basis. The Bank is not required to maintain coverage if payment is not timely made. If you fail to make your contributions under this option and the Bank voluntarily continues coverage, the Bank may recoup those payments upon return from leave under the catch-up option described below without a prior agreement with the employee.

- **Catch-up** – The Bank, in its sole and absolute discretion, may elect to continue to provide coverage during the leave without the employee's payment of premiums during the leave. The Bank recoups such payments upon the employee's return to work. The employee and the Bank agree in advance (a) as to the length of the coverage period that the Bank will continue coverage; (b) that the Bank will assume responsibility for advancing payment of contributions on the employee's behalf during the leave; and (c) that the employee will pay back the Bank for contributions advanced upon return to work. The employee may repay the Bank on a pre-tax basis from taxable compensation or on an after-tax basis provided that coverage for a Plan Year will be made available on a pre-tax basis only if repayment is made by the last day of such Plan Year.

You should contact the Plan Administrator for more information regarding the Bank's leave of absence policies and how your benefits may be affected.

Q&A 34. What If Coverage Under My Health Care Flexible Spending Account Terminates While On A FMLA Leave?

If your coverage under a health care flexible spending account terminates while on FMLA leave (e.g., by revocation or non-payment of your premium), you are not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If you subsequently elect to reinstate your health care flexible spending account upon return from FMLA leave for the remainder of the Plan Year, you may not retroactively elect coverage under the health care flexible spending account for claims incurred during the period when the coverage was terminated. Upon the reinstatement of your health care flexible spending account upon return from FMLA leave, you may resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments or resume coverage at a level that is reduced and resume premium payments at the level in effect before the FMLA leave. If you choose to resume your health care flexible spending account coverage at a level that is reduced, the coverage is prorated for the period during the FMLA leave for which no premiums were paid. In both cases, your coverage level is reduced by prior reimbursements.

Q&A 35. What Happens If I Go On Military Leave?

If you go on an unpaid military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may, in accordance with procedures established by the Bank, continue coverage under the Bank's group health plan and, if applicable, continue to participate in the health care flexible spending account during the USERRA leave until the earlier to occur of:

- the day after the date on which you fail to apply for or return to employment, as described in USERRA; or
- 24 months from the date the USERRA leave commences or such longer period of time as may be permitted under the Bank's leave of absence policies.

If your USERRA leave is 31 days or longer, you may be required to pay up to 102 percent of the required contributions. If the USERRA leave is for less than 31 days, your required contributions will remain the same as when you were actively employed.

If you elect to continue group health plan coverage or to continue to participate in the health care flexible spending account, you must pay contributions in the same amount (not to exceed 102 percent of the total cost of coverage under the Plan), form and manner as provided for those individuals who elect to continue coverage under COBRA. Coverage under USERRA will run concurrently with any right to continue coverage under COBRA.

For more information on your rights under USERRA and military leaves, a VETS directory and additional information is available at www.dol.gov/vets. You can also contact the Claims Administrator for the applicable component plan or the Benefits Administration Unit for information.

Q&A 36. What Happens If I Fail To Make Required Contributions After Going On Unpaid Leave?

If, after going on an unpaid leave of absence approved by the Bank, you fail to make the required contributions to continue coverage under the Bank's group health plans and/or the health care flexible spending account, your participation will cease on the last day of the payroll period for which required contributions were last paid.

TERMINATION OF EMPLOYMENT

Q&A 37. What Happens If I Terminate Employment?

If group health plan coverage for you or your dependents ceases because you leave or terminate employment, you and your dependents may have the right to purchase continuation coverage under COBRA for a temporary period of time.

If you leave or terminate employment and have an unused balance in a dependent care flexible spending account, you may only submit claims for eligible expenses incurred during the Plan Year or Grace Period and before you terminated employment. If you have a balance in a

health care flexible spending account when you terminate employment and you qualify for COBRA continuation coverage, you may continue contributing and receiving reimbursement of eligible expenses incurred after your termination of employment provided you timely elect continuation coverage in accordance with procedures established by the Bank.

If you do not elect COBRA to continue your health care flexible spending account, expenses incurred only through the date on which your employment terminates will be considered eligible for reimbursement.

For more information on COBRA continuation coverage, you should refer to the section of this booklet entitled "Continuation Rights under COBRA" or contact the Bank's COBRA Administrator (see the section entitled "Plan Information" for contact information).

Q&A 38. What If I Am Reemployed By The Bank?

If you terminate employment and again become an eligible employee during the same Plan Year in which participation terminated and within 30 days of the date on which your participation terminated, you will not be entitled to make a new election under the Plans for the remainder of the Plan Year. Rather, upon reemployment, you will continue the same elections you had before participation terminated unless you may otherwise change your elections as described above in the section entitled "Election Changes". If you become an eligible employee during the same Plan Year in which participation terminated and more than 30 days after the date on which your participation terminated, you will be treated as newly eligible and permitted to make new elections as described in Q&A 2 above.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Q&A 39. Who Is Eligible For COBRA Continuation Coverage?

In compliance with federal law, the Bank offers continuation coverage for you and your dependents that are covered by component plans that provide medical benefits. This continuation coverage is called COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA offers continuation of Plan benefits, subject to certain conditions.

This description is intended to comply with COBRA, but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent (as determined by the Plan Administrator in its sole discretion) will prevail over the summary in this booklet.

Q&A 40. How Does COBRA Apply To My Health Plan Coverage?

You and your dependents who meet the definition of a "qualified beneficiary" (see Q&A 41 "Who is a Qualified Beneficiary" below) have the option to continue coverage by paying the required premiums from the date coverage would otherwise terminate, for up to 18 months if one of the following qualifying events occurs:

- Your employment with the Bank terminates for any reason (including voluntary resignation or retirement) other than gross misconduct, or

- Your hours are reduced so that your eligibility for Employer-sponsored health care coverage is affected.

Coverage for your eligible dependents who meet the definition of a qualified beneficiary may be continued by paying the required premiums from the date coverage would otherwise terminate, for up to 36 months if one of the following qualifying events occurs:

- You die while still employed, or
- You and your spouse legally separate or divorce, or
- Your dependent child no longer qualifies for coverage under the terms of the Bank-sponsored health plan, or
- You become entitled to Medicare. (For COBRA purposes, "entitlement" means the effective date of enrollment in Medicare Part A or Part B, whichever occurs first.)

Notwithstanding any other provision of this booklet, COBRA coverage for your health care spending account is only available until the end of the Plan Year in which the qualifying event occurs.

If a qualifying event that provides an 18-month maximum coverage period is followed by a second qualifying event that allows a 36-month maximum coverage period, the original period may be expanded to up to 36 months, but only for individuals other than the Employee who are qualified beneficiaries at the time of both qualifying events. In no circumstance can the COBRA maximum coverage period be more than 36 months from the date coverage would end due to the first qualifying event. Also, this additional period of coverage is available only if the second qualifying event would have, but for the original qualifying event, resulted in a loss of coverage.

For example, a child who was originally eligible for continuation coverage due to termination of the covered Employee's employment (a qualifying event) and who was enrolled for continuation coverage as a qualified beneficiary would be entitled to up to 18 months of continuation coverage. If, during this 18 month period, the child reaches the upper age limit of the plan (a second qualifying event), the child may be eligible to extend coverage for up to 36 months from the date coverage would end due to the **original** qualifying event (the termination of the Employee's employment), provided the Employee or qualified beneficiary properly notifies the COBRA Administrator of the child's loss of dependency status (see "How Do I Obtain COBRA Continuation Coverage" Q&A 42 below).

If the covered Employee becomes entitled to Medicare (even if his/her entitlement to Medicare is not a qualifying event) before a termination of employment or reduction in hours (qualifying events), a qualified beneficiary other than the Employee may be eligible for continuation coverage for up to the longer of:

- 36 months from the day on which the Employee became entitled to Medicare; or

- 18 months from the date coverage would end due to the Employee's termination or reduction in hours.

If the covered Employee becomes entitled to Medicare within the 18-month period following a termination of employment or reduction in hours (qualifying events) and such entitlement results in a loss of coverage under a group health plan, a qualified beneficiary other than the Employee may be eligible for continuation coverage for up to 36 months from the date coverage would end due to the Employee's termination or reduction in hours.

Q&A 41. Who Is A Qualified Beneficiary?

A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under a Bank-sponsored group health plan, either as an Employee, the spouse of a covered Employee or the dependent child of a covered Employee. Qualified beneficiary status will be forfeited if an individual declines COBRA coverage when first eligible.

Note: A domestic partner who does not qualify as the covered Employee's tax dependent, or a child of a domestic partner who is not the dependent child of the covered Employee, is not eligible for COBRA continuation coverage. However, the Bank's group health plans provide such individuals with continuation coverage under generally similar terms and conditions as provided under COBRA to an Employee's spouse and dependent children. Also, special rules apply to retirees and their family members. For more information, you should check with the COBRA Administrator or the Bank's Retirement Benefits Office.

If you are entitled to COBRA coverage and a child is born to you or placed with you for adoption while you are on COBRA coverage, you can enroll your new child for COBRA coverage immediately. Your newborn or adopted child will have independent election rights. Your qualifying event date and resultant continuation coverage period will also apply to the child.

