YOUR SUMMARY PLAN DESCRIPTION

Bank of the West

Effective January 1, 2015

Dental Benefits for You and Your Dependents

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Summary Plan Description is merely a specimen, which you should review with your own tax or legal advisors to ensure compliance with ERISA and any other applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with ERISA or any other applicable laws. Changes may be necessary to assure compliance with ERISA and to assure consistency with your specific plan provisions and plan administration.

INTRODUCTION

This Summary Plan Description describes the benefits available to you under the benefits plan of Bank of the West. Please read this booklet carefully to become familiar with your benefits. The plan is effective as of January 1, 2015.

Claims and certain other services are administered on behalf of This Plan by Metropolitan Life Insurance Company ("MetLife") as the Claim Administrator pursuant to the terms of an administrative service agreement.

MetLife does not insure the benefits described in this booklet.

Please note that the terms "You" and "Your" throughout this booklet refer to the employee, except where otherwise indicated. Many of the terms that are important in understanding your benefits are explained in the DEFINITIONS section.

Bank of the West

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BENEFITS AT A GLANCE

This section provides You with a description of Your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that You refer to the provisions contained in this Summary Plan Description for details about Your benefits.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Benefits For You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Temporomandibular Joint Disorder (TMJ)	80%	80%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	$50 for the following Covered Services Combined: Type B; Type C excluding Temporomandibular Joint Disorder	$50 for the following Covered Services Combined: Type B; Type C excluding Temporomandibular Joint Disorder
Yearly Family Deductible	$100 for the following Covered Services Combined: Type B; Type C excluding Temporomandibular Joint Disorder	$100 for the following Covered Services Combined: Type B; Type C excluding Temporomandibular Joint Disorder
Maximum Benefit:		
Yearly Individual Maximum	$2,500 for the following Covered Services: Type A*; Type B; Type C including Temporomandibular Joint Disorder	$2,500 for the following Covered Services: Type A*; Type B; Type C including Temporomandibular Joint Disorder
Lifetime Individual Maximum for Orthodontic Covered Services	$1,500	$1,500

*NOTE: The Yearly Individual Maximum does not apply to cleanings and oral exams.

DEFINITIONS

As used in this Summary Plan Description, the terms listed below will have the meanings set forth below. When defined terms are used in this Summary Plan Description, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time or Part-Time basis. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a place to which the Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

Your natural or adopted child; Your stepchild who resides with You; or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide MetLife notice, a Child also includes a child for whom You must provide Dental Benefits due to a Qualified Medical Care Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term does not include any person who:

- is in the military of any country or subdivision of any country;
- lives outside of the United States or Canada; or
- is covered under This Plan as an employee.

For Texas residents **"Child"** means the following:

Your natural child, adopted child or stepchild who is under age 25 and unmarried. **The term also includes** Your grandchild who is under age 25, unmarried and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Dental Benefits.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

If You provide us notice, a Child also includes a child for whom You must provide Dental Benefits due to a Qualified Medical Care Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term does not include any person who:

- lives outside of the United States or Canada; or
- is covered under This Plan as an employee.

Claim Administrator means Metropolitan Life Insurance Company ("MetLife"), New York, New York. The Claim Administrator does not insure the benefits described in this Summary Plan Description.

Contributory Coverage means coverage for which the Employer requires You to pay any part of the contribution.

Contributory Coverage includes: Dental Benefits.

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that This Plan will pay for such services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that This Plan will pay for such services after any required Deductible is satisfied.

Covered Service means a dental service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is covered for Dental Benefits;
- Dentally Necessary to treat the condition; and
- described in the section entitled BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Summary Plan Description.

Deductible means the amount You or Your Dependents must pay before This Plan will pay for Covered Services.

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse’s:
    - parents;
    - children (natural, step or adopted);
    - siblings;
    - grandparents; or
    - grandchildren.

DEFINITIONS (continued)

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by This Plan and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

- a person licensed to practice dentistry in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of This Plan. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

For purposes of Dental Benefits, the term will include a Physician who performs a Covered Service.

Dentures means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

Dependent(s) means Your Spouse and/or Child.

Domestic Partner means each of two people of the same or opposite sex, one of whom is an employee of the Employer, who represent themselves publicly as each other's domestic partner and have:

- registered as domestic partners or members of a civil union with a government agency or office where such registration is available; or
- submitted a domestic partner affidavit.

