

THE EPSOA SUPPLEMENTAL BENEFITS PLAN SUMMARY PLAN DESCRIPTION

**Dental Benefits
Accidental Death and Dismemberment
Felony Assault Coverage**

**Administered by The County of El Paso and Access Administrators, Inc.
500 E. San Antonio
El Paso, Texas 79901
(915) 546-2218**

This Summary Plan Description includes a summary of the benefits provided by the EPSOA SUPPLEMENTAL BENEFITS PLAN ("the Plan") and in effect as of January 1, 2003. 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.

This Summary Plan Description 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.

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MEMBER AND DEPENDENT DENTAL BENEFITS

SUMMARY OF PLAN PROVISIONS

Covered Procedures

The following list of covered procedures 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 1 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.

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.

SCHEDULE A - DENTAL BENEFITS

SCHEDULE OF DENTAL BENEFITS

Deductibles

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

Percentages Payable

Type I: Preventive and Diagnostic Procedures* (Deductible waived)	100%
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*These procedures are shown in the List of Dental Procedures under the headings "Visits and Examinations," "X-rays" and "Space Maintainers".

Type I: All Other Procedures except Type II	80%
Type II: Prosthodontic Services	60%
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

Calendar Year Deductible

For orthodontic treatment and Type I preventive and diagnostic procedures the Deductible is waived. For other procedures, the amount of the Deductible (Calendar Year Deductible) shall be as shown in the Schedule of Dental Benefits.

A separate Calendar Year Deductible shall be required for each Covered Person, with the following exception:

The Calendar Year Deductible shall not apply to Covered Dental Expenses of any family member which are incurred during a Calendar Year after the date the Family Calendar Year Deductible shown in the Coverage Schedule has been satisfied for that year.

Deductible Carryover

Covered Expenses incurred in the last three (3) months of a Calendar Year which were used to meet a person's Calendar Year Deductible for that year may be used to meet the same person's Calendar Year Deductible for the immediately following Calendar Year.

Percentages Payable

After any required Deductible, Benefits based on Covered Dental Expenses shall be payable at the rates shown under the heading "Percentages Payable" in the Schedule of Dental Benefits. .

Maximum Benefit

The maximum Benefit available for all Covered Dental Expenses incurred for any one (1) Covered Person during a Calendar Year shall be the Calendar Year Maximum shown in the Schedule of Dental Benefits.

Allocation of Deductible

The Plan reserves the right to allocate the amount of the Calendar Year Deductible to any Covered Dental Expenses and to apportion the Benefits to the Covered Employee and any assignees. Such allocation and apportionment shall be binding upon the Covered Employee and all assignees.

Free Choice of Dentist

A Covered Person shall have free choice of any legally qualified dentist. If more than one dentist furnishes services or materials for a dental procedure, the Administrator shall not be liable for more than its liability had one dentist furnished the services or materials.

Covered Dental Expenses

The Plan shall pay benefits for "Covered Dental Expenses". This means Reasonable and Customary Charges (a) incurred for a person while covered under this Plan and (b) made by a Physician for:

- A) any of the Type I or Type II procedures shown in the List of Dental Procedures of the Plan, or their equivalents; and/or
- B) "Orthodontic Treatment," as defined in this Schedule under the heading "Orthodontic Expense Benefits".

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 Dental Expenses shall be limited to the charge for the least expensive procedure.

The Administrator may request submission of dental x-rays to determine the Plan's liability for any dental procedure. Should the x-rays not be submitted, the Administrator shall have the right to determine, to the best of its ability, such procedures which would provide professionally adequate restoration, replacement or treatment. If, upon receipt of such dental x-rays, the Administrator determines that procedures other than those previously determined are more appropriate, the Administrator shall make such adjustments as it deems proper.

When Expenses Are Incurred

For an appliance or modification of an appliance an expense shall be considered incurred at the time the impression is made. For a crown, bridge or gold restoration an expense shall be considered incurred at the time the tooth or teeth are prepared. For root canal therapy an expense shall be considered incurred at the time the pulp chamber is opened. All other expenses shall be considered incurred at the time service is rendered or a supply furnished.

LIST OF DENTAL PROCEDURES

The following is a list of dental procedures for which Benefits shall be available under this Schedule A.

TYPE I PREVENTIVE PROCEDURES

VISITS AND EXAMINATIONS

Initial Exam

Periodic Exam

Emergency Exam

Prophylaxis for children under age 14 (limited to two treatments every twelve months).

Prophylaxis for individuals age 14 and over, treatment to include scaling and polishing (limited to two treatments every 12 months. If more than two are performed in 12 months, payment shall not exceed 80%).

