



**A GREATER FORCE OF LAW
ENFORCEMENT PROFESSIONALS**

THE CLEAT BENEFIT PLAN SUMMARY PLAN DESCRIPTION

**Dental, Vision and Blood Benefits
Accidental Death and Dismemberment**

**Administered by Employer Plan Services, Inc.
2180 North Loop West, Suite 400
Houston, Texas 77018
P.O. Box 19776
Houston, Texas 77224
1-800-447-6588
(713) 932-8917**

This Summary Plan Description includes a summary of the benefits provided by the CLEAT BENEFIT PLAN (“the Plan”) and in effect as of September 1, 2008. It is provided to help you understand what benefits, rights and obligations you have under the plan and to comply with the Employee Retirement Income Security Act of 1974, commonly known as ERISA. It is not a policy of insurance and does not modify or extend the liability of the Plan as set forth in the Plan Document. In the event of a conflict between this booklet and the Plan Document, the Plan Document will prevail.

TABLE OF CONTENTS

	Page
Dental Benefits	2-7
Vision Care Benefits	8-11
Accidental Death and Dismemberment Benefits	12
Blood Benefits	13
Filing of Claims	14
General Provisions	15-23
Continuation of Coverage (COBRA)	24-26
Definitions	27-28
Plan Information	29-33

**SCHEDULE OF DENTAL BENEFITS FOR EMPLOYEE GROUPS
WITH PPO PARTICIPANTS**

Deductibles

Calendar Year Deductible	\$ 50
Family Calendar Year Deductible (3 separate Calendar Year Deductibles of \$50 each)	\$150

Percentages Payable

	<u>PPO</u>	<u>Non PPO</u>
Type I Preventive and Diagnostic Procedures* (Deductible waived for PPO procedures)	100%	90%
*These procedures are shown in the List of Dental Procedures under the headings "Visits and Examinations," "X-rays" and "Space Maintainers".		
All Other Procedures except Type II *	80%	70%
*These include fillings, extractions, root canals and gum surgery.		
Type II: Prosthodontic Services*	60%	50%
*These include inlays, crowns, bridges and dentures.		
Type II: Orthodontic Treatment (Deductible waived)	50%	

Maximum Benefits

Calendar Year Maximum (Does not apply to orthodontic treatment)	\$2,000 per person
Lifetime maximum for orthodontic treatment	\$1,500 per person

MEMBER AND DEPENDENT DENTAL BENEFITS FOR GROUPS THAT DO NOT PARTICIPATE IN A PPO

SUMMARY OF PLAN PROVISIONS

Covered Procedures

The percentages shown below are intended only for those Covered Units that do not participate in the PPO. The list may not be complete. Please refer to the Plan Document for a more complete listing. Benefits for any Covered procedure are based on Reasonable and Customary charges.

TYPE I Preventive Procedures Covered at 100%

The preventive procedures listed in this category are covered at 100%, with no deductible. Examples include cleaning, fluoride treatments, X-Rays and space maintainers.

TYPE I Routine Procedures Covered at 80%

After satisfying the deductible requirement, routine procedures listed in this category are covered at 80%. Examples include fillings, extractions, root canals and gum surgery.

TYPE II Major Procedure Covered at 60%

After satisfying the deductible requirements, major procedures listed in this category are covered at 60%. Examples include inlays, crowns, bridges and dentures.

Orthodontic Benefits Covered at 50%

Orthodontic benefits are available only for Covered orthodontic expenses incurred for a person after that person has been covered under the Plan for at least twelve (12) consecutive months. Benefits for Covered Expenses are paid at 50%.

Deductible Requirement

A deductible consisting of the first \$50 of Covered Expenses incurred by a Covered Person during a Calendar Year will be applied before any Type I Routine or Type II benefit is payable. No more than three separate deductibles will be applied to Covered Expenses incurred in the same Calendar Year by all members of one family. No deductible will be applied to orthodontic expenses.

Dental Benefits - Continued

Maximum Benefit

The maximum benefit for all Covered dental charges incurred during a Calendar Year is \$2,000 per person, not including orthodontic treatment.

The maximum lifetime benefit for orthodontic treatment is \$1,500 per person.