An individual who is not covered under the group health plan on the day before a qualifying event because he or she was denied coverage or was not offered coverage and such denial or failure to offer coverage constitutes a violation of applicable law will be considered to have had such coverage and will be a qualified beneficiary if that individual experiences a qualifying event.

Q&A 42. How Do I Obtain COBRA Continuation Coverage?

IMPORTANT! YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

An Employee or other qualified beneficiary is responsible for notifying the COBRA Administrator by telephone or in writing within 60 days of the later of (i) the date one of the following qualifying events occurs, or (ii) the date coverage would terminate due to one of the following qualifying events:

- a child's ceasing to be eligible under the requirements of the plan; or
- a divorce or legal separation of the Employee from his/her spouse.

Once the COBRA Administrator is timely notified by phone or in writing of the occurrence of one of these qualifying events, the qualified beneficiary(ies) will be mailed information explaining each qualified beneficiary's continuation coverage rights as well as an enrollment form.

For all other qualifying events, the COBRA Administrator will notify the qualified beneficiary of the right to elect continuation coverage.

To elect COBRA continuation, a qualified beneficiary must complete the election form and return it to the COBRA Administrator within 60 days of the **later** of:

- The date the qualified beneficiary would otherwise lose coverage due to a qualifying event, or
- The date the COBRA continuation coverage election materials were mailed to the qualified beneficiary.

IMPORTANT!

If you don't elect continuation coverage during the initial enrollment period, you may not elect it at a later date.

Each individual who is a qualified beneficiary with respect to a qualifying event has an independent right to elect continuation coverage, even if others in the same family have declined coverage. A parent or legal guardian may elect or decline coverage for minor dependent children.

An election of an incapacitated or deceased qualified beneficiary can be made by the legal representative of the qualified beneficiary or the qualified beneficiary*'s* estate, as determined under applicable state law, or by the spouse of the qualified beneficiary.

If, during the election period, a qualified beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the COBRA Administrator.

Q&A 43. When Is COBRA Coverage Effective?

COBRA continuation coverage will be effective retroactively to the date coverage would otherwise have terminated due to the qualifying event, provided:

- The qualified beneficiary(ies) returns to the election form to the COBRA Administrator within the 60-day election period described above; and

- The qualified beneficiary(ies) pays the initial COBRA continuation coverage premium within 45 days of the date the qualified beneficiary(ies) elects continuation coverage.

See Q&A 42 above for exceptions to the effective date of coverage when a qualified beneficiary initially waives COBRA continuation coverage and then revokes his/her waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Q&A 44. What Level Of Coverage Is Provided Under COBRA?

COBRA continuation coverage will be equivalent to coverage provided to similarly situated non-COBRA beneficiaries. A "non-COBRA beneficiary" is an individual who is covered under the particular health plan on an "active" basis (i.e., an individual as to whom a qualifying event has not occurred). If coverage is modified for similarly situated non-COBRA beneficiaries, the same modification will apply to qualified beneficiaries.

Open enrollment rights, which allow non-COBRA beneficiaries to choose among any available coverage options, are also applicable to each qualified beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to qualified beneficiaries. However, if a former qualified beneficiary did not elect COBRA, he or she does not have special enrollment rights, even though active Employees not participating in the plan have such rights under HIPAA.

If the plan includes a deductible requirement, a qualified beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his/her deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a qualifying event, the family deductibles are computed separately based on the members in each unit. Other plan limits are treated in the same manner as deductibles.

If a qualified beneficiary is participating in a region-specific health plan that will not be available if the qualified beneficiary relocates, any other coverage that the Bank makes available to the active Employees and that provides service in the relocation area must be offered to the qualified beneficiary.

Q&A 45. Is COBRA Continuation Coverage Available For Health Care Flexible Spending Accounts?

Yes. COBRA continuation of your health care flexible spending account may be available if you experience a qualifying event (see Q&A 40 "How Does COBRA Apply to My Health Plan Coverage?" above). However, you can only elect to continue coverage under your health care flexible spending account until the end of the Plan Year in which the qualifying event occurs (see Q&A 40 "How Does COBRA Apply to My Health Plan Coverage?").

Q&A 46. When Is A Disability Extension Available?

If, during the first 60 days of COBRA coverage, you or one of your associated qualified beneficiaries are determined to be disabled for Social Security purposes, you and your associated qualified beneficiaries may be entitled to extend the 18 month COBRA coverage period for up to 29 months of continuation coverage, measured from the date coverage would end due to your termination date or reduction in hours (the initial qualifying event).

To elect this extension, you or your associated qualified beneficiary must furnish the COBRA Administrator with proof of the Social Security determination of disability no later than 60 days after the latest of (i) the date of the Social Security determination; (ii) the date on which the qualifying event occurs; or (iii) the date on which you or your associated qualified beneficiary loses (or would lose) coverage due to the qualifying event. The notice **must** also be provided before the end of your initial 18 month COBRA coverage period.

Unless coverage terminates on an earlier date (see Q&A 49 below), this period of extended continuation coverage will end on the earlier of:

- 29 months from the date coverage would have otherwise ended due to the initial qualifying event (i.e., your earlier termination or reduction in hours); or

- The end of the month following a period of 30 days after the Social Security Administration's final determination that you or your associated qualified beneficiary are no longer disabled. You **must** notify the COBRA Administrator within 30 days of the date Social Security determines that you or your dependent is no longer disabled.

Q&A 47. What Is The Cost Of COBRA Continuation Coverage?

A qualified beneficiary is responsible for paying the full cost of continuation coverage, plus a 2% administration charge. This cost includes both the Employee and the Bank portion of the applicable premium. In other words, the cost is 102% of the total Plan cost for similarly situated non-COBRA beneficiaries.

If continuation coverage is extended because of disability, the cost to cover the disabled qualified beneficiary for months 19 through 29 (or months 19 through 36 of coverage, if a second qualifying event occurs after the initial 18 months of continuation coverage) will be 150% of the total Plan cost. The cost to cover any associated qualified beneficiaries whose coverage is also extended may also increase to up to 150% of the total Plan cost. You should contact the COBRA Administrator for more information on the cost of continuing coverage in the event of an extension due to a qualified beneficiary's disability.

Q&A 48. When Must Premium Payments Be Paid?

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary.

IMPORTANT!

If you do not make your initial premium payment within the 45-day period, your COBRA election will be null and void and you will lose your right to continue coverage under COBRA.

The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date coverage would otherwise terminate due to the qualifying event (or the date a COBRA waiver was revoked, if applicable).

Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment.

Suspension of Coverage: COBRA premiums are due on the first day of the month. If your premium is paid late (but within the 30-day grace period), your continuation coverage will be suspended until the payment is received. You will be responsible for health care costs incurred during any such suspension; however, you could apply for reimbursement of these costs after your continuation coverage payment is received.

Termination of Coverage: Your COBRA continuation coverage will end if you do not pay all premiums on a timely basis (i.e., within 30 days of their due date) – so make sure you follow the billing instructions carefully.

Q&A 49. What Will Cause COBRA Coverage To Terminate?

COBRA continuation ends on the earliest of the following events:

- The end of the 18-, 29- or 36-month continuation period, as applicable;
- The last day of the month following a 30-day period after Social Security makes a final determination that a qualified beneficiary is no longer disabled (you MUST inform the COBRA Administrator within 30 days of that final determination);
- The date, after the date of the initial continuation coverage election, on which the qualified beneficiary becomes entitled to Medicare coverage;
- The date, after the date of the initial continuation coverage election, on which the qualified beneficiary first becomes covered under another group health plan (as an employee or otherwise) – unless the other group health plan applies limitations and then only so long as the qualified beneficiary is affected by the limitation or exclusion, or until eligibility for continuation coverage otherwise ends;
- The end of the premium period if the qualified beneficiary fails to make premium payments within 30 days of the due date; and
- The date the Bank stops offering any group health plans to its employees.

Importantly, COBRA continuation coverage may end earlier for any of the same reasons applicable to active employees and their dependents.

Q&A 50. What Are The Consequences Of Failure To Elect Continuation Coverage?

Your decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries under COBRA to portability of group health coverage, guaranteed access to individual health coverage and special enrollment rights under Part 7 of Title 1 of ERISA. You should contact the COBRA Administrator for more information on these important rights.

Q&A 51. Are Coverage Options Other Than COBRA Available?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which are you eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Q&A 52. Do I Need To Keep The Plan Administrator Informed Of Address Changes?

In order to protect your family's rights, you should keep the Bank's Benefits Administration Unit informed of any changes in the addresses of your family members. You should always keep a copy, for your records, of any notices you send to the Bank's Benefits Administration Unit or the COBRA Administrator.

Q&A 53. What If I Have Questions About COBRA Coverage?

Questions concerning the Plans (and any component plan, as applicable) should be addressed to the Plan Administrator. Questions concerning your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA") and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or vista the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website)

EXTENDED CONTINUATION COVERAGE UNDER STATE LAW

In addition to your rights to continuation coverage under the federal COBRA law, you and your covered dependents may be eligible for an additional extension of continuation coverage under California law (or other state law) beyond the date COBRA continuation coverage is normally scheduled to end. This extension is limited to group health benefits and may not apply to all of the component plans that provide group health benefits.

For additional information about whether or not extended continuation coverage is available to you and the cost of such coverage, contact the Claims Administrator for the applicable component plan.