Topical application of fluoride, including prophylaxis (limited to two treatments per year).

X-RAYS

(Except for injuries, film fees include interpretation and diagnosis.)

Single film.

Additional films (up to 12) each.

Entire denture series consisting of at least 14 films, including bitewings if necessary (limited to once every three years).

Intra-oral, occlusal view, maxillary and mandibular, each.

Superior or inferior maxillary, extra-oral, single, first.

Superior or inferior maxillary, extra-oral, each additional.

Bitewing films, two including examination (once every 6 months).

Bitewing films, four including examination (once every 6 months).

Panoramic survey, maxilla and mandible film (once every three years).

OTHER VISITS/CONSULTATIONS

Office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures).

Professional visit after hours (payment will be made on basis of services rendered or visit, whichever is greater).

Special consultation fee by a specialist for case presentation when diagnostic procedures have been performed by a general dentist.

Emergency palliative treatment, per visit.

SPACE MAINTAINERS

(fee includes all adjustments within six months after installation).

Fixed space maintainer, unilateral.

Fixed space maintainer, bilateral.

Removable space maintainer, unilateral.

Removable space maintainer, bilateral.

Diagnostic casts.

Removable appliance to correct thumb sucking.

Fixed or cemented appliance to correct thumb sucking.

Office visit for observation, adjustment and activation, more than 6 months after installation.

TYPE I ALL OTHER PROCEDURES

PATHOLOGY

Biopsy of oral tissue, hard.
Biopsy of oral tissue, soft.
Histopathologic examination.

ORAL SURGERY

Extractions. Includes local anesthesia and routine post operative visits.
Uncomplicated (single).
Each additional tooth.
Surgical removal of erupted teeth.
Post-operative visit (sutures and complications) after multiple extractions and impaction.

Impacted Teeth.

Removal of tooth (soft tissue).
Removal of tooth (partially bony).
Removal of tooth (completely bony).

Alveolar or Gingival Reconstruction.

Alveolectomy (without extractions), per quadrant.
Alveolectomy (with extraction), per quadrant.
Stomatoplasty - complicated - with ridge extension, per arch.
Remove exostosis, maxilla or mandible.
Excision of hyperplastic tissue, per arch.

Cysts and Neoplasms

Intra-oral incision and drainage of abscess.
Extra-oral incision and drainage of abscess.
Excision of pericoronal gingiva.
Sialolithotomy: removal of salivary calculus.
Closure of salivary fistula.
Dilation of salivary duct.
Excision of tumor, up to 1.25 cm.
Excision of tumor, 1.25 cm and over.
Transplantation of tooth or tooth bud.
Removal of foreign body from bone (independent procedure).
Radical resection of bone for tumor with bone graft.
Maxillary sinusotomy for removal of tooth fragment or foreign body.
Closure of oral fistula of maxillary sinus.
Sequestrectomy for osteomyelitis.
Condylectomy.
Menisectomy.

Miscellaneous.

Incision and removal of foreign body from soft tissue
Frenectomy.
Suture of soft tissue wound or injury, up to 5 cm.
Crown exposure for orthodontia.

ANESTHESIA.

General anesthesia or (V sedation, related to surgical procedures only (not available without cutting procedures).

PERIODONTICS.

Subgingival curettage, root planing, per quadrant.
Correction of occlusion when performed in conjunction with periodontal

procedures, per quadrant.
Gingivectomy (including post-surgical visits), per quadrant.
Gingivectomy, osseous or muco-gingival surgery (includes post-surgical visits), per quadrant.
Gingivectomy, treatment per tooth (fewer than six teeth).
Periodontal scaling and root planing.
Periodontal prophylaxis
Bone graft
Soft tissue graft
Tissue regeneration
Crown lengthening
Actisite therapy

ENDODONTICS.

Direct pulp capping
Indirect pulp capping
Putpotomy (in addition to restoration), per treatment.

Remineralization (Calcium Hydroxide, temporary restoration), as a separate procedure only, per tooth.

Root Canals including necessary X-Rays and cultures but excluding final restoration.
Anterior tooth.
Bicuspid.
Molar.
Apicoectomy (including filling of root canal).
Apicoectomy (separate procedure).

RESTORATIVE DENTISTRY (excluding inlays, crowns and bridges)

Sealants (limited to children under age 16 and to molars and bicuspid, occlusal surfaces only).

Amalgam Restorations - Primary Teeth.

Cavities involving one tooth surface.
Cavities involving two tooth surfaces.
Cavities involving three tooth surfaces.
Cavities involving four tooth surfaces.

Amalgam Restorations - Permanent Teeth.