The domestic partner affidavit must be notarized, signed by both parties, and establish that:

- each person is 18 years of age or older;
- neither person is married;
- neither person has had another domestic partner within 6 months prior to the date they enrolled for coverage for the Domestic Partner under This Plan;
- they have shared the same residence for at least 6 months prior to the date they enrolled for coverage for the Domestic Partner under This Plan;
- they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and
- they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations which commitment existed for at least 6 months prior to the date they enrolled for coverage for the Domestic Partner under This Plan, and such commitment is expected to last indefinitely.

DEFINITIONS (continued)

Employer means Bank of the West.

Full-Time means Active Work on the Employer's regular work schedule for the eligible class of employees to which You belong. The work schedule must be at least 40 hours a week.

In-Network Dentist means a Dentist who participates in the Preferred Dentist Program and has a contractual agreement with MetLife to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the In-Network Dentist has agreed with the Claims Administrator to accept as payment in full for the dental service.

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program.

Part-Time means Active Work on the Employer's regular work schedule for the eligible class of employees to which You belong. The work schedule must be at least 20 hours a week.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the group benefits. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
    - parents;
    - children (natural, step or adopted);
    - siblings;
    - grandparents; or
    - grandchildren.

Proof means Written evidence satisfactory to the Claims Administrator that a person has satisfied the conditions and requirements for any benefit described in this Summary Plan Description. When a claim is made for any benefit described in this Summary Plan Description, Proof must establish:

- the nature and extent of the loss or condition;
- This Plan's obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

DEFINITIONS (continued)

Reasonable and Customary Charge is the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- the usual charge of most other Dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to This Plan and consistent with applicable law.

Spouse means Your lawful spouse. The term also includes Your Domestic Partner.

The term does not include any person who:

- is in the military of any country or subdivision of any country;
- lives outside of the United States or Canada; or
- is covered under This Plan as an employee.

This Plan means the self-funded Dental Benefits plan of the Employer.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to This Plan and consistent with applicable law.

Year or **Yearly**, for Dental Benefits means the 12 month period that begins January 1.

You and **Your** mean an employee who is eligible for the benefits described in this Summary Plan Description.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Employer, working at least 40 hours per week.
All Part-Time employees of the Employer, working between 20 and 30 hours per week.

You are eligible for coverage if You were Actively at Work and covered for coverage on the day immediately preceding the date of Your retirement and have retired in accord with the Employer's retirement plan. Please be aware that:

- references to Active Work and Actively at Work will not apply; and
- end of employment will mean the end of the person's status as a retiree, as stated in the Employer's retirement plan.

DATE YOU ARE ELIGIBLE FOR COVERAGE

You may only become eligible for the Coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

You will be eligible for Coverage described in this Summary Plan Description on the later of:

1. January 1, 2015; and

2. the first day of the calendar month following the date You complete the Waiting Period of 1 month.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for Coverage. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS FOR DENTAL BENEFITS

If You are eligible for coverage, You may enroll for such coverage by completing the required form in Writing. If You enroll for Contributory Coverage, You must also give the Employer Written permission to deduct contributions from Your pay for such coverage. You will be notified by the Employer how much You will be required to contribute.

The Dental Benefits has a regular enrollment period established by the Employer. Subject to the rules of This Plan, You may enroll for Dental Benefits only when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the flexible benefits plan.

DATE YOUR COVERAGE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for coverage, such coverage will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Coverage would otherwise take effect, the benefit will take effect on the first day of the month after You resume Active Work.

Enrollment During the Next Dental Enrollment Period Following the Date You Become Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for coverage until the next enrollment period for Dental Benefits, as determined by the Employer, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

The coverage enrolled for will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the first day of the month after You resume Active Work.

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period as determined by the Employer, You may enroll for coverage for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your coverage made during a subsequent enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the first day of the month after You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for coverage for which You are eligible or change the amount of Your coverage between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for or changes to Your coverage made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the first day of the month after You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this coverage or under other group coverage; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to COBRA continuation of the other group coverage becoming exhausted.

DATE YOUR COVERAGE ENDS

Your coverage will end on the earliest of:

1. the date This Plan ends;
2. the date coverage ends for Your class;
3. the end of the period for which the last contribution has been paid;
4. the last day of the month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE WITH CONTRIBUTION PAYMENT.