Alternative Procedures

If two or more procedures are separately adequate and appropriate treatment for the correction of a specific condition, the amount of the Covered Expense will be limited to the charge for the least expensive procedure.

Covered Expenses

“Covered Expenses” means the Reasonable and Customary Charges for necessary care and treatment of a Covered Person. Such charges must be incurred (a) by a Covered person while that person has dental coverage under this Plan and (b) for the Type I and Type II procedures shown on the List of Dental Procedures in the Plan Document. Such Covered Expenses must not exceed the amount allowed in accordance with the Alternative Procedures provision. Covered Expenses will include only expenses for procedures performed by a licensed dentist or a dental hygienist (for cleaning) or a dental student working under the direct supervision of a licensed dentist.

Preestimate of Benefits. A Preestimate of benefits is recommended - but not required -if your proposed dental work is to cost \$300 or more. Just ask your dentist to submit a preestimate to Employer Plan Services, the claims administrator of the Plan, whose address and telephone information is on the first page of this brochure A preestimate is not a guarantee of payment. However, when benefits are payable, a preestimate will give you a better idea of how much of the dentist’s charges are likely to be paid by the Plan before the work is done. This way you can work out the necessary financial arrangements or postpone some work to a later date if possible. When Employer Plan Services receives your preestimate request, they will estimate your expected benefits and notify you and your dentist.

DENTAL EXCLUSIONS AND LIMITATIONS

Covered expenses do not include and no benefits are payable for:

- Any procedures performed during the first 12 months that a late entrant is covered under this Plan.
- Any treatment that is for cosmetic purposes or for the correction of congenital malformations.
- The replacement of any prosthetic appliance, crown, fixed bridge, inlay or onlay restoration within 5 years of the last such placement, unless this replacement is needed because of an accidental bodily injury sustained by a person while covered under this Plan or for reasons other than a defect of such appliance, crown, inlay, onlay or fixed bridge.
- The placement of any prosthetic appliance or fixed bridge unless the placement is needed because of the extraction of one or more teeth (except wisdom teeth) while covered under this Plan (the prosthetic appliance or fixed bridge must replace the extracted tooth or teeth).
- Any prosthetic appliance installed or delivered more than 30 days after the person's coverage terminates.
- The replacement of lost or stolen appliances.
- Appliances, restorations or procedures to alter vertical dimension, restore or maintain occlusion, splint or replace tooth structure lost because of abrasion or attrition, or to treat disturbances of the temporomandibular joint.
- Any procedure not included in the List of Dental Procedures in the Plan Document, but this will not apply to a procedure which is essentially the equivalent of a procedure that is included in that list.
- The completion of claim forms, or missed appointments.
- Injury arising out of or in the course of any employment for wage or profit.
- Sickness for which a person is entitled to or eligible for benefits under any worker's compensation act or similar legislation.
- Services for which the person is not legally required to pay or for which no charges would have been made if coverage had not existed.
- War injuries.
- Services not recommended by a licensed dentist or not required for Necessary Care and Treatment, as defined in the Plan Document.
- Dental care that does not meet the standards established by the American Dental Association.
- Services or supplies of the type intended for sport or home use.

Dental Exclusions and Limitations - Continued

- Overdentures, including root canal therapy and supportive restorations.
- Orthodontic services rendered to a person before such person has been covered under this Plan for at least twelve (12) consecutive months.
- Services not performed by a legally licensed dentist or by a dental student or dental hygienist working under the direct supervision of such a dentist.
- Services rendered or supplies, including drugs and medicines, furnished by a hospital or other facility.
- Services rendered to a person before that person's dental coverage under this plan began or after it terminated.

Coordination of Benefits. Members and their dependents should not make a profit from being covered under more than one group health plan. To prevent this from happening, most group health plans include a coordination of benefits provision. The coordination of benefits provision under this Plan allows for coordinating benefits with any other group payments. When all benefits are added together, no more than 100% of the covered expenses are paid. The entire coordination of benefits provision will be sent to you at your request.

MEMBER AND DEPENDENT VISION CARE BENEFITS

(NOTE: This coverage is not automatically included with any other type of coverage. It is available only as arranged between the Plan Administrator and a Member group.)