CONVERSION COVERAGE

Under certain circumstances, you may be eligible to convert your group coverage under a particular component plan to an individual plan (a "conversion plan"). You must refer to the applicable component plan for information regarding conversion rights, if any, or contact the Claims Administrator for the applicable component plan for information. Importantly, where conversion rights are available, there are limits on the amount of time that you have to make an application for a conversion plan and provide necessary information.

BENEFIT CLAIMS AND LEGAL RIGHTS

Q&A 54. How Do I File A Claim For Benefits Under The Group Health And Welfare Plan Or The Flexible Benefits Plan?

This claims procedure only applies to claims as they pertain to the administration of the Group Health and Welfare Plan and the Flexible Benefits Plan (such as the determination of whether an event qualifies as a change in status for purposes of election changes). Claims for benefits under the component plans are governed by the claims procedures set forth in the applicable plan. For the claims procedure for benefits under the Dependent Care Flexible Spending Account Plan see Q&A 55. For the claims procedure for benefits under the Health Care Flexible Spending Account Plan, see Q&A 56. For the claims procedures for benefits under plans subject to contracts with insurance carriers, see Q&A 57.

(a) *Filing of Claim.* You or your authorized representative may file a claim for a benefit to which you believe you are entitled. Such a claim must be in writing and delivered to the Plan Administrator in person or by mail, postage prepaid. Within 90 days after receipt of such claim, the Plan Administrator shall send to you notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial period. If such extension is necessary, you will be given a notice to this effect prior to the expiration of the initial 90-day period.

(b) *Notification of Denied Claim.* The Plan Administrator will provide you a written notice if your claim is denied that sets forth (a) the specific reasons for the denial; (b) specific references to pertinent Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material is necessary; (d) an explanation of the Plan's appeal procedure; (e) a statement of your right to submit written comments and have them considered; (f) a statement of your right to review relevant documents and other information on request and at no charge; and (g) a statement of your right to file suit under section 502 of ERISA (if applicable) with respect to any adverse determination after appeal of the denied claim.

(c) *Appeal of Denied Claim.* Within 60 days after your receipt of written notification of the denial (in whole or in part), you or your duly authorized representative may make a written request to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a review of the denial. If you do not appeal within the 60 day period, you will lose the right to appeal the denial and the right to file suit in court. Your request for review must be in writing, state the reasons why the claim should not have been denied and include any facts or documents pertinent to your claim. You or your authorized representative will have the opportunity ask additional questions to the Plan Administrator, submit written comments to the Plan Administrator and review and request documents and other information relevant to your appeal at no charge.

(d) *Review of Denied Claim.* The Plan Administrator will review and decide a request for a review within 60 days after receipt of such claim, unless special circumstances require an extension of time for processing the review of such denied claim. In no event may the extension exceed 60 days from the end of the initial period. If such extension is necessary, you will be given a notice to this effect prior to the expiration of the initial 60-day period. The Plan Administrator, in its discretion, may hold a hearing on the denied claim. If the Plan Administrator affirms the initial denial of a claim, you will be furnished with a notice of adverse benefit determination on review setting forth (a) the specific reasons for the denial; (b) specific references to pertinent provisions of the Plan document on which the denial is based; (c) a statement of your right to review relevant documents and other information on request and at no charge; (d) a statement of your right to file suit under section 502 of ERISA (if applicable); and (e) a description of any voluntary appeal procedures request.

(e) *Legal Action.* No legal or equitable action for benefits under this Plan can be brought unless and until the claimant (1) has submitted a written claim for benefits in accordance with the procedures described in section (a) above, (2) has been notified that the claim is denied as described in section (b) above, (3) timely has filed a written request for a review of the denied claim in accordance with the procedures described in section (c) above; and (4) has been notified in writing that the denial of the claim has been affirmed in accordance with section (d) above; provided, however, that an action may be brought if a claim or appeal has not been acted upon within the time periods described in sections (a) and (d) above. However, no legal action may be brought under section 502(a) of ERISA more than one year after the final adverse benefit determination under section (d) above or, if earlier, more than four years after the facts or events giving rise to the allegation(s) in the claim or when the claim first occurred. Notwithstanding anything to the contrary in the Plan document or this summary, the Plan Administrator has discretionary authority to deny or grant benefits under this Plan, and no benefits will be paid or made available under this Plan unless the Plan Administrator has determined that the claimant is entitled to them.

Please note that any claim that you may have relating to or arising under the Plan may only be brought in the United States District Court for the Northern District of California. No other court is a proper venue for your claim. The United States District Court for the Northern District of California will have personal jurisdiction over you and any other Participant or Beneficiary named in the action.

Q&A 55. How Do I File A Claim For Benefits Under The Dependent Care Flexible Spending Account Plan?

This claims procedure only applies to claims as they pertain to the administration of the Dependent Care Flexible Spending Account Plan.

(a) *Filing of Claim.* You or your authorized representative may file a claim for a benefit to which you believe you are entitled. Such a claim must be in writing and delivered to the Claims Administrator for the Flexible Benefits Plan in person or by mail, postage prepaid. Within 90 days after receipt of such claim, the Claims Administrator for the Flexible Benefits Plan shall send to you notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial period. If such extension is necessary, you will be given a notice to this effect prior to the expiration of the initial 90-day period.

(b) *Notification of Denied Claim.* The Claims Administrator for the Flexible Benefits Plan will provide you a written notice if your claim is denied that sets forth (a) the specific reasons for the denial; (b) specific references to pertinent Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material is necessary; (d) an explanation of the Plan's appeal procedure; (e) a statement of your right to submit written comments and have them considered; (f) a statement of your right to review relevant documents and other information on request and at no charge; and (g) a statement of your right to file suit under section 502 of ERISA (if applicable) with respect to any adverse determination after appeal of the denied claim.

(c) *Appeal of Denied Claim.* Within 60 days after your receipt of written notification of the denial (in whole or in part), you or your duly authorized representative may make a written request to the Claims Administrator for the Flexible Benefits Plan, in person or by certified mail, postage prepaid, to be afforded a review of the denial. If you do not appeal within the 60 day period, you will lose the right to appeal the denial and the right to file suit in court. Your request for review must be in writing, state the reasons why the claim should not have been denied and include any facts or documents pertinent to your claim. You or your authorized representative will have the opportunity ask additional questions to the Claims Administrator for the Flexible Benefits Plan, submit written comments to the Claims Administrator and review and request documents and other information relevant to your appeal at no charge.

(d) *Review of Denied Claim.* The Claims Administrator for the Flexible Benefits Plan will review and decide a request for a review within 60 days after receipt of such claim, unless special circumstances require an extension of time for processing the review of such denied claim. In no event may the extension exceed 60 days from the end of the initial period. If such extension is necessary, you will be given a notice to this effect prior to the expiration of the initial 60-day period. The Claims Administrator, in its discretion, may hold a hearing on the denied claim. If the Claims Administrator affirms the initial denial of a claim, you will be furnished with a notice of adverse benefit determination on review setting forth (a)

the specific reasons for the denial; (b) specific references to pertinent provisions of the Plan document on which the denial is based; (c) a statement of your right to review relevant documents and other information on request and at no charge; (d) a statement of your right to file suit under section 502 of ERISA (if applicable); and (e) a description of any voluntary appeal procedures request.

(e) *Legal Action.* No legal or equitable action for benefits under this Plan can be brought unless and until the claimant (1) has submitted a written claim for benefits in accordance with the procedures described in section (a) above, (2) has been notified that the claim is denied as described in section (b) above, (3) timely has filed a written request for a review of the denied claim in accordance with the procedures described in section (c) above; and (4) has been notified in writing that the denial of the claim has been affirmed in accordance with section (d) above; provided, however, that an action may be brought if a claim or appeal has not been acted upon within the time periods described in sections (a) and (d) above. However, no legal action may be brought under section 502(a) of ERISA more than one year after the final adverse benefit determination under section (d) above or, if earlier, more than four years after the facts or events giving rise to the allegation(s) in the claim or when the claim first occurred. Notwithstanding anything to the contrary in the Plan document or this summary, the Claims Administrator for the Flexible Benefits Plan has discretionary authority to deny or grant benefits under this Plan, and no benefits will be paid or made available under this Plan unless the Claims Administrator for the Flexible Benefits Plan has determined that the claimant is entitled to them.

Please note that any claim that you may have relating to or arising under the Plan may only be brought in the United States District Court for the Northern District of California. No other court is a proper venue for your claim. The United States District Court for the Northern District of California will have personal jurisdiction over you and any other Participant or Beneficiary named in the action.

Q&A 56. How Do I File A Claim For Benefits Under The Health Care Flexible Spending Account Plan?

This claims procedure only applies to claims for benefits under the Health Care Flexible Spending Account Plan.

(a) *Filing of Claim.* You or your authorized representative may file a claim for a benefit to which you believe you are entitled. Such a claim must be in writing and delivered to the Claims Administrator for the Flexible Benefits Plan in person or by mail, postage paid. Within 30 days after receipt of such claim, the Claims Administrator shall send to you notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 15 days from the end of the initial period. If such extension is necessary, you will be given a notice to this effect prior to the expiration of the initial 30-day period.

