THE CLEAT BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

DENTAL, VISION AND BLOOD BENEFITS
ACCIDENTAL DEATH AND DISMEMBERMENT

Administered by Ameritas
5900 O Street
Lincoln, NE 68510

Administered by Baybridge
1101 South Capital of
Texas Hwy Bldg E.
Suite 200
Austin, TX 78746

This Summary Plan Description includes a summary of the benefits provided by the CLEAT BENEFIT PLAN ("the Plan") and in effect as of May 1, 2019. It is provided to help you understand what benefits, rightsand obligations you have under the plan and to comply with the Employee Retirement Income Security Act of 1974, commonly known as ERISA. Itis 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.

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SCHEDULE OF DENTAL BENEFITS FOR COVERED UNITS WITH A PPO

Deductibles

Per Visit Deductible for Type I Services – Network	$10
Calendar Year Deductible for Type I Services – Non Network	$50
Calendar Year Deductible for Type II and Type III Services	$50

Percentages Payable

	PPO	Non PPO
Type I Preventive Procedures * These procedures include visits and examinations, cleaning, fluoride treatments, x-rays and space maintainers.	100%	90%
Type II Routine Procedures * (Deductible applies) These include fillings and simple extractions.	80%	70%
Type III: Major Procedures* (Deductible applies) These include inlays, crowns, root canals, gum treatment, bridges and dentures.	60%	50%
Type IV: 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

*For a more complete listing of covered dental procedures, please refer to the Plan Document

SCHEDULE OF DENTAL BENEFITS FOR COVERED UNITS NOT PARTICIPATING IN THE PPO

Deductibles

Per Visit Deductible for Type I Services	$10
Calendar Year Deductible for Type II and Type III Services	$50

Percentages Payable

Type I Preventive Procedures * These procedures include visits and examinations, cleaning, fluoride treatments, x-rays and space maintainers.	100%
Type II Routine Procedures * (Deductible applies) These include fillings and simple extractions.	80%
Type III: Major Procedures * (Deductible applies) These include inlays, crowns, root canals, gum treatment, bridges and dentures.	60%
Type IV: 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

*For a more complete listing of covered dental procedures, please refer to the Plan Document.

SUMMARY OF PLAN PROVISIONS

Orthodontic Benefits

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.

Deductible Requirement

A deductible consisting of the first $50 of Covered Expenses incurred by a Covered Person during a Calendar Year will be applied as noted in the Schedule of Benefits. No deductible will be applied to orthodontic expenses.

Deductible Three Month Carryover. Covered expenses incurred in, and applied toward the person's deductible in October, November and December will be applied toward the same person's deductible in the next Calendar Year.

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 considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

Covered Expenses

Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is covered under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have

determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Planholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Planholder.

Pre-estimate of Benefits. A Pre-estimate 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 pre-estimate to Ameritas, the claims administrator of the Plan, whose address and telephone information is on the first page of this brochure. A pre-estimate is not a guarantee of payment. However, when benefits are payable, a pre-estimate 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.

DENTAL EXCLUSIONS AND LIMITATIONS

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

1. in the first 12 months that a person is covered if the person is a Late Entrant.

2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the covered person is covered under this plan. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the covered person is covered on January 1, 2015. For those Members covered on January 1, 2015, see b.

   b. Limitation a. will be waived for those Members whose coverage was effective on January 1, 2015 and

      i. the person has the tooth extracted while covered under the prior plan: and

      ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while covered under our plan;

      but such extraction and installation must take place within a twelve-month period; and

      iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

3. for appliances, restorations, or procedures to:

   a. alter vertical dimension;
   b. restore or maintain occlusion; or
   c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the covered person's coverage under this plan terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Member's coverage under this plan terminates.

5. to replace lost or stolen appliances.

6 for any treatment which is for cosmetic purposes.

7 for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8 for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this plan, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

4. for which the Covered person is entitled to benefits under any worker's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9 for charges which the Covered person is not liable or which would not have been made had no coverage been in force.

10 for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11 because of war or any act of war, declared or not.

Coordination of Benefits. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

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

The following is a complete list of eye care services for which benefits payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

Deductibles: **Exam $10** **Eye Glass Lenses or Frames: $25**

SERVICE	**WHEN COVERED**	**PLAN MAXIMUM COVERED EXPENSE** *Participating Provider*	*Non-Participating Provider**
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to $ 55.00
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to $ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to $ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to $ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to $100.00
Frames			
Single Frame%	Once every 12 months	Up to $150.00	Up to $ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles) Includes allowance for Contact Lens Fitting & Evaluation			
Elective	Once every 12 months	Up to $160.00	Up to $160.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to $210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider)
Members can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Member's condition meets the criteria for coverage of this benefit. Members may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

*Members may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

**The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

%Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.

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.

2) 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

This section applies if a covered person has eye care coverage under more than one Plan definition below. All benefits provided under this plan are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

EXCLUSIONS

No benefit will be payable under this Schedule for:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits,
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,
- Two pairs of glasses in lieu of Bifocals,
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,
- Orthoptics or vision training and any associated supplemental testing,
- Medical or surgical treatment of the eyes,
- Contact lens modification, polishing or cleaning,
- The refitting of Contact Lenses after the initial 90-day fitting period,
- Contact Lens plans or service contracts,
- Additional office visits associated with contact lens pathology,
- Local, state and/or federal taxes, except where law requires us to pay,
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

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 $17,500 for the accidental death of a covered member, or twice this amount, $35,000, 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 Baybridge Administrators. at 1.800.845.7519 or 210.824.8004.