In certain cases coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE WITH CONTRIBUTION PAYMENT.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT COVERAGE

All Full-Time employees of the Employer, working at least 40 hours per week.

All Part-Time employees of the Employer, working between 20 and 30 hours per week.

DATE YOU ARE ELIGIBLE FOR DEPENDENT COVERAGE

You may only become eligible for the Dependent coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

You will be eligible for Dependent coverage described in this Summary Plan Description on the latest of:

1. January 1, 2015;
2. the date You enter a class eligible for coverage;
3. the date You obtain a Dependent; and
4. the first day of the calendar month following the date You complete the Waiting Period of 1 month.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for coverage. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be covered as a Dependent of more than one employee.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL BENEFITS

If You are eligible for Dependent Coverage, You may enroll for such coverage by completing the required form in Writing for each Dependent to be covered. If You enroll for Contributory Coverage, You must also give the Employer Written permission to deduct contributions from Your pay for such coverage. You will be notified by the Employer how much You will be required to contribute.

The Dental Benefits have a regular enrollment period established by the Bank of the West flexible benefit plan. Subject to the rules of This Plan, You may enroll for Dependent Dental Benefits only when You are first eligible or during an enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the flexible benefits plan.

DATE DENTAL BENEFITS TAKE EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent Coverage, such coverage will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Coverage would otherwise take effect, the coverage will take effect on the first day of the month after You resume Active Work.

Enrollment During the Next Dental Enrollment Period Following the Date You Become Eligible For Dependent Coverage

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Coverage until the next enrollment period for Dental Benefits, as determined by the Employer, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

The coverage enrolled for will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the first day of the month after You resume Active Work.

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period as determined by the Employer, You may enroll for Dependent Coverage for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent Coverage made during a subsequent enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the first day of the month after You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for Dependent Coverage for which You are eligible or change the amount of Your Dependent Coverage between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for or changes to Your coverage made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the first day of the month after You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this coverage or under other group coverage; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to COBRA continuation of the other group coverage becoming exhausted.

DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS

A Dependent's coverage will end on the earliest of:

1. the last day of the month in which You die;
2. the date This Plan ends;
3. the date Coverage for Your Dependents ends for Your class;
4. the last day of the month in which Your employment ends; Your employment will end if You cease to

be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE WITH CONTRIBUTION PAYMENT;

5. the end of the period for which the last contribution has been paid; or
6. the last day of the calendar month in which the person ceases to be a Dependent.

In certain cases coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE WITH CONTRIBUTION PAYMENT.

CONTINUATION OF COVERAGE WITH CONTRIBUTION PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Coverage for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to the Claims Administrator within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE COVERAGE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS, coverage will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) for continuation of coverage. Please contact the Employer for information regarding the FMLA.

COBRA CONTINUATION FOR DENTAL BENEFITS

If Dental Benefits for You or a Dependent ends, You or Your Dependent may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of this summary plan description or contact the Employer for information regarding continuation of coverage under COBRA.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue coverage for employees who cease Active Work in an eligible class for any of the reasons specified below; If Your coverage is continued, coverage for Your Dependents may also be continued.

1. if You cease Active Work due to a layoff contact the Employer to determine if Your coverage can be continued and for how long.
2. if You cease Active Work due to a leave of absence contact the Employer to determine if Your coverage can be continued and for how long.
3. if You cease Active Work due to injury or sickness contact the Employer to determine if Your coverage can be continued and for how long.

At the end of any of the continuation periods listed above, Your coverage will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be covered under This Plan;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your coverage will end in accordance with the DATE YOUR COVERAGE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOU.

If Your coverage ends, Your Dependents' coverage will also end in accordance with the DATE COVERAGE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS.

DENTAL BENEFITS

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the Claims Administrator. When the Claims Administrator receives such Proof, the Claims Administrator will review the claim and if the Claims Administrator approves it, This Plan will pay the Dental Benefits in effect on the date that service was completed.

This Dental Benefits gives You access to Dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the PDP, This Plan pays benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with the Claims Administrator to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from the Claims Administrator to choose a Dentist.

The PDP does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, This Plan will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, it is recommended that You:

- identify Yourself as covered under the Preferred Dentist Program; and
- confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as a member in the Preferred Dentist Program.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-942-PDP1 (7371) or by visiting MetLife's website at www.metlife.com/dental.