(b) *Notification of Denied Claim.* The Claims Administrator for the Flexible Benefits Plan will provide you a written notice if your claim is denied that sets forth (a) the specific reasons for the denial; (b) specific references to pertinent Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to

complete your claim and an explanation of why such material is necessary; (d) an explanation of the Plan's appeal procedure; (e) a statement of your right to submit written comments and have them considered; (f) a statement of your right to review relevant documents and other information on request and at no charge; (g) a statement of your right to file suit under section 502 of ERISA with respect to any adverse determination after appeal of the denied claim; and (i) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request.

(c) *Appeal of Denied Claim.* Within 180 days after your receipt of written notification of the denial (in whole or in part), you or your duly authorized representative may make a written request to the Claims Administrator for the Flexible Benefits Plan, in person or by certified mail, postage prepaid, to be afforded a review of the denial. If you do not appeal within the 180 day period, you will lose the right to appeal the denial and the right to file suit in court. Your request for review must be in writing, state the reasons why the claim should not have been denied and include any facts or documents pertinent to your claim. You or your authorized representative will have the opportunity ask additional questions to the Claims Administrator for the Flexible Benefits Plan, submit written comments to the Claims Administrator and review and request documents and other information relevant to your appeal at no charge.

(d) *Review of Denied Claim.* The Claims Administrator for the Flexible Benefits Plan will review and decide a request for a review in a reasonable time not later than 60 days after the Claims Administrator receives your request for a review. The Claims Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with an appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the Claims Administrator affirms the initial denial of a claim, you will be furnished with a notice of adverse benefit determination on review setting forth (a) the specific reasons for the denial; (b) specific references to pertinent provisions of the Plan document on which the denial is based; (c) a statement of your right to review relevant documents and other information on request and at no charge; (d) a statement of your right to file suit under section 502 of ERISA; (e) a description of any voluntary appeal procedures; and (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request.

(e) *Legal Action.* No legal or equitable action for benefits under this Plan can be brought unless and until the claimant (1) has submitted a written claim for benefits in accordance with the procedures described in section (a) above, (2) has been notified that the claim is denied as described in section (b) above, (3) timely has filed a written request for a review of the denied claim in accordance with the procedures described in section (c) above; and (4) has been notified in writing that the denial of the claim has been affirmed in accordance with

section (d) above; provided, however, that an action may be brought if a claim or appeal has not been acted upon within the time periods described in sections (a) and (d) above. However, no legal action may be brought under section 502(a) of ERISA more than one year after the final adverse benefit determination under section (d) above or, if earlier, more than four years after the facts or events giving rise to the allegation(s) in the claim or when the claim first occurred. Notwithstanding anything to the contrary in the Plan document or this summary, the Claims Administrator for the Flexible Benefits Plan has discretionary authority to deny or grant benefits under this Plan, and no benefits will be paid or made available under this Plan unless the Claims Administrator has determined that the claimant is entitled to them.

Please note that any claim that you may have relating to or arising under the Plan may only be brought in the United States District Court for the Northern District of California. No other court is a proper venue for your claim. The United States District Court for the Northern District of California will have personal jurisdiction over you and any other Participant or Beneficiary named in the action.

Q&A 57. How Do I File a Claim For Benefits Under A Component Plan?

To obtain benefits provided through a component plan, you must follow the claims procedures under the applicable component plan. If the component plan is insured, the claims procedures may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form will be available from the Plan Administrator.

The Claims Administrator for the component plan will decide your claim in accordance with the component plan's claims procedures. The Claims Administrator has the right to secure independent medical advice (as applicable) and to require such other evidence as it deems necessary in order to decide your claim. If the Claims Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reasons for the denial.

If your claim is denied, you may appeal to the Claims Administrator for a review of the denied claim, and the Claims Administrator will decide your appeal in accordance with its claims procedures. If you do not appeal on time, you will lose your right to file suit in a state or federal court because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

The Claims Administrator for each of the component plans offered under the Group Health and Welfare Plan and their contact information is set forth in Appendix A to the Plan Information section of this booklet. The Claims Administrator for each of the component plans offered under the Flexible Benefits Plan and their contact information is set forth in Appendix B to the Plan Information section.

Q&A 58. Is Private Health Information Kept Confidential?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. This protection extends to your health care flexible spending account only to the extent that it is subject to HIPAA's privacy regulations.

The Plan and the Bank will not use or further disclose "protected health information" except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of it business associates to also observe HIPAA's privacy rules. In particular, this Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Bank. The Plan is part of an "organized health care arrangement" under which the individual health benefits, service providers and insurers may share protected health information for treatment, payment and health care operations and may undertake joint activities to manage the organized health care arrangement's operations and improve the quality of health care it provides.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You have the right to be notified of any impermissible acquisition, access, use or disclosure of your protected health information that compromises the security or privacy of your protected health information. You also have the right to file a complaint with the HIPAA Complaint Officer identified in the section entitled "Plan Information" or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, or if you wish to file a complaint under HIPAA, please contact the Plan's Privacy Officer or Complaint Officer, as applicable, identified in the section "Plan Information."

Q&A 59. Can The Bank Amend Or Terminate The Plan (Or A Component Plan)?

Yes. The Bank intends to continue the Plan but reserves the right to amend or terminate the Plan at any time and for any reason. The Plan may be amended or terminated by a resolution of the Bank's Board of Directors. Also, the Chief Administrative Officer (or his or her delegate) or the Plan Administrator may adopt such amendments as provided in the Plan.

Similarly, the Bank reserves the right to amend or terminate any of the component plans offered the Plans at any time and for any reason in accordance with the process described above.

Q&A 60. What Rights Do I Have Under ERISA?

As a Plan participant you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Bank's office and at any other specified locations, such as worksites, all Plan documents governing the Plan and the latest annual report (Form 5500 series), if any, filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

- obtain, upon written request to the Bank and for a reasonable charge, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description; and

- receive a summary of the Plan's annual fiscal report. The Bank is required by law to furnish each participant with a copy of the Summary Annual Report, if such report is required to be prepared.

- continue health care coverage for yourself and your family members if there is a loss of coverage under a component plan providing medical benefits as a result of a qualifying event. Your or your family members may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

- reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a component plan providing medical benefits, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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 the Bank or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits from the Plan, or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits from the Plan 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 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 the Plan documents or the latest annual report from the Plan, and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Bank to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Bank. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file

suit in a state or federal court only after you have pursued your claim through the Plan's claims procedures.

If it should happen that the 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 your case is successful, the court may order the person you sued to pay these costs and fees. If you lose (for example, if your claim were deemed to be frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Bank.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or logging onto its website at http://www.dol.gov/ebsa/.

OTHER MISCELLANEOUS RIGHTS AND PROCEDURES

Q&A 61. What Rights Do I Have Under The Women's Cancer Rights Act Of 1998?

As required by the Women's Cancer Rights Act of 1998, the component plans providing medical benefits provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For more information on this benefit, contact the Claims Administrator for the applicable component plan.

Q&A 62. What Rights Do I Have Under The Newborns' And Mother's Health Protection Act?

In accordance with federal law, the component plans providing medical benefits will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan may pay for a shorter stay if the attending physician, after consultation with the mother, discharges the mother or newborn earlier.

Also, as required under federal law, the level of benefits or out-of-pocket costs will not be set so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a physician or other health care provider is not required to obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce

your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Claims Administrator for the applicable component plan.

Q&A 63. What Rights Do I Have Under The Genetic Information Nondiscrimination Act Of 2008?

As required by the Genetic Information Nondiscrimination Act of 2008 (GINA), the component plans providing medical benefits will not collect genetic information (including family medical history) prior to or in connection with enrollment. In addition, the component plans providing medical benefits will not collect or use genetic information for "underwriting purposes", which include the determination of eligibility for benefits under the plan, the computation of premium or contribution amounts, the application of any pre-existing condition exclusion, and the creation, renewal or replacement of a contract of health insurance or health benefits. GINA also generally prohibits group health plans from requesting or requiring an individual to undergo a genetic test. There is a research exception that permits a plan to request (but not require) that a participant or beneficiary undergo a genetic test.

Additional information about GINA is available at the Department of Labor's website at www.dol/gov/ebsa/compliance_assistance.html.

Q&A 64. Do Pre-Existing Condition Exclusions Apply?

There are no pre-existing condition exclusions under the component plans providing medical benefits. The Affordable Care Act prohibits group health plans from imposing pre-existing condition exclusions, effective for plan years beginning on or after January 1, 2014.

Q&A 65. What Is Creditable Coverage?

Before the Affordable Care Act prohibition on pre-existing conditions took effect, "creditable coverage" referred to health coverage that an individual had in place before enrolling in a new health plan, which could be used to reduce or offset a pre-existing condition exclusion in the new health plan. See Q&A 66 below.

Q&A 66. Will I Need A Certificate Of Creditable Coverage From A Component Plan Providing Medical Benefits?

Certificates of creditable coverage are no longer necessary because pre-existing condition exclusions have been eliminated by the Affordable Care Act.

Before the prohibition on pre-existing condition exclusions took effect, a group health plan could exclude coverage for pre-existing conditions for up to 12 months (18 months for late enrollees). Certificates of creditable coverage were used to prove prior coverage and thereby have pre-existing condition exclusions waived or reduced.

Effective January 1, 2015, under final regulations issued jointly by the Department of the Treasury, Department of Labor, and Department of Health and Human Services, employer group health plans, including the component plans providing medical benefits under this Plan, are no longer required to provide certificates of creditable coverage upon termination of an individual's

health coverage. The regulations recognize that the prohibition on pre-existing condition exclusions has eliminated the need for certificates of creditable coverage.