SCHEDULE OF COVERED SERVICES AND SUPPLIES FOR ENROLLED MEMBERS (NO DEDUCTIBLE REQUIRED)

Vision Care Benefits are based on:

- a. Reasonable and Customary Charges (this means, for any item or service, the usual charge of the provider, but no more than the prevailing charge for a like item or service in the geographical area where the item or service is provided); and
- b. a limit of: one examination of the eyes, one pair of lenses and one frame ordered or purchased (whichever is first) during a calendar year (January 1 through December 31 of the same year). All lenses must be prescribed by an optometrist or an ophthalmologist and be necessary to correct one or more refractive visual disorders.

Eye Examinations and Lenses

The plan will pay 100% of Reasonable and Customary Charges incurred for eye examinations and the following types of unmodified lenses which are made from standard 70mm blanks: single vision, bifocal, trifocal, progressive and lenticular. No benefits are payable for coatings, tints, or any other options or modifications.

Frames

The plan will pay 100% of the charge incurred for a frame, up to a benefit limit of \$50.00.

Vision Care Benefits - Continued

Contact Lenses

The plan pays 80% of the actual charge incurred for a pair of lenses up to the benefit limit shown below:

	<u>BENEFIT LIMIT</u>
1. If visual acuity is not correctable to 20/70 in the better eye, except by the use of contact lenses	\$360.00
2. If the patient is being treated for a condition such as Keratoconus or Anisometropia, and contact lenses are customarily used as part of the treatment	\$360.00
3. If required following cataract surgery	\$360.00
4. Cosmetic ("Cosmetic," as used here, refers to contact lenses used to correct a refractive visual disorder which can be just as effectively corrected by means of spectacle lenses.)	
Single vision	\$110.00
Bifocal (see below)	

The benefit for bifocal contact lenses will be 80% of the actual charge incurred for such lenses, not to exceed the amount payable under this Schedule for bifocal spectacle lenses. Furthermore, any benefit payable for examination of the eyes in connection with bifocal contact lenses will be limited to the benefit available for an examination of the eyes relating to spectacle bifocal lenses.

Disposable Contact Lenses: Coverage will not be limited to one pair per Calendar year, but the maximum benefit for all such lenses purchased during a Calendar year will be subject to the benefit limits shown above.

Vision Care Benefits - Continued

Laser Surgery

Definition: The term "Laser Surgery", as used here, means lasik surgery or refractive photo keratotomy.

The following will apply to Laser Surgery performed on a person while covered for vision care benefits under this Plan:

- 1) The Plan will pay the amount of the Reasonable and Customary Charge for Laser Surgery, up to a maximum Benefit of \$250 per eye. For Laser Surgery performed on a person during any Calendar Year, the Benefit will be reduced by the amount of all other vision care benefits paid under this Plan for services rendered to the same person during the same Calendar Year.
- 2) No other vision care benefits will be payable under this Plan for any other services rendered to such person during the same Calendar Year.
- 3) The maximum Benefit for all Laser Surgery procedures performed for any one person while covered under this Plan will be \$500.00.

COORDINATION OF BENEFITS

The plan will coordinate benefits with other group payments in the same manner as described in connection with dental benefits.

Vision Care Benefits - Continued

EXCLUSIONS

No benefit will be payable under this Schedule for:

1. services and supplies not listed in the Schedule of Covered Services and Supplies;
2. services and supplies to the extent restricted or excluded in the Schedule of Covered Services and Supplies;
3. lenses which can be obtained without the prescription of a legally licensed optometrist or ophthalmologist;
4. orthoptics, vision training or subnormal vision aids;
5. services and supplies covered under any worker's compensation or similar act or plan;
6. charges which, in the absence of this coverage, there would be no legal obligation to pay;
7. services rendered and/or supplies purchased with respect to any person after termination of that person's coverage under this Schedule;
8. expenses incurred for a Late Entrant during the first twelve (12) consecutive months of his coverage under this Schedule;
9. any item purchased or service rendered outside of the United States, except that this exclusion shall not apply to Laser Surgery performed in Canada.
10. lenses made more than 365 days after the date they were prescribed;
11. lenses prescribed by any person while not licensed and practicing as a physician or optometrist in the United States.

MEMBER AND DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

This coverage is provided through a group accident insurance policy issued and administered by Federal Insurance Company, a member of the CHUBB insurance group.