BENEFIT AMOUNTS

This Plan will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the section entitled BENEFITS AT A GLANCE, subject to the conditions set forth in this Summary Plan Description.

In-Network

If a Covered Service is performed by an In-Network Dentist, This Plan will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible; and
- any other part of the Maximum Allowed Charge for which This Plan do not pay benefits.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, This Plan will base the benefit on the Covered Percentage of the Reasonable and Customary Charge.

Out-of-Network Dentists may charge You more than the Reasonable and Customary Charge. If an Out-of-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible;
- any other part of the Reasonable and Customary Charge for which This Plan does not pay benefits; and
- any amount in excess of the Reasonable and Customary Charge charged by the Out-of-Network Dentist.

DENTAL BENEFITS (continued)

Maximum Benefit Amounts

The section entitled BENEFITS AT A GLANCE sets forth Maximum Benefit Amounts This Plan will pay for Covered Services received In-Network and Out-of-Network. This Plan will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

Deductibles

The Deductible amounts are shown in the section entitled BENEFITS AT A GLANCE.

The Yearly Individual Deductible is the amount that You and each Dependent must pay for Covered Services to which such Deductible applies each Year before This Plan will pay benefits for such Covered Services.

The Lifetime Individual Deductible is the amount that You and each Dependent must pay for Orthodontic Covered Services to which such Deductible applies before This Plan will pay benefits for Orthodontic Covered Services. Each person only has to satisfy this deductible once.

This Plan applies amounts used to satisfy Yearly Individual Deductibles to the Yearly Family Deductible. Once the Yearly Family Deductible is satisfied, no further Yearly Individual Deductibles are required to be met.

The amount This Plan applies toward satisfaction of a Deductible for a Covered Service is the amount This Plan uses to determine benefits for such service.

Alternate Benefit

If the Claims Administrator determines that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, This Plan will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Claims Administrator may base the benefit determination upon the partial denture which is the less costly service.

If This Plan pays benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the amount charged by the Dentist.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Benefits is in effect for the person receiving the orthodontic treatment; and
- Proof is given to the Claims Administrator that the orthodontic treatment is continuing.

If the initial placement was made prior to this Dental Benefits being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to this Dental Benefits being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Benefits was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After the Claims Administrator receives this information, the Claims Administrator will provide You with an estimate of the Dental Benefits available for the service. The estimate is not a guarantee of the amount This Plan will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for This Plan to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Benefits This Plan Will Pay After Coverage Ends

This Plan will pay benefits for a 90 day period after Your coverage ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your coverage ends; and
- the device is installed within 90 days after the date the coverage ends.

This Plan will pay benefits for a 90 day period after Your coverage ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your coverage ends; and
- the Cast Restoration is installed within 90 days after the date the coverage ends.

This Plan will pay benefits for a 90 day period after Your coverage ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your coverage ends; and
- the treatment is finished within 90 days after the date the coverage ends.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams three in a Year.
2. Bitewing x-rays 1 set in a Year.
3. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.
4. Cleaning of teeth (oral prophylaxis) three times in a Year.
5. Emergency palliative treatment to relieve tooth pain.
6. Topical fluoride treatment for a Child under age 14, once in 12 months.

Type B Covered Services

1. Full mouth or panoramic x-rays once every 60 months.
2. Intraoral-periapical and extraoral x-rays.
3. Space maintainers for a Child under age 14.
4. Amalgam or resin fillings.
5. Sedative Fillings.
6. Oral Surgery except as mentioned elsewhere in this Summary Plan Description.
7. Consultations.
8. Root canal treatment.
9. Periodontal scaling and root planing.
10. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery.
11. Simple extractions.
12. Surgical extractions.
13. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed.
14. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
15. Pulp therapy and apexification/recalcification.
16. Local chemotherapeutic agents.
17. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claims Administrator determines such anesthesia is necessary in accordance with generally accepted dental standards.
18. Injections of therapeutic drugs.
19. Relinings and rebasings of existing removable Dentures:
    if at least 6 months have passed since the installation of the existing removable Denture; and
    not more than once in any 36 month period.
20. Repair of Dentures.
21. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
22. Simple Repairs of Cast Restorations.
23. Non-surgical treatment of temporomandibular joint disorders.
    The Aggregate Maximum Benefit for temporomandibular joint disorders is shown in the section entitled BENEFITS AT A GLANCE.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES (continued)