Q&A 67. What Are The Procedures For Processing A Qualified Medical Child Support Order?

In accordance with federal law, the component plans providing medical benefits provide medical coverage to certain children (called alternate recipients) if directed to by so by a Qualified Medical Child Support Order ("QMCSO"). This is an order or judgment from a court, or produced as part of a state-authorized administrative process, directing the Plan Administrator to include a child in an Employee's medical coverage.

In addition to requiring the Employee to provide coverage for the child, the law authorizes the Bank to make applicable payroll deductions, if any.

Upon receipt of a medical support order purporting to be a QMCSO, the Bank will transmit the order to the Claims Administrator for the applicable component medical plan in accordance with the procedures established for reviewing and implementing such orders with respect to coverage under the component plans providing medical benefits. The Claims Administrator will promptly notify both you and the alternate recipient that the order has been received and what procedures will be used to determine if the order is qualified. Then the Claims Administrator will decide, on the basis of the Bank's written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the Claims Administrator will notify you and the alternate recipient by mail.

Upon receipt of a properly completed National Medical Child Support Notice ("Notice") issued by a state child support agency, the Notice shall be treated as a QMCSO. If the Bank cannot comply with the Notice in Part A for one of the permitted reasons, the Bank must complete the Employer Response form included in Part A of the Notice and advise the issuing agency. If the Bank can comply with the Notice, then it must follow the procedures described in the Notice and so advise the issuing agency and all affected parties.

You can obtain more information on QMSCO procedures by contacting the Claims Administrator for the applicable component medical plan. A copy of the QMSCO procedures is available without charge from the Claims Administrator.

Q&A 68. How Are Benefits For Domestic Partners Paid?

The cost of coverage for domestic partners is paid on an after-tax basis unless the partner qualifies as the Employee's tax dependent, in which case the cost of coverage may be paid pre-tax with Bank approval and by completing the applicable procedures (e.g., completing a domestic partner affidavit). Paying for coverage on an after-tax basis means that the value of coverage (less any contributions you make for such coverage) will be imputed to you as income and your contributions for domestic partner coverage will be paid on after-tax basis. Same-sex domestic partnerships may be eligible for the waiver of California income tax for domestic partner health coverage if both partners have filed a Declaration of Domestic Partnership with the State of California. Opposite-sex domestic partnerships may be eligible for the waiver of California income tax for domestic partner health coverage if both partners have filed a

Declaration of Domestic Partnership with the State of California and at least one domestic partner (a) is age 62 or over; (b) is insured for Social Security Benefits; and (c) has filed an application for old-age insurance benefits or will be entitled to Social Security Benefits as of the month before reaching retirement age. Please consult your tax advisor for more details.

Q&A 69. What Procedures Apply Regarding Subrogation And Reimbursement For Acts Of Third Parties?

Under some circumstances, you (or someone you have enrolled for dependent coverage) may need services provided under a component plan providing medical benefits for which a third party may be liable or legally responsible (for example, by reason of negligence, an intentional act, or breach of any legal obligation). As a condition of coverage and participation in the plan as a covered Employee or covered dependent, you and your covered dependents (each, a "covered person") agree to the following conditions under which the services will be provided:

1. As used below:

   a. "plan" means a component plan providing medical benefits.

   b. "responsible person" means a third party or its insurer or guarantor, or anyone else who may be legally responsible for an illness, disease, injury or condition or the costs thereof (whether in tort, contract, by statute, or otherwise).

   c. "recovery" means any actual or potential payment on account of any illness, disease, injury or condition, for which a responsible person may be liable to you, regardless of whether the payment results from a settlement, judgment or otherwise, and regardless of how it is characterized (for example, as economic, non-economic or other compensatory damages, punitive or exemplary damages, actual medical expenses, pain and suffering, wrongful death, or loss of consortium).

   d. "you" means you, your covered dependents, or anyone acting in your stead or on your behalf, including your estate, parent, or legal guardian.

2. The plan shall automatically have a first priority lien upon any recovery that you receive, or may be entitled to receive, directly or indirectly, from a responsible person. The lien shall constitute an equitable lien by agreement and shall be in the full amount of the benefits provided through or paid under the plan for the treatment of any illness, disease, injury, or condition for which the responsible person may be liable to you. You hereby consent to this lien and agree to cooperate with the plan or its agents or assignees to enforce any rights that the plan may have with respect to any recovery. Your failure to acknowledge the plan's lien shall be a sufficient ground for termination of your future participation in the plan, as well as discontinuance of payment of some or all of your future benefits under the plan.

3. The plan shall have an automatic, specific, and first-priority right of reimbursement, up to the amount of the plan's lien, out of the proceeds of any recovery that you may receive or be entitled to receive. You shall reimburse the plan, in full and as a first priority, for benefits provided by or through the plan, immediately upon collecting any recovery from a

responsible person or receiving the benefit of such recovery. The plan's rights under this section are enforceable regardless of the purpose of the payment by the responsible person or how it may be characterized in any agreement or judgment between you and the responsible person. If the covered person is a minor, then any amount recovered by the minor or the minor's representative shall also be subject to the subrogation and reimbursement provisions in this section, regardless of state law and regardless of whether the minor or the minor's representative has access to or control over such funds.

4. The plan's lien and its rights of subrogation and reimbursement shall not be affected, reduced, or eliminated without the plan's prior written consent. Without limiting the generality of the foregoing, the plan's lien and its rights of subrogation and reimbursement shall not be reduced or offset on account of the common fund doctrine, the doctrine of unjust enrichment, the make-whole doctrine, the double-recovery rule, principles of comparative or contributory fault, the argument that another party is liable only in part, the argument that the recovery is less than the actual loss suffered by the covered person, the argument that the responsible person's resources or insurance may be limited, the argument that the covered person had to pay legal fees, court costs, or other expenses to obtain the recovery, the argument that the plan should share in a pro rata allocation of a covered person's fees and costs (including attorneys' fees) incurred in pursuit of a claim, or any similar theory whether based on federal common law, state law or some other source. To the extent that such a theory would otherwise have provided equitable or other defenses against the plan's lien, each covered person disclaims all such defenses and recognizes that the plan is providing benefits to the covered person in reliance upon that disclaimer. The plan shall not be responsible for paying any part of a covered person's legal fees or costs in connection with obtaining a recovery from a responsible person. The plan shall be entitled to recover from the covered person the value of all services provided and paid for by, through or on behalf of the plan, when the covered person is reimbursed or paid for the cost of care by a responsible person. The plan shall not be required to apportion recoveries and shall remain entitled to one hundred percent (100%) reimbursement from any recovery for all benefits provided to the covered person on account of the illness, disease, injury or condition that is the subject of the recovery, regardless of whether the covered person obtains a full or partial recovery (i.e., is "made whole"), regardless of whether the recovery is a settlement, judgment, or award, and regardless of the attorneys' fees and costs incurred by the covered person in seeking the recovery from the responsible person. Any recovery received by or on behalf of a covered person shall first be used to reimburse the benefits and expenses paid by the plan (including attorneys' fees and court costs if the plan brings suit in the name of the covered person).

5. You shall serve as a constructive trustee for the plan over any recovery you receive to which the plan may have a claim. You must segregate any recovery received (up to the amount of the plan's first lien) in a separate account, and must preserve that recovery so that the plan may enforce its lien and any disputes as to entitlement may be resolved. Your failure to hold any recovery in trust for the plan shall be deemed a breach of your duties under the plan. Any recovery or overpayment (as defined below) must be segregated as described in this section until the plan has confirmed in writing that no dispute exists. If you dissipate or transfer the recovery or overpayment when the plan has a lien upon or claim to such funds, that shall constitute inequitable conduct and a breach of the plan by you. You agree that the plan may, without limitation, trace the transferred or dissipated recovery or overpayment and

recover the disputed amount from your other assets or assets paid over to a third person (including, without limitation, your attorney), all of which for this purpose shall be subject to an equitable lien by agreement in the amount of the plan's claim.

6. Within 30 days of the date when a covered person or the covered person's representative initiates any action to assert a claim against a responsible person (for example, by sending notice of the claim, submitting a claim, or filing a lawsuit), the covered person must advise the Claims Administrator for the applicable component plan in writing of that fact. The plan shall be entitled to intervene and participate in such action, and the plan's lien shall apply to any resulting recovery regardless of whether the plan elects to intervene.

7. You must, in a timely manner, furnish such information and assistance, execute and deliver such instruments and papers, and take such other actions as the plan or its agents or assignees may reasonably request to secure, protect, or facilitate the exercise or enforcement of the plan's rights or interests. The instruments and papers that you may be required to execute may include a separate subrogation agreement that does not conflict with the provisions of this section, if the plan's fiduciaries or its counsel deem such an agreement to be necessary or appropriate. You shall not do anything to hinder the plan's assertion of its right to a recovery. Without the prior written consent of the plan or its agents or assignees, as may be applicable, you must not take any action that may prejudice the plan's rights or interests, including without limitation disbursing or dissipating any recovery, or releasing or compromising any claim against a responsible person as to which the plan may have an interest. You must cooperate fully with the plan and its fiduciaries, agents or assignees and abide by the terms of the plan, including the provisions of this section. The plan shall have the right to withhold and/or set off payment of claims and/or benefits pending the resolution of disputes relating to subrogation or reimbursement. Failing to advise the plan of a claim against a third party, failing to cooperate with the plan or its agents or assignees, disbursing, transferring, or dissipating any recovery to which the plan has a claim or upon which the plan has a lien, or taking actions that prejudice the plan's rights or interests would be a material breach of the plan, shall entitle the plan to the imposition of a constructive trust, and may result in your being equitably responsible for reimbursing the plan.