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 coordinatedwith 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

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

Dental and Vision Claims
Ameritas
5900 O Street
Lincoln, NE 68510

Blood Benefit Claims
Baybridge Administrators
1101 S. Capital of Texas Highway
Building E Suite 200
Austin, TX 78746

DentalClaims

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

Howto File a DentalClaim

1. If the benefits are to be paid to your dentist, ask them to send a standard ADA form or a completed claim form to Ameritas at the address shown above. In the case of dental services performed outside the U.S., benefits will be paid to you and cannot be assigned to the dentist.

2. If the benefits are not assigned to the dentist and are to be paid to you, send a completed claim form to Ameritas at the address shown above.

Claim forms are available through Ameritas and Baybridge.

Other Claims

For information on filing other claims, such as for blood benefits or accidental death and dismemberment benefits call Baybridge Administrators at the number shown above.

GENERAL PROVISIONS

ELIGIBILITY AND EFFECTIVE DATE

MEMBERS

You are eligible to enroll for coverage on, before or within the number of days applicable, following the beginning date of an 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.

RETIRED OR FORMER MEMBERS

Participants who retired or terminated employment prior to July 1, 2011 are eligible for enrollment in the CLEAT Benefit Trust Dental & Vision Plans if they meet the following requirements:

- honorably terminated or honorably retired prior to July 1, 2011.
- an active participant in the CLEAT Benefit Trust Dental and Vision Plan for 12 consecutive months prior to termination or retirement.
- submitted a complete retiree application with authorization form for monthly premium payments, within the open enrollment period.
- Further, a Retiree who has remained an active Participant and has otherwise met the above requirements may participate even if previously a participant in a group that terminated its Dental and Vision coverage through the CLEAT Benefit Trust Dental and Vision Plan
- Forms may be found on-line at: www.cleatbenefittrust.org

Applications will be reviewed as submitted. If an application is received by the 20th day of the month, a newly enrolled member will be eligible for benefits on the first day of the month, if approved. Otherwise, coverage will begin the first day of the second month following the Administrator's receipt of a completed application, payment authorization, verification of status, and notice of acceptance to the applicant. Neither a submission of an application nor of a payment authorization will bind the CLEAT Benefit Trust Dental and Vision Plan for enrollment or payment of benefits. Participants retiring after July 1, 2011 must meet the same requirements as indicated above and make application within 90 days of the qualifying event (retirement or departure from employment). A Member will become eligible for Benefits in General

the same manner indicated above. Again, neither submission of an application nor of a payment authorization will bind the CLEAT Benefit Trust Dental and Vision Plan as to enrollment or payment of benefits.

DEPENDENTS (See definition of *Dependent in Plan Document*)

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. Thedental 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 30 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 30 days thereafter.

Late Entrants

A Late Entrant is a Member or Dependent whose enrollment card was received by the Administrator more than thirty (30) consecutive days immediately following:

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

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.

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

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Plan on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate of coverage for such information, call us, or contact your state regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

LEGAL ACTIONS

No legal action can be brought against us until 60 days after the Member sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

TERMINATION OF COVERAGE

MEMBERS. The coverage for any Member, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Member's coverage terminates;
2. the date on which the Member ceases to be a Member;
3. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
4. the date all Dependent Coverage under the plan is terminated.

The coverage for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the coverages may be continued. Contact your plan administrator for details.

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."

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 hisgross misconduct) or reduction in the number of hours worked;

c. divorce or legal separation;

d. the Member's becoming covered by Medicare;

a

Joyce Lopez Dell Optiplex, AIO , don't know date, Service Code: J9VKJ02, windows 10 **might not be up for replacement

e. 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 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 ContinuedCoverage

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 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 of 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 QualifyingEvent

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 Plan Administrator or Ameritas.

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 subject to submission to the Administrator of a certificate of common-law marriage or legal proof of marriage issued by the state in which the marriage occurred. Spouse includes a same-sex domestic partner subject to the requirements stated in the Domestic Partnership Affidavit. The required Affidavit must be obtained from the Administrator.

b. any child to age 26.

The word *child*, whenever used in this Plan, includes the Participant's natural child, stepchild, legally adopted child or a child being placed for adoption. A Participant's child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Participant or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month. *Child* includes any child of a Participant who is an alternate recipient under a qualified medical child support order (QMCSO). In addition, *child* may include a Participant's grandchild subject to the following: The Participant's grandchild must be dependent upon the Participant for federal income purposes and tax documentation must be provided to the Administrator for proof of dependent status.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption hasbecome final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention of such Participant of a legal obligationfor total or partial support of the child in anticipation of adoptionof the child. The child must be available for adoption and the legal process must have commenced.

Each Dependent child of parents who are both Participants shall be considered as a Dependent of one or the other, but not both. The "Dependent" term 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: Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Planholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is

reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Planholder.

IMPORTANT PLANINFORMATION

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 100, 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.

7. TRUSTEES

   Trustees of the CLEAT Benefit Plan and Trust, at a given time consistof the current President of CLEAT, and two appointees who are members of the plan and serve on the CLEAT Executive Board. Current Trustees are as follows:

Todd Harrison CLEAT
400 West 14th St., Suite 100
Austin, TX 78701

Ron Martin
El Paso Municipal Police Officers Association
747 E. San Antonio, Suite 103
El Paso, TX 79901

Greg Shipley
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.

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 entitledto:

Receive Information about Your Plan andBenefits

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 ofdocuments 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 areasonable charge for the copies.

Receive a summary of the plan's annual financial report. The planadministrator is required by law to furnish each participant with acopy 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 qualifyingevent. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governingthe plan on the rules governing your COBRA continuation coverage rights.

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 fromthe plan

administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed inyour 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.