Type C Covered Services

1. Initial installation of full or removable Dentures:
when needed to replace congenitally missing teeth; or
when needed to replace natural teeth that are lost while the person receiving such benefits was covered for Dental Benefits under this Summary Plan Description.
2. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Benefits was in effect for the person receiving such services.
3. Replacement of a non-serviceable Denture if such Denture was installed more than 84 months prior to replacement.
4. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture.
5. Precision attachments.
6. Initial installation of Cast Restorations.
7. Replacement of any Cast Restoration with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 84 months of a prior replacement.
8. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 84 months.
9. Core buildup, but no more than once per tooth in a period of 84 months.
10. Posts and cores, but no more than once per tooth in a period of 84 months.
11. Labial veneers, but no more than once per tooth in a period of 84 months.
12. Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal, but no more than once for the same tooth position in an 84 month period.
13. Implant supported prosthetics but no more than once for the same tooth position in an 84 month period.
14. Repair of implant supported prosthetics, but not more than once in a 12 month period.
15. Repair of implants.
16. Cone beam imaging, but not more than once for the same tooth position in 84 months.
17. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

Orthodontic Covered Services

Orthodontia, if the orthodontic appliance is initially installed while Dental Benefits is in effect for You, Your Spouse, and Your Children up to age 26.

DENTAL BENEFITS: EXCLUSIONS

This Plan will not pay Dental Benefits for charges incurred for:

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which the Claims Administrator deems experimental in nature;
2. services for which You would not be required to pay in the absence of Dental Benefits;
3. services or supplies received by You or Your Dependent before the Dental Benefits starts for that person;
4. services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments;
5. services which are primarily cosmetic, (For residents of Texas), unless required for the treatment or correction of a congenital defect of a newborn child.
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. initial installation of a Denture to replace one or more teeth which were missing before such person was covered for Dental Benefits, except for congenitally missing teeth;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. missed appointments;
14. services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
15. services covered under other coverage provided by the Employer;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. This Plan will not exclude payment of benefits for such services if the Government Plan requires that Dental Benefits under This Plan be paid first;

    Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.

    The term does not include:

    - any plan, program or coverage provided by a government as an employer; or
    - Medicare.

DENTAL BENEFITS: EXCLUSIONS (continued)

21. the following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide;
22. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
23. caries susceptibility tests;
24. sealants;
25. modification of removable prosthodontic and other removable prosthetic services;
26. fixed and removable appliances for correction of harmful habits;
27. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
28. duplicate prosthetic devices or appliances;
29. replacement of a lost or stolen appliance, Cast Restoration or Denture;
30. repair or replacement of an orthodontic device;
31. intra and extraoral photographic images.

DENTAL BENEFITS: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, This Plan may reduce what This Plan pays based on what the other Plans pay. This Coordination of Benefits section explains how and when This Plan does this.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a covered person must pay it, and
- it is at least partly covered by one or more of the Plans that provide benefits to the covered person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred) such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, This Plan treats the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a Plan's network of providers; or
    - any other similar provisions.

This Plan won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

Job-Related Injury or **Sickness** means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

Parent means a person who covers a child as a dependent under a Plan.

Plan means any of the following if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uncovered arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle No Fault coverage if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family coverage or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan which limit benefits based on benefits or services provided under:

- Government Plans; or
- Plans which the Employer (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Plan means the dental benefits described in this Summary Plan Description, except for any provisions in this Summary Plan Description that limit coverage based on benefits for services provided under government plans, or plans which the Employer (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the “Rules to Decide Which Plan Is Primary” section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, This Plan determines which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan's rules.

The first rule below which will allow This Plan to determine which Plan is Primary is the rule that This Plan will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a dependent; and
- Primary to the Plan covering the person as other than a dependent (e.g., a retired employee);

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent).