8. The plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the plan's lien and/or to obtain (or to preclude or reverse the transfer, dissipation, or disbursement of) such portion of any recovery in which the plan may have a right or interest. The plan shall be entitled to enforce its lien even if the recovery is less than the actual loss you suffered.

9. If you fail, refuse, or are unable to institute legal action against a responsible person, then the plan shall have the right, at its option and in its sole and absolute discretion, at any time to become subrogated to, and thereby assume and prosecute, your claim against any responsible person for amounts paid under the plan on account of your illness, disease, injury, or condition. The plan may exercise that option by written notice to you or your legal representative. Upon such written notice, you or your legal representative shall transfer to the plan any rights that you may have to a recovery from a responsible person of any amounts paid by the plan to you or on your behalf. The plan shall be entitled to prosecute such a claim in your name, with or without specific consent. If the plan chooses to proceed

by subrogation, the plan shall be entitled to obtain, out of any recovery, the amount of benefits paid or to be paid to you, together with the plan's costs and attorneys' fees. If the plan becomes subrogated to your claim against a responsible person, you must cooperate in the plan's efforts to pursue a recovery, including assisting the plan's attorneys in preparing or pursuing the case and attending hearings, depositions and trial of the case. The plan's subrogation rights are independent of, and in addition to, the rights of reimbursement set forth in this section.

10. It is the intent of the plan that you or a covered dependent should recover only one payment for any costs that may be covered or reimbursable under the plan. You acknowledge and agree that the intent of this section (entitled "What Procedures Apply Regarding Subrogation and Reimbursement for Acts of Third Parties?") is to restore and preserve the *status quo ante* and to avoid duplicative or undeserved recovery or payments to you.

11. You shall not, without the plan's prior written consent, assign any right, claim, or cause of action against a responsible person to recover for any illness, disease, injury, or condition on account of which benefits were paid by the plan. Each covered person assigns to the plan any benefits that the covered person may have under any automobile policy or other coverage on account of any illness, disease, injury, or condition for which the plan pays or provides benefits, to the extent of the plan's lien.

12. The plan is governed by ERISA and, to the extent that such law is not preempted by ERISA, is subject to California law. To the extent that any portion of the plan is inconsistent with applicable law in whole or in part, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the plan shall remain in full force and effect. Thus, for example, if an applicable law were to limit the amount of the lien provided for in paragraph 2 above, then the lien shall be enforceable in the greatest amount allowable consistent with that law.

13. The plan's fiduciaries may (but are not required to) determine in a particular instance that any or all of the plan's rights under this section should not be exercised, or that the exercise of such rights should be discontinued. In making such a determination, the plan's fiduciaries may (but are not required to) consider factors such as the size of any potential recovery, the likelihood of obtaining a recovery, and the cost to the plan of doing so.

14. You might receive payments through the plan that exceed the payments to which you are legally entitled under the plan. Such payments, to the extent that they exceed the amount to which you are legally entitled under the plan, are hereinafter referred to as "overpayments." In the event that you receive an overpayment, (i) the overpayment shall belong to the plan; (ii) the plan shall have a right to reimbursement of the full amount of the overpayment; (iii) the plan shall have a first-priority equitable lien by agreement upon the overpayment; (iv) you shall not have any right to use the overpayment; (v) you shall segregate and not disburse or dissipate the overpayment so that the overpayment may be returned to the plan and any dispute over entitlement to the overpayment can be resolved; (vi) you shall be required to return the overpayment to the plan; (vii) you shall cooperate with any efforts by the plan to recover the overpayment; (viii) the plan shall automatically have a lien, in the amount of the overpayment, upon any monies paid or payable to you by the plan; (ix) the plan shall have a right of equitable restitution with respect to the overpayment; (x) the plan shall have a right to the imposition of a constructive trust on the overpayment; (xi) if the

overpayment is the subject of a declaratory judgment action, no costs or expenses, including attorneys' fees, may be recovered out of the overpayment; and (xii) the plan shall be entitled, at its option and in its sole discretion, to recoupment by withholding and retaining any monies payable to you, up to the amount of the overpayment.

15. If the plan takes legal action against a covered person to enforce its rights under this section, the plan shall be entitled to recover its attorneys' fees and expenses from the covered person.

16. The plan's fiduciaries, in their sole discretion, may waive the plan's right of recovery. To be enforceable, such a waiver must be in writing and signed by a duly authorized representative of the plan. The plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to any other claim; and the plan's waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to any other covered person.

17. For purposes of this section, any action, right, or entitlement of the plan may be taken, asserted, or enforced by the plan's fiduciary. Any ambiguity in this section, or any dispute arising out of or in connection with this section, shall be resolved by the plan fiduciary, and the interpretation and application of this section shall be committed to the plan fiduciary's discretion.

Q&A 70. Does The Plan Provide Any Employment Rights?

No. Nothing in the Plan (or any component plan, as applicable) or this booklet shall be deemed to give any person any right to employment with the Bank or to affect the Bank's right to terminate the employment of any person at time with or without cause. The Bank reserves the right to terminate your employment at any time for any reason.

PLAN INFORMATION

A. PLAN NAME:

Bank of the West Group Health and Welfare Plan

Bank of the West Flexible Benefits Plan (the Flexible Benefits Plan is not an ERISA plan; however, some of its component plans are subject to ERISA)

B. NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN SPONSOR AND PLAN ADMINISTRATOR:

Bank of the West
180 Montgomery Street
San Francisco, CA 94104
(415) 432-3598

C. CLAIMS ADMINISTRATOR:

Bank of the West
180 Montgomery Street
San Francisco, CA 94104
(415) 432-3598

D. COBRA ADMINISTRATOR:

ADP Benefits Services
P.O. Box 1853
Phoenix, AZ 85062-8328
(800) 654-6695

E. PLAN YEAR:

January 1 to December 31.

F. PLAN SPONSOR IDENTIFICATION NUMBER:

IRS Employer Identification Number: 94-0475440

G. PLAN NUMBER:

The Plan Number is 506.

H. COMPONENT PLANS

The Plan Information for the component plans of the Group Health and Welfare Plan is set forth in Appendix A.

The Plan Information for the component plans of the Flexible Benefits Plan is set forth in Appendix B.

I. AGENT FOR LEGAL PROCESS:

Service of legal process may be made on the Plan by serving the Director of Human Resources, Bank of the West, 180 Montgomery Street, San Francisco, California 94104.

J. PRIVACY OFFICER FOR COMPONENT PLANS SUBJECT TO HIPAA:

SVP and Compensation and Benefits Manager, Bank of the West, 180 Montgomery Street, San Francisco, California 94104.

K. COMPLAINT OFFICER FOR COMPONENT PLANS SUBJECT TO HIPAA:

Compensation and Benefits Manager, Bank of the West, 180 Montgomery Street, San Francisco, California 94104.

L. CONTRIBUTION PAYMENTS:

The Bank may pay all or some portion of the cost of coverage for a particular component plan. The Bank pays for Plan administrative expenses and may elect to pay administrative expenses from the Plan.

M. TYPE OF PLAN:

The Group Health and Welfare Plan is an "employee welfare benefit plan" within the meaning of Section 3(1) of ERISA.

N. GRANDFATHERED PLAN NOTICE:

Bank of the West believes its medical, dental and vision plans (with the exception of Anthem HMO, Kaiser Northern California, Kaiser Oregon and Providence plans) are "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered status can be directed to the plan administrator or HR Connections at (877) 977-6947. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Appendix A
Plan Information - Component Plans of the
Bank of the West Group Health and Welfare Plan (Plan No. 506)[1]

Plan Name	Flexible Benefits Plan	Employee Assistance Plan	Life Insurance (Dependent Coverage)	Wellness Program	Legal Services Plan
Plan Sponsor	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	BancWest Corporation Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Sponsor's Employer Identification Number	94-0475440	94-0475440	99-0156159	94-0475440	94-0475440
Plan Number	506	506	502	506	506
Plan Type	Cafeteria plan within the meaning of Section 125 of the Internal Revenue Code	Welfare plan providing professional support services designed to help employees cope with a variety of personal and career-related issues	Welfare plan providing Group Life Insurance, Dependent Life Insurance and AD&D	Welfare plan providing services designed to help promote employee health and prevent disease	Welfare plan providing professional legal services
Claims Administrator	ADP Benefits Services P.O. Box 1853 Phoenix, AZ 85062-8328 (800) 654-6695	Aetna Employee Assistance Program Attn: Quality Unit 151 Farmington Avenue, RS32 West Hartford, CT 06156	Metropolitan Life Insurance Company P.O. Box 14590 Lexington, KY 40511 (800) 300-4296	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Hyatt Legal Plan, Inc. 111 Superior Ave. Cleveland, OH 44114-2407
Funding Method and Contributions	See Appendix B for funding and contribution information for the component plans of the Flexible Benefits Plan.	The plan is insured by Aetna. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Metropolitan Life Insurance Company. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is self-insured by Bank of the West and plan benefits are paid from the Bank's general assets, which means that benefits under the plan are not guaranteed under a contract of insurance. The total contributions for the plan are determined by Bank of the West. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward the cost of plan benefits will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Met-Life Hyatt Legal. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.