The plan pays \$15,000 for the accidental death of a covered member, or twice this amount, \$30,000, for the accidental death of a covered member due to felonious assault, subject to provisions in the policy. The felonious assault benefit is not available for dependents.

Also included is a benefit for accidental death of a covered dependent, a schedule of benefits for accidental dismemberment, a Seat Belt Benefit, benefits in connection with injury resulting in certain types of paralysis, natural disaster, occupational hepatitis and occupational HIV.

All benefits are subject to the terms, provisions, conditions and exclusions of the group insurance policy. For more information or to obtain desired documents, call Employer Plan Services, Inc. at 1-800 447-6588 or 713 932-8917.

BLOOD BENEFITS

Pays 100% of blood processing fees and blood non-replacement fees with no deductible, subject to the Plan provisions.

SUMMARY OF PLAN PROVISIONS

If you or a covered dependent receives a blood transfusion which is not excluded by the Plan, and which you are required to pay for, the Plan will pay to you the actual cost of the transfusion service, as defined in the Plan, not exceeding the customary charge, per unit transfused, established by the hospital or blood bank furnishing the blood. The maximum benefit is \$2,500 for covered expenses incurred in a calendar year. Benefits are coordinated with other plans, as explained in the Plan document.

EXCLUSIONS AND LIMITATIONS

No benefits are payable for:

1. any service rendered in connection with crossmatching or the administration of a transfusion;
2. any expenses incurred in connection with any transfusion:
 - a. administered during the 30 day period immediately following a covered person's effective date of coverage under the Plan;
 - b. administered during the first twelve months following the effective date of a covered person's coverage under the Plan and resulting from any disease or condition existing prior to such effective date.

FILING OF CLAIMS

All claims under this Plan, except accidental death and dismemberment claims, are administered by:

Employer Plan Services, Inc.
P.O. Box 19776
Houston, Texas 77224-9776
(713) 932-8917 or (800) 447-6588

Dental Claims

You can find out how much your plan will pay before any extensive work is done. Refer to Preestimate of Benefits in the Dental section of this booklet.

How to File a Dental Claim

1. If the benefits are to be paid to your dentist, ask him to send a standard ADA form or a completed claim form to Employer Plan Services at the address shown above.
2. If the benefits are not assigned to the dentist and are to be paid to you, send a completed claim form to Employer Plan Services at the address shown above.

Claim forms are available through Employer Plan Services.

Other Claims

For information on filing other claims, such as for blood benefits, accidental death and dismemberment benefits or, if applicable, vision benefits, call Employer Plan Services at the number shown above.

GENERAL PROVISIONS

ELIGIBILITY AND EFFECTIVE DATE

MEMBERS

You are eligible to enroll for coverage on, before or within 31 consecutive days following the beginning date of the enrollment period established by the Plan Administrator which applies to you. You must enroll on a form approved by the Plan Administrator and agree to contribute toward the cost of the coverage.

Your Coverage takes effect on the first day of the month following acceptance of your enrollment form by the Plan Administrator.

DEPENDENTS (See definition of *Dependent*)

Dependent coverage for Blood Benefits and for Accidental Death and Dismemberment is automatically included with your own coverage. If you want dependent dental or vision coverage, however, you must request it. The dental or vision coverage becomes effective:

1. the date your personal dental or vision coverage takes effect if your request is made on or before that date or within 31 days thereafter: or
2. the date you first acquire a dependent (i.e., the date of your marriage, the date you adopt a child) if your request is made on or before that date or within 31 days thereafter.

Late Entrants

Definition: A Late Entrant is a Member or Dependent whose enrollment card was received by the Administrator more than thirty-one (31) consecutive days immediately following:

1. the earliest date that Member or Dependent could be Covered, or
2. with respect to dental or vision coverage of the Covered Member's spouse, the

General Provisions - Continued

date such spouse lost dental or vision coverage under the spouse's health plan due to termination of the spouse's employment or discontinuance of that coverage by the spouse's employer. In such a case, the Member must submit to the Administrator a letter signed by the spouse's employer specifying the type of coverage lost, and the date and cause of that loss.