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage: The Plan that covers a person as an active employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

EFFECT ON BENEFITS OF THIS PLAN

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then This Plan will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

This Plan needs certain information to apply the Coordination of Benefits rules. This Plan has the right to decide which facts This Plan needs. This Plan may get facts from or give them to any other organization or person. This Plan does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give This Plan any facts it need to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case This Plan may pay the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount This Plan pays is more than This Plan should have paid under this Coordination of Benefits provision, This Plan may recover the excess from one or more of:

- the person This Plan has paid or for whom This Plan has paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

Assignment

Upon receipt of a Covered Service, You may assign Dental Benefits to the Dentist providing such service.

Dental Benefits: Who This Plan Will Pay

If You assign payment of Dental Benefits to Your or Your Dependent's Dentist, This Plan will pay benefits directly to the Dentist. Otherwise, This Plan will pay Dental Benefits to You.

Conformity with Law

If the terms and provisions of this Summary Plan Description do not conform to any applicable law, this Summary Plan Description shall be interpreted to so conform.

Overpayments

Recovery of Dental Benefits Overpayments

This Plan has the right to recover any amount that This Plan determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if This Plan determines that:

- the total amount paid by This Plan on a claim for Dental Benefits is more than the total of the benefits due to You under this Summary Plan Description; or
- payment This Plan made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse This Plan.

How This Plan Recovers Overpayments

This Plan may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental Benefits;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

This Plan may recover such overpayment in accordance with that agreement.

If the overpayment results from This Plan having made a payment to You that should have been made under another group plan, This Plan may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

COBRA CONTINUATION

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS

When your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may continue coverage under This Plan for a period of up to 18 months. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may continue coverage under This Plan for up to 36 months. Also, your covered children may continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan.

COBRA coverage may extended if it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within 60 days after your termination of employment or reduction of hours, you and your covered dependents may continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period for termination of employment or reduction in hours. During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

Coverage may also be extended for an additional 18 months if, while receiving 18 months of COBRA coverage, you die, become eligible for Medicare Part A and/or Part B, get divorced or legally separated from the spouse receiving COBRA, or your dependent child is no longer eligible as a Dependent child under This Plan. Extension of coverage for the additional 18 months only is available if the second event would have caused your dependent to lose coverage under This Plan if the first event not occurred and if proper notice is given to This Plan.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

1. the end of the 18, 29 or 36 month continuation period, as the case may be;
2. the date of expiration of the last period for which the required payment was made;
3. the date, after a Covered Person elects to continue coverage, that the Covered Person first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to any preexisting condition on the Covered Person;
4. the date This Plan is cancelled.

Notice will be given when you or your covered dependents become entitled to continue coverage under the Plan. You, or they, will then have at least 60 days to elect to continue coverage. However, you or your covered spouse or your covered child must notify the Employer within 60 days in the event you receive a determination of disability under the terms of the Social Security Act, you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under This Plan.
Any person who elects to continue coverage under the Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

It is your responsibility to keep the Plan Administrator informed of any changes in the addresses of family members. It is recommended that you keep a copy, for your records, of any notices you send to the Plan Administrator.

For additional information about your rights and obligations under This Plan and under federal law, you should review this Summary Plan Description or you may contact your Plan Administrator for further assistance.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Bank of the West

300 So. Grand Avenue, Suite 600

Los Angeles, CA 90071

213-972-0220

EMPLOYER IDENTIFICATION NUMBER: 94-0475440

PLAN NUMBER	COVERAGE	PLAN NAME
506	All Coverages	Bank of the West Flexible Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are administered on behalf of the Plan by Metropolitan Life Insurance Company ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under This Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan covered by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR COVERAGE; DESCRIPTION OR SUMMARY OF BENEFITS

Your Summary Plan Description describes the eligibility requirements for coverage provided under the Plan. It also includes a detailed description of the coverage provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

This Plan sets forth those situations in which the Employer has the rights to end the Plan.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the coverage described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your coverage ends in accord with the "DATE YOUR COVERAGE ENDS" and "DATE COVERAGE FOR YOUR DEPENDENTS ENDS" subsections of Your Summary Plan Description, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your Summary Plan Description.

GENERAL PROVISIONS

CONTRIBUTIONS

You must make a contribution to the cost of Dental Benefits.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

Qualified Domestic Relations Orders/Qualified Medical Child Support Orders

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Dental Benefits Claims

Procedures for Presenting Claims for Dental Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who can also answer questions about the coverage benefits and to assist you or, if applicable, your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from Claims Administrator by dialing 1-800-942-0854.