[1] The information in Appendix A is subject to change at any time. While every effort is made to keep this information current, you should contact the Plan Administrator if you have questions about possible changes to Appendix A.

Plan Name	Flexible Benefits Plan	Employee Assistance Plan	Life Insurance (Dependent Coverage)	Wellness Program	Legal Services Plan
Name and Address of Plan Administrator	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Agent for Legal Service	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	BancWest Corporation Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Year	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31

Appendix B
Plan Information - Component Plans of the Bank of the West Flexible Benefits Plan (Plan No. 506)[2]

Plan Name	Medical	Medical	Prescription	Medical	Medical	Medical
Plan Sponsor	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Sponsor's Employer Identification Number	94-0475440	94-0475440	94-0475440	94-0475440	94-0475440	94-0475440
Plan Number	506	506	506	506	506	506
Plan Type	Welfare plan providing comprehensive PPO medical benefits	Welfare plan providing routine care medical benefits	Welfare plan providing prescription drug coverage under the PPO medical plan	Welfare plan providing HMO medical benefits	Welfare plan providing HMO medical benefits	Welfare plan providing HMO medical benefits
Claims Administrator	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060 (877) 216-3990	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060 (877) 216-3390	Express Scripts 300 Ocean Gate Blvd. Suite 350 Long Beach, CA 90802 (800) 987-5248	Kaiser Foundation Health Plan PO Box 23758 San Diego, CA 92193 (800) 464-4000	Kaiser Foundation Health Plan PO Box 23448 San Diego, CA 92193 (800) 464-4000	Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232 (508) 813-4480
Funding Method and Contributions	The plan is self-insured by Bank of the West and plan benefits are paid from the Bank's general assets, which means that benefits under the plan are not guaranteed under a contract of insurance. The total contributions for the plan are determined by Bank of the West. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward the cost of plan benefits will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is self-insured by Bank of the West and plan benefits are paid from the Bank's general assets, which means that benefits under the plan are not guaranteed under a contract of insurance. The total contributions for the plan are determined by Bank of the West. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward the cost of plan benefits will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is self-insured by Bank of the West and plan benefits are paid from the Bank's general assets, which means that benefits under the plan are not guaranteed under a contract of insurance. The total contributions for the plan are determined by Bank of the West. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward the cost of plan benefits will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Kaiser Foundation Health Plan, Inc. (Southern California). The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Kaiser Foundation Health Plan, Inc. (Northern California). The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Kaiser Foundation Health Plan of the Northwest. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.

[2] The information in Appendix B is subject to change at any time. While every effort is made to keep this information current, you should contact the Plan Administrator if you have questions about possible changes to Appendix B.

Appendix B (continued)
Plan Information - Component Plans of the
Bank of the West Flexible Benefits Plan (Plan No. 506)

Plan Name	Medical	Medical	Prescription	Medical	Medical	Medical
Name and Address of Plan Administrator	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Agent for Legal Service	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Year	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31

Appendix B (continued)
Plan Information - Component Plans of the
Bank of the West Flexible Benefits Plan (Plan 506)

Plan Name	Medical	Medical	Medical	Medical	Dental	Dental	Dental
Plan Sponsor	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Sponsor's Employer Identification Number	94-0475440	94-0475440	94-0475440	94-0475440	94-0475440	94-0475440	94-0475440
Plan Number	506	506	506	506	506	506	506
Plan Type	Welfare plan providing HMO medical benefits	Welfare plan providing HMO medical benefits	Welfare plan providing HMO medical benefits	Welfare plan providing HMO medical benefits	Welfare plan providing dental benefits.	Welfare plan providing DMO dental benefits.	Welfare plan providing DMO dental benefits
Claims Administrator	Kaiser Foundation Health Plan of the Colorado P.O. Box 373150 Denver, CO 80237 (303) 338-3600	Anthem Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060 (877) 216-3990	Presbyterian Health Plan P.O. Box 27489 Albuquerque, NM 87125 (505) 923-5678	Providence Health Plan P.O. Box 4327 Portland, OR 97208 (503) 574-7500	MetLife P.O. Box 14083 Lexington, KY 40512-4083 (800) 282-8738	Cigna Dental Health of California, Inc. 400 S. Brand Blvd Suite 600 Glendale, Ca 91203 (800) 367-1037	Delta Dental Health Plan 12898 Towne Center Drive Cerritos, Ca 90703 (800) 422-4234
Funding Method and Contributions	The plan is insured by Kaiser Foundation Health Plan of the Colorado. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The	The plan is insured by Anthem Blue Cross of California. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West. .	The plan is insured by Presbyterian Health Plan. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Providence Health Plan. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is self-insured by Bank of the West and plan benefits are paid from the Bank's general assets, which means that benefits under the plan are not guaranteed under a contract of insurance. The total contributions for the plan are determined by Bank of the West. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward the cost of plan benefits will be used in their entirety prior to using Bank contributions. The	The plan is insured by Cigna Dental. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Delta Dental Health Plan. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.

Appendix B (continued)
Plan Information - Component Plans of the
Bank of the West Flexible Benefits Plan (Plan No. 506)

Plan Name	Medical	Medical	Medical	Medical	Dental	Dental	Dental
	balance of the cost of the plan, if any, is paid by Bank of the West.				balance of the cost of the plan, if any, is paid by Bank of the West.		
Name and Address of Plan Administrator	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Agent for Legal Service	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Year	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31

Appendix B (continued)
Plan Information - Component Plans of the
Bank of the West Flexible Benefits Plan (Plan No. 506)

Plan Name	Long Term Disability	Short Term Disability	Health Care Flexible Spending Account Plan	Dependent Care Flexible Spending Account Plan
Plan Sponsor	BancWest Corporation Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Sponsor's Employer Identification Number	99-0156159	94-0475440	94-0475440	94-0475440
Plan Number	509	506	506	506
Plan Type	Welfare Plan providing long term disability benefits	Welfare plan providing short term disability benefits	Welfare plan providing for reimbursement of eligible health care expenses	Welfare plan providing reimbursement of eligible dependent care expenses.
Claims Administrator	Metropolitan Life Insurance Company P.O. Box 14590 Lexington, KY 40511 (800) 300-4296	Metropolitan Life Insurance Company P.O. Box 14590 Lexington, KY 40511 (800) 300-4296	ADP Benefits Services PO Box 1853 Phoenix, AZ 85062 (800) 6546695	ADP Benefits Services PO Box 1853 Phoenix, AZ 85062 (800) 6546695
Funding Method and Contributions	The plan is insured by Metropolitan Life Insurance Company. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The plan is insured by Metropolitan Life Insurance Company. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	Participants may elect to make contributions up to maximum contribution limit set forth by the plan. The plan is unfunded and benefits are paid from Bank of the West's general assets.	Participants may elect to make contributions up to maximum contribution limit set forth by the plan. The plan is unfunded and benefits are paid from Bank of the West's general assets.
Name and Address of Plan Administrator	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Agent for Legal Service	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Year	January 1 to December 31	January 1 to December 31	January 1 to December 31	January 1 to December 31

Appendix B (continued)
Plan Information - Component Plans of the
Bank of the West Flexible Benefits Plan (Plan No. 506)

Plan Name	Group Life Insurance and AD&D	Vision
Plan Sponsor	BancWest Corporation Bank of the West 180 Montgomery Street San Francisco, CA 94104	BancWest Corporation Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Sponsor's Employer Identification Number	99-0156159	99-0156159
Plan Number	502	513
Plan Type	Welfare Plan providing Group Life Insurance, Dependent Life Insurance and AD&D	Welfare plan providing Vision benefits.
Claims Administrator	Metropolitan Life Insurance Company P.O. Box 14590 Lexington, KY 40511 (800) 300-4296	Vision Service Plan PO Box 997105 Sacramento, CA 95899 (800) 877-7195
Funding Method and Contributions	The Plan is insured by Metropolitan Life Insurance Company. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.	The Plan is insured by Vision Service Plan. The premiums for plan benefits are set forth in or determined pursuant to the terms of the contract and paid from Bank of the West's general assets. The participant rate of contribution for the plan is set by Bank of the West and may be adjusted from time to time. Participant contributions toward premiums will be used in their entirety prior to using Bank contributions. The balance of the cost of the plan, if any, is paid by Bank of the West.
Name and Address of Plan Administrator	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Agent for Legal Service	Bank of the West 180 Montgomery Street San Francisco, CA 94104	Bank of the West 180 Montgomery Street San Francisco, CA 94104
Plan Year	January 1 to December 31	January 1 to December 31

ELIGIBLE HEALTH FSA EXPENSES

This list is provided as general guidance on what amounts may be reimbursed under a Health Care Flexible Spending Account under prevailing IRS guidance. It is not intended to be comprehensive and is subject to amendment and modification by the Plan Administrator. The Plan Administrator has discretionary authority to determine whether any expense may be reimbursed and its determinations shall be conclusive and binding on all persons. The maximum amount that may be reimbursed for any Plan Year is $2,500.