For dental and/or vision coverage of a Late Entrant, contributions will be required for a period of twelve (12) months before benefits are available, and no benefits will be payable, and no benefits will be payable for any dental or vision expenses incurred during that 12 month period. This requirement will not apply, however, to a newly acquired dependent if you have one or more dependents covered for dental or vision benefits, (whichever may be the case) when you acquire the new dependent.

MEDICAL CHILD SUPPORT ORDERS

If the administrator receives a court order or similar document relating to support for a member's child, the Administrator will review that document. If the document proves to be a Qualified Medical Child Support Order as described in the Plan Document, Coverage for that child must be provided. For more information about this, please ask to review the Plan Document or ask the Administrator to give you more information from the Plan Document.

PROOF OF LOSS

Proof of loss in connection with any person's claim for benefits must be received by the Plan Administrator in proper form and with all required information not later than three months after the date of that person's termination of coverage under this plan; otherwise within one (1) year after the date the expense or loss is incurred. The Plan Administrator shall not be obligated to pay benefits for any claim if the required proof of loss is received later than the time period stated in this section.

General Provisions - Continued

FORMS

Upon receipt of written notice of claim, the Administrator will furnish to the Covered Person the claim form it customarily furnishes for filing proof of loss. If the Covered Person does not receive these claim forms within fifteen (15) days after receipt by the Administrator of the notice of claim, the Covered Person will be considered to have complied with requirements for Proof of Loss upon submitting written proof covering the occurrence, character, and extent of loss for which claim is made.

LEGAL ACTIONS

No action at law or in equity will be brought to recover under the Plan, prior to the expiration of sixty (60) days after Proof of Loss has been filed as required by the Plan, nor will any action be brought unless within two (2) years from the expiration of the time within which Proof of Loss is required by the Plan.

TIME LIMITATIONS

If any time limitation provided in the Plan for furnishing Proof of Loss, or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

REVIEW AND APPEAL OF CLAIM PROCEDURE

A Claim is defined as any request for a Plan benefit, made by a claimant or a representative of a claimant, that complies with the Plan's procedures for submission of claims.

The initial determination as to your eligibility for benefits and the amount of your payments will be made by Employer Plan Services, Inc. Should any request for benefits be wholly or partially denied, Employer Plan Services, Inc., on behalf of the Plan Administrator, will provide you with notification which complies with the following rules:

General Provisions - Continued

The Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim.
You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

General Provisions - Continued

- (7) If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information is considered relevant to a Claim if it:

- 1) was relied upon in making the benefit determination;
- 2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- 3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- 4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

General Provisions - Continued

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Voluntary appeals, including voluntary arbitration

During voluntary dispute resolution, any statute of limitations or other Claim defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled, "Appeals." However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal.

General Provisions - Continued

This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

In making claim determinations, the Administrator shall consider the terms of the Plan and shall have the discretionary power and authority to construe such terms, including ambiguous terms. All such determinations made by the Administrator, whether in the case of an appeal from an initial claim denial or in the case of an initial determination which is not appealed, arising in connection with the administration, interpretation and/or application of the Plan shall be conclusive and binding upon all persons.

TERMINATION OF COVERAGE

Your coverage terminates on the earliest to occur of the following:

1. the end of the calendar month during which you cease to be a member of the group of persons covered by this plan;
2. the last day of the most recent period for which the required contribution for your coverage has been made, if required contributions cease;
3. the date the Plan Administrator receives written notice from you to terminate your coverage; and
4. the date this plan terminates.

Coverage for your dependent(s) will terminate on the earliest to occur of the following:

1. the end of the calendar month during which the dependent ceases to be "Dependent" as defined in the Plan Document;

General Provisions - Continued

2. the last day of the most recent period for which the required contribution has been made for your dependent coverage, if the required contributions cease;
3. the date your coverage under this plan terminates; and
4. the date this plan terminates.

DISABLED DEPENDENT CHILD

The following applies to a Member's Covered child who reaches the age at which he would cease to be a Dependent under this Plan. At that time, if the child is disabled (physically or mentally unable to earn his own living and dependent primarily upon the Member for support), he shall be considered to be a Dependent as long as he remains so disabled, subject to all other terms and provisions of the Plan. The Member must, however, submit to the Administrator proof of the child's incapacity as described above.