Claim Submission

For claims for dental benefits, the claimant must complete the appropriate claim form and submit the required proof as described below:

When a claimant files a claim for Dental Benefits described in this Summary Plan Description, the required Proof should be sent to the Claim Administrator within 90 days of the date of the claim.

The required Proof may also be given to the Claim Administrator by following the steps set forth below:

Step 1
A claimant may request a claim form by calling the Claim Administrator at 1-800-942-0854.

Step 2
MetLife will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

Step 3
When the claimant receives the claim form the claimant should fill out as instructed and return it with the required Proof described in the claim form.

Step 4
The claimant must give MetLife Proof no later than 90 days after the date of the claim.

If such notice and Proof are not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Initial Determination

After you submit a claim for dental benefits to Claims Administrator, Claims Administrator will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a 30 day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If Claims Administrator needs such an extension, Claims Administrator will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of Claims Administrator's notice requesting further information and an extension until Claims Administrator receives the requested information does not count toward the time period Claims Administrator is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from Claims Administrator.

If Claims Administrator denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because Claims Administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If Claims Administrator denies your claim, you may take two appeals of the initial determination. Upon your written request, Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to Claims Administrator at the address indicated on the claim form within 180 days of receiving Claims Administrator's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After Claims Administrator receives your written request appealing the initial determination or determination on the first appeal, Claims Administrator will conduct a full and fair review of your claim. Deference will not be given to initial denials, and Claims Administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, Claims Administrator will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

Claims Administrator will notify you in writing of its final decision within 30 days after Claims Administrator's receipt of your written request for review, except that under special circumstances Claims Administrator may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, Claims Administrator will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If Claims Administrator denies the claim on appeal, Claims Administrator will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

Urgent Care Claim Submission

A small number of claims for dental benefits may be urgent care claims. Urgent care claims for dental benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However your dentist may also submit such a claim to Claims Administrator by telephoning Claims Administrator and informing Claims Administrator that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, Claims Administrator will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If you or your covered dependent does not provide the claims administrator with enough information to decide the claim, Claims Administrator will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, Claims Administrator will then notify you of the claim decision within 48 hours after Claims Administrator received the information. If the needed information is not provided, Claims Administrator will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. Claims Administrator will provide you any necessary information to assist you in your appeal. Claims Administrator will then notify you of its decision within 72 hours of your request in writing. However, Claims Administrator may notify you by phone within the time frames above and then mail you a written notice.

Discretionary Authority of Plan Administrator, the Claim Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator, the Claim Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Plan Coverage

Continue dental benefits for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

PLAN PRIVACY INFORMATION

Notwithstanding any other Plan provision in this or other sections of this Plan, the Plan will operate in accordance with the HIPAA privacy laws and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to protected health information ("PHI") as that term is defined therein. The Plan Administrator and/or his or her designee retains full discretion in interpreting these rules and applying them to specific situations. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.

The term "Plan Sponsor" means Bank of the West.

The term "Plan Administrator" means Bank of the West.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including Employer service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized coverage or benefit function.

- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.

- Other uses relating to plan administration which are approved in writing by the Plan Administrator or Plan Privacy Officer.

- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.

- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

- As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

Not use or further disclose PHI other than as permitted or required by the plan documents in titled "Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor" and Uses and Disclosures of PHI by the Plan Sponsor for Required Purposes" above;

Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

(A) Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

Benefits Manager, Benefits Assistant

(B) Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

(C) Mechanism for Resolving issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.

Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this Section III.

IV. Participants Rights

Participants and their covered dependents will have the rights set forth in the Plan's or its dental insurer's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan or its dental insurer.

V. Privacy Complaints/Issues

All complaints or issues raised by Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator or the Plan's appointed Privacy Officer. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution of their complaint. The Plan Administrator or Privacy Officer shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator or Privacy Officer shall be final and be given full deference by all parties.

VI. Security

As a condition of the Plan Sponsor receiving electronic PHI ("ePHI") from the Plan, the Plan Documents are hereby amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Bank of the West reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Bank of the West shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Summary Plan Description is merely a specimen, which you should review with your own tax or legal advisors to ensure compliance with ERISA and any other applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with ERISA or any other applicable laws. Changes may be necessary to assure compliance with ERISA and to assure consistency with your specific plan provisions and plan administration.