DRUGS AND MEDICINES

ALLOWABLE EXPENSES:

Prescription drugs or insulin
Medicines and drugs for personal use may only be reimbursed if purchased with a prescription or constituting insulin.
Stop smoking patches and nicotine gum when purchased with a prescription

DISALLOWED EXPENSES:

Cost of items that are not for the alleviation or treatment of personal injuries or sickness, such as the following:
- Cost of vitamins, unless prescribed by a physician for treatment of a specific illness
- Cost of herbs
- Cost of Rogaine (unless prescribed by a physician for a specific medical condition – such as hypertension)
- Cost of Retin- A (unless prescribed by a physician to treat a specific medical condition – such as acne)

Cost of illegal drugs

MEDICAL EQUIPMENT

ALLOWABLE EXPENSES:

Wheelchair or autoette (cost of operating/maintaining)
Crutches (purchased or rented)
Special mattress & plywood boards prescribed to alleviate arthritis

Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition.
Artificial limbs
Support hose (if medically necessary)
Wigs (where necessary to mental health of individual who loses hair because of disease - such as cancer)
Excess cost of orthopedic shoes over cost of ordinary shoes

DISALLOWED EXPENSES:

Wigs, when not medically necessary for mental health
Vacuum cleaner purchased by an individual with dust allergy
Mechanical exercise devise not specifically prescribed by a physician
Breast pump if not for use to treat a medical condition

FEE/SERVICES

ALLOWABLE EXPENSES:

Co-insurance, co-pays and deductibles under a group health plan
Physician's fees
Obstetrical expenses
Hospital services
Nursing services for care of a specific medical ailment
Cost of a nurse's room & board if paid by the employee where nurse's services qualify
The Social Security tax paid with respect to wages of a nurse where nurse's services qualify
Surgical or diagnostic services
Services for chiropractors and osteopaths
Anesthesiologist's fees
Dermatologist's fees
Gynecologist's fees
Christian Science practitioner fees
Cosmetic surgery necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

ELIGIBLE HEALTH FSA EXPENSES (continued)

DISALLOWED EXPENSES:

Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non medical nature
Nursemaids or practical nurses who render general care for healthy infants
Fees for exercise, athletic, or health club membership
Payments for which the child care credit is taken on your income tax form
Elective cosmetic surgery/cosmetic services or products

PSYCHIATRIC CARE

ALLOWABLE EXPENSES:

Services of psychotherapists, psychiatrists and psychologists
Psychiatric therapy for sexual problems
Long distance telephone tolls for psychiatric counseling conducted over the phone
Legal fees directly related to mental commitment of mentally ill person

DISALLOWED EXPENSES:

Psychoanalysis undertaken to satisfy curriculum requirements of a student
Marriage counseling fee

DENTAL & ORTHODONTIC CARE

ALLOWABLE EXPENSES:

Dental Care
Artificial teeth/dentures
Cost of fluoridation of home water supply advised by dentist
Braces, orthodontic devices (*contact the Plan Administrator for details)

DISALLOWED EXPENSES:

Bleaching of teeth
Mouthwash
Floss
Electric toothbrushes

THERAPY TREATMENTS

ALLOWABLE EXPENSES:

X ray treatments
Treatment for alcoholism or drug dependency
Abortions (if legal)
Sterilization (if legal)
Vasectomy (if legal)
Acupuncture
Chiropractor's fees
Vaccinations
Physical therapy (as a medical treatment)
Fee to use swimming pool for exercises prescribed by a physician to alleviate specific medical condition such as rheumatoid arthritis
Speech therapy
Stop smoking programs
Weight loss programs prescribed by a physician to treat a specific illness (e.g., heart disease)
Weight loss programs to treat obesity if diagnosed by a physician

DISALLOWED EXPENSES:

Tattoos and ear piercing
Religious cult de programming
Physical treatments unrelated to a specific health problem (e.g. massage for general well-being)
Any illegal treatment

ELIGIBLE HEALTH FSA EXPENSES (continued)

PHYSICALS

ALLOWABLE EXPENSES:

Routine & preventive physicals
School & work physicals

HEARING AIDS

ALLOWABLE EXPENSES:

Hearing aids
Batteries for operation of hearing aids

VISION CARE

ALLOWABLE EXPENSES:

Optometrist's or Ophthalmologist's fees
Prescription Eyeglasses
Contact lens
Contact lens solution
Radial Kerotonomy
Corrective eye surgery

ASSISTANCE FOR THE HANDICAPPED

ALLOWABLE EXPENSES:

Cost of guide for a blind person
Cost of note taker for a deaf child in school
Cost of Braille books and magazines in excess of cost of regular editions
Excess costs of specifically equipping automobile for handicapped person over cost of ordinary automobile; device for lifting handicapped person into an automobile

Cost of seeing eye dog or other animal used by the visually impaired, hearing impaired or persons with other physical disabilities (cost of buying, training, and maintaining)

MISCELLANEOUS CHARGES

ALLOWABLE EXPENSES:

X rays
Vaccinations
Expenses of services connected with donating an organ
Cost of computer storage of medical records
Child birth preparation classes addressing specific medical issues such as labor, delivery and breathing techniques (limited to expenses incurred by mother-to-be).
Cost of physician services for weight loss, but only if medically necessary to remedy a condition other than general well being.
Treatment of infertility, including in vitro fertilization, fertilization, and surgery
Cost of transportation primarily for, and essential to, medical care

DISALLOWED EXPENSES:

Expenses of divorce when doctor or psychiatrist recommends divorce
Cost of toiletries, cosmetics, and sundry items (e.g. soap, toothbrushes)
Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or employee cannot show cost in excess of cost of a normal diet
Maternity clothes
Diaper service
Distilled water purchased to avoid drinking fluoridated city water
Installation of power steering in automobile
Pajamas purchased to wear in hospital
Mobile telephone used for personal calls as well as calls to physician
Insurance against loss of income, loss of life, limb, or sight
Any portion of a premium charge which represents a tax
Union dues for sick benefits for members
Contributions to state disability funds

ELIGIBLE HEALTH FSA EXPENSES (continued)

Long-term care insurance premiums
Long-term care services
Auto insurance providing medical coverage for all persons injured in or by the taxpayer's automobile
Cost of purchasing diet food
Insurance premiums for other health coverage or long-term coverage

Attachment 2

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT vs. DEPENDENT CARE TAX CREDIT

ONE DEPENDENT ILLUSTRATION

The following example is based on a married couple filing a joint return. The couple has one child under age 13, and spends $5,000 on dependent care. On their federal tax return, they claim the standard deduction and three exemptions.

	DCAP - $5,000 Contribution	**Claiming Dependent Care Tax Credit**
W-2 Gross Wages Before Salary Reduction (both spouses combined)	$40,000	$40,000
DCAP Salary Reduction	($5,000)	$ 0
W-2 Gross Wages After Salary Reduction	$35,000	$40,000
Standard Deduction	($12,600)	($12,600)
Exemptions (3 individuals x $4,000)	($12,000)	($12,000)
Taxable Income	$10,400	$15,400
Out-of-Pocket Dependent Care Expenses (i.e., not reimbursed by DCAP)	$ 0	($5,000)
FICA Tax	($2,678)	($3,060)
Federal Income Tax	($1,040)	($1,540)
Dependent Care Tax Credit (appropriate percentage (22%) x dependent care expenses up to first $3,000)	$ 0	$ 660
Child Tax Credit (up to $1,000 per qualifying child; cannot exceed tax liability after application of Dependent Care Tax Credit, if applicable)	$ 1,000	$ 880
Disposable Income (after dependent care expenses and taxes, taking applicable credits into account)	$32,282	$31,940

This chart is based on 2015 federal income tax rates and is for illustrative purposes only. The preferable method for a particular Participant will depend on factors such as tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, and the like. It is recommended that you consult your tax advisor for guidance on which is best for you.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT vs. DEPENDENT CARE TAX CREDIT

TWO DEPENDENTS ILLUSTRATION

The following example is based on a married couple filing a joint return. The couple has two children, both under age 13, and spends $5,000 on dependent care. On their federal tax return, they claim the standard deduction and four exemptions.

	DCAP - $5,000 Contribution	**Claiming Dependent Care Tax Credit**
W-2 Gross Wages Before Salary Reduction (both spouses combined)	$40,000	$40,000
DCAP Salary Reduction	($5,000)	$ 0
W-2 Gross Wages After Salary Reduction	$35,000	$40,000
Standard Deduction	($12,600)	($12,600)
Exemptions (4 individuals x $4,000)	($16,000)	($16,000)
Taxable Income	$ 6,400	$11,400
Out-of-Pocket Dependent Care Expenses (i.e., not reimbursed by DCAP)	$ 0	($5,000)
FICA Tax	($2,678)	($3,060)
Federal Income Tax	($640)	($1,140)
Dependent Care Tax Credit (appropriate percentage (22%) x dependent care expenses up to first $6,000)	$ 0	$ 1,100
Child Tax Credit (up to $1,000 per qualifying child; cannot exceed tax liability after application of Dependent Care Tax Credit, if applicable)	$ 640	$ 40
Disposable Income (after dependent care expenses and taxes, taking applicable credits into account)	$32,322	$31,940

This chart is based on 2015 federal income tax rates and is for illustrative purposes only. The preferable method for a particular Participant will depend on factors such as tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, and the like. It is recommended that you consult your tax advisor for guidance on which is best for you.