The Administrator shall have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child, but not more than once a year. Upon failure to submit such required proof or to permit such an examination, or when such child ceases to be so incapacitated, Coverage with respect to him shall cease.

SURVIVOR BENEFIT

If a Covered Member dies as a result of accidental bodily injury sustained while performing his duties as a peace officer or fire fighter, Coverage for his Dependents will continue as follows: If the Member's death occurs within ninety (90) consecutive days immediately following the date he sustains such injury, the Coverage in effect for his Dependents at the time of his death, not including Coverage relating to accidental death and dismemberment, will continue while the Plan is in force, at no cost to those Dependents, for a period of twelve (12) consecutive months. At the end of that period, the Coverage for those Dependents will terminate, subject to the section entitled "Continuation of Coverage."

General Provisions - Continued

EXAMINATION

The Administrator shall have the right and opportunity to examine the person whose injury or sickness is the basis of claim hereunder when and so often as it may reasonably require during the pendency of such claim.

RIGHT OF RECOVERY

Whenever payments have been made in excess of the amounts provided by the Plan, the Administrator will have the right to recover such payments, to the extent of any excess, from among one or more of the following, as the Administrator will determine: any person to or for or with respect to whom these payments were made, any insurance companies, or other organizations.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability and implementation of the terms of this Plan or the provisions of any other plan, the Administrator may, without the consent of or notice to any person, release to or obtain from an insurance company or other organization or person any information, with respect to any person, which the Administrator considers to be necessary for those purposes. Any person claiming benefits under this Plan will furnish to the Administrator any information that may be necessary to implement this provision.

AMENDMENT AND TERMINATION OF THE PLAN

The Plan Administrator shall be empowered with the right at any time and from time to time to amend in whole or in part any or all of the provisions of this Plan or terminate the entire Plan without prior notice to or the consent of any Covered Person. Such action shall be subject to approval of the Executive Board of Directors of the Administrator. Trust funds remaining after termination shall be used only to provide benefits to Plan participants and their beneficiaries.

CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows certain individuals the option of continuing their group health coverage under specified conditions.

A person who is eligible for continuation is called a “qualified beneficiary.” The circumstances allowing a person to be eligible for continuation are called “qualifying events.”

Eligibility for Continuation

A Covered Person becomes a qualified beneficiary as follows:

If a Member’s dental or dental and vision care Coverage terminates because of termination of employment (other than because of his gross misconduct) or reduction in the number of hours worked, such a Member is a qualified beneficiary and may elect to continue that coverage for himself and any of his Dependents whose coverage is being lost because of either one of these events.

A Dependent becomes a qualified beneficiary and may also elect to continue the dental or dental and vision care coverage if any of the following qualifying events would otherwise cause a loss of such Dependent’s coverage under this Plan:

- a. death of the Member;
- b. termination of the Members employment (for reasons other than his gross misconduct) or reduction in the number of hours worked;
- c. divorce or legal separation;
- d. the Member’s becoming covered by Medicare;
- e. a Dependent child ceasing to be a “Dependent” as defined in this Plan.

Type of Coverage Continued

The Plan shall provide the same dental and vision care (if any) coverage to a qualified beneficiary that it provides to all active Participants of the Covered Unit through which that beneficiary was Covered, including the right to enroll eligible Dependents who are not yet covered. Except as stated below, a newly enrolled Dependent shall not be considered a qualified beneficiary, and Coverage for such Dependent shall terminate as otherwise provided by the Plan, with no right of

Continuation of Coverage (COBRA) - Continued

continuation coverage under federal law. Exception, effective January 1, 1997: a child who is enrolled in the Plan within thirty (30) days of being born to or placed for adoption with a former Member during the period of such former Member's COBRA continuation coverage shall be considered a qualified beneficiary. Such a child may be eligible for an extension of COBRA continuation coverage as described below under "Duration of Continued Coverage."

Duration of Continued Coverage

Continuation coverage shall terminate on the earliest to occur of the following:

a. at the end of a continuous period of:

1) 18 months, in a case where the coverage originally terminated because of termination of employment or reduction in hours worked, except that (i) such period may be extended to 29 months if, at the beginning of such 18 month period, a qualified beneficiary is totally disabled as determined by the Social Security Administration and the Plan receives the Notice of Determination of Disability from the Social Security Administration before the expiration of the 18 months and within 60 days of the determination; provided that, effective January 1, 1997, this 11-month COBRA extension for disability also applies to (a) any qualified beneficiary who is determined to have been disabled at any time within the first 60 days of COBRA coverage, and (b) all of the members of such qualified beneficiary's family, but only if the qualified beneficiary has provided notice to the Administrator of such determination before the end of the 18-month period and within 60 days of the determination; and if another qualifying event occurs during the 18 month continuation, 36 months after the first qualifying event; or

2) 36 months for other qualifying events;

b. the first date following election of continuation coverage on which the qualified beneficiary first becomes (i) covered by another group health plan which does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary, (ii) covered by another group health plan, if the other group health plan has a preexisting condition exclusion but is prohibited from imposing that preexisting condition exclusion of the qualified beneficiary by the

Continuation of Coverage (COBRA) - Continued

guaranteed accessibility rules of the Health Insurance Portability and Accountability Act of 1996, or (iii) covered under Medicare;

- c. the date this Plan ends; or
- d. at the end of the most recent period for which a required contribution has been made if such contributions cease.

Payment for Continuation Coverage

A person electing to continue coverage under COBRA must pay to the Administrator on a monthly basis the entire amount due for such coverage. The amount due will be no more than 102% of the actual cost monthly, except that beneficiaries who qualify for an extension of continuation coverage on the basis of disability shall be required to pay 150% (instead of 102%) of the cost monthly for each additional month of coverage after the initial 18 month period. The first contribution must cover the period from the date coverage would otherwise have terminated until the end of the month in which the first contribution is made. Subsequent contributions shall be due and payable on the first day of each month, subject to a 30 day grace period. The first contribution must be received by the Administrator no later than 45 days after continuation coverage is elected.

Notice of Qualifying Event

It is the responsibility of the Member or a member of his family to notify the Plan of a divorce, legal separation or a child losing Dependent status under the Plan within 60 days of the later of the date of the qualifying event or the date on which coverage would be lost because of such event. If notice is not given within this time period the right to continuation coverage will be lost.

Election Period

A qualified beneficiary must elect continuation of coverage within 60 days after the later of:

- a. the date coverage under this Plan terminates because of the qualifying event; or
- b. the date the qualified beneficiary receives notice from the Administrator of the right to such continuation.

Questions about continuation of coverage should be addressed to the Administrator or Employer Plan Services, Inc.

DEFINITIONS

Administrator or Plan Administrator means the Combined Law Enforcement Associations of Texas, Inc. (CLEAT) or such other persons as CLEAT may designate.

Calendar Year means the period January 1 through December 31 of the same year.

Covered, Coverage means or refers to coverage under this Plan.

Covered Person means a person who is covered under the Plan.

Covered Unit: means a group of Members organized as any one of the following: (1) employees of the Administrator; (2) members and employees of a collective bargaining unit; or (3) employees of a political subdivision.

Dependent: means:

- a. the spouse of a Participant, including a domestic partner when the relationship is validated by a certificate of common-law marriage submitted to the Administrator, and a same-sex partner, subject to submission to the Administrator of legal proof of marriage issued by the state in which the marriage occurred.
- b. any unmarried child who is under nineteen (19) years of age or under twenty-four (24) years of age if attending school or college regularly and who depends on the Participant for the majority of his support. A child shall be considered as attending school or college regularly during a period of 120 consecutive days immediately following completion of a semester at a school or college, or until he becomes covered under another group health plan, whichever occurs first.

The word *child*, whenever used in this Plan, means the Participant's natural child, legally adopted child, a child being placed for adoption* by a Participant or Plan beneficiary on or after August 10, 1993, and any other child, including the Participant's grandchild or step-child who depends on the Participant for the majority of his support, lives with the Participant in a regular parent-child relationship and qualifies as a dependent of the Participant with respect to federal income tax.

Definitions - Continued

*"being placed for adoption," as used above, means that a Participant or Plan beneficiary has assumed and retained a legal obligation for the partial or total support of a child to be adopted. A child's placement with a Participant or beneficiary ends whenever the legal support obligation ends.

Each Dependent child of parents who are both Participants shall be considered a Dependent of one or the other, but not both. The term "Dependent" shall not include any person who is eligible for Coverage as a Member or on active duty with the armed forces of any country or international authority.

Member means a member or employee of an organization which has agreed with the Administrator to participate in this Plan.

Plan means the plan of benefits described in the Plan Document of the CLEAT Benefit Plan, to include any schedules of benefits attached to the Plan Document and applicable to a given participant's employee group.

Plan Document means the document which describes in its entirety the plan of benefits and all related provisions of the CLEAT Benefit Plan.

PPO: means Preferred Provider Organization, and refers to an organization of dental providers that has made an arrangement with the Plan Administrator to provide services to Covered Persons at reduced cost. A non-PPO dental specialist is considered as providing PPO services when a dental specialist is needed but no PPO specialist is located in the geographic area where the services are rendered. Furthermore, any non-PPO dental provider is considered as a PPO provider when used by a Covered Person in the event of an emergency or in any situation where no PPO provider is accessible to such person.

Reasonable and Customary Charges means the usual charges of a provider of a service or supply, but not more than the prevailing charges being made for a like service or supply in the same geographical area.

PLAN INFORMATION

The contents of this booklet, including the following information, constitute a Summary Plan Description as required under the Employee Retirement Income Security Act of 1974. If a conflict exists between this Summary Description and the Plan Document, the Plan Document will prevail.

1. NAME OF PLAN

CLEAT Benefit Plan

2. NAME AND ADDRESS OF PLAN ADMINISTRATOR AND PLAN SPONSOR

Combined Law Enforcement Associations of Texas (CLEAT), 400 West 14th Street, Suite 200, Austin, Texas 78701 (512) 495-9111. CLEAT also acts as an “employee organization,” as such term is defined in ERISA.

3. FEDERAL IDENTIFICATION NUMBER

74-2352970

4. TYPE OF PLAN

Employee Welfare Benefit Plan, as such term is defined in ERISA. Benefits include the following: Comprehensive Dental Benefits, Blood Benefits, Accidental Death and Dismemberment Benefits and optional Vision Care Benefits. Benefits are described in more detail in other pages of this booklet. A participant so requesting is entitled to receive copies of applicable detailed schedules of benefits from the Plan Administrator.

5. TYPE OF ADMINISTRATION

Self-administered for all coverages except Accidental Death and Dismemberment, the benefits of which are administered by an insurance company.

6. AGENT FOR SERVICE OF LEGAL PROCESS

Service of process may be made on a plan trustee or the Plan Administrator.)

Plan Information - Continued

7. TRUSTEES

Chris McGill, CLEAT, 400 West 14th St., Suite 200, Austin, TX 78701

John Bertolino, Galveston Police Officers Association, P.O. Box 895, Galveston, TX 77553

Mike Staff, Corpus Christi Police Officers Association, 3122 Leopard, Corpus Christi, TX 78408

8. PLAN FISCAL YEAR AND RECORDS

The Plan fiscal year (“Plan Year”) ends December 31 of each year. Plan records are kept on a Plan Year basis.

9. PLAN FUNDING

The Plan is funded through contributions from employers and members. The funding medium used for the accumulation of assets through which benefits are provided is the CLEAT Benefit Trust. Contribution levels of different employers are determined by the experience of their particular group of employees.

10. EMPLOYERS AND COLLECTIVE BARGAINING AGREEMENTS

A number of different employers contribute to the Plan in behalf of their employees. Also, some of the employee groups which participate in the Plan do so under a collective bargaining agreement. Participants and Beneficiaries of the Plan may receive from the Plan Administrator upon written request the names and addresses of all such employers and employee organizations, as well as copies of such collective bargaining agreements.

11. ELIGIBILITY

All employees of participating employers or sponsoring employee organizations are eligible to participate on the first day of the calendar month as determined by the Plan Administrator, based on enrollment and arrangements for contributions to the Plan.

Plan Information - Continued

12. STATEMENT OF RIGHTS UNDER ERISA

As a participant in the CLEAT Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants 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 documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the public disclosure room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Plan Information - Continued

Prudent Action 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 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 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 certain 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 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 a 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 a 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 **Plan Information - Continued**

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.

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 hotline of the Pension and Welfare Benefits Administration.