Cavities involving one tooth surface.
Cavities involving two tooth surfaces.
Cavities involving three tooth surfaces.
Cavities involving four or more tooth surfaces.

Synthetic Restorations.

Silicate cement filling.
Acrylic or plastic filling.
Composite resin involving one surface.
Composite resin involving two surfaces.
Composite resin involving three surfaces.
Sedative filling.

Crowns.

Stainless Steel (primary teeth only).

TYPE II PROSTHODONTIC PROCEDURES

Full and Partial Denture Repairs, Acrylic.

Broken dentures, no teeth involved.

Repair denture, replace one missing or broken tooth.

Replace additional missing or broken tooth, each tooth.

Replace missing or broken tooth on denture, no other repairs.

Partial denture repairs; based on time and laboratory charges.

RESTORATIVE.

Crowns and gold restorations are covered only when necessitated by decay or traumatic injury.

Inlays.

One tooth surface.

Two tooth surfaces.

Three or more tooth surfaces.

Onlays per tooth, in addition to inlay allowance.

Crowns.

Plastic (acrylic).

Plastic with gold.

Plastic with nonprecious metal.

Plastic with semiprecious metal.

Porcelain.

Porcelain with gold.

Porcelain with nonprecious metal.

Porcelain with semiprecious metal.

Gold (full).

Nonprecious metal (full).

Semiprecious metal (full).

3/4 Gold.

Gold dowel pin, in addition to crown.

Core buildup, including any pins

Prefabricated post and core

PROSTHETICS.

Bridge Abutments.

Pontics.

Cast gold.

Cast nonprecious.

Cast semiprecious.

Slotted facing.

Slotted pontic.

Porcelain fused to gold.

Porcelain fused to non-precious metal.

Porcelain fused to semiprecious metal.

Plastic processed to gold.

Plastic processed to nonprecious metal.

Plastic processed to semiprecious metal.

Crown retainer - porcelain.

Crown retainer fused to non-precious.

Implant Services

Surgical placement of implant body: endosteal implant

Abutment placement or substitution: endosteal Implant

NOTE: The maximum Benefit available for one or both of these procedures in connection with any tooth or teeth shall not exceed the maximum Benefit otherwise available for the placement of a corresponding fixed bridge, including any necessary attachments.

Removable (Unilateral Bridges).

One piece chrome casting, clasp attachments (all types, per unit).

Recementation.

Inlay.

Crown.

Bridge.

Repairs, crowns and bridges.

Repairs - Fee based on time and laboratory charges.

Dentures and Partials (Fees for dentures, partials and relining include adjustments within six months after installation. Specialized techniques and characterizations are not Covered). Covered Expenses shall include expenses for temporary dentures and partials.

Complete upper denture.

Complete lower denture.

Partial upper with chrome clasps, acrylic base.

Partial lower with chrome clasps, acrylic base.

Partial lower, chrome lingual bar and acrylic base.

Partial upper, chrome palatal bar and acrylic base.

Stress breaker.

Stayplate, upper.

Stayplate, lower.

Immediate splint denture, upper.

Immediate splint denture, lower.

Adjustment to dentures more than 6 months after installation.

Office reline, complete denture.

Office reline, partial denture.

Lab reline, complete denture.

Lab reline, partial denture.

Special tissue conditioning, per denture.

Denture duplication (jumpcase), complete denture.

Denture duplication (jumpcase), partial denture.

Addition of teeth to partial denture to replace extracted natural teeth.

First tooth, without clasp or abutment.

First tooth, with clasp or abutment.

Each additional tooth.

Each additional clasp with rest.

TYPE II PROCEDURES

Orthodontic Expense Benefits

If a person, while covered for Orthodontic Expense Benefits of this Plan, receives orthodontic treatment from a licensed doctor of dentistry, the Plan shall pay Benefits in accordance with the following, based on Covered Dental Expenses for such treatment :

Orthodontic Treatment: The term "orthodontic treatment":

A) Shall mean the movement of teeth by means of active appliances to correct a functional malocclusion, i.e. a malocclusion which interferes with chewing, swallowing or speech, including any one of the following:

- 1) Overbite or overjet;
- 2) Maxillary and mandibular arches in either protrusive or retrusive relation;
- 3) Crossbite;
- 4) Overcrowding of teeth;

And

B) Shall include all related diagnostic procedures and materials.

Treatment Program: The term "Treatment Program" (referred to here as Program) shall mean an interdependent series of orthodontic services prescribed by a licensed doctor of dentistry for orthodontic treatment. A Program shall begin with the diagnostic procedures required for a treatment program and shall end when the services are done, or after twenty-four consecutive months starting with the day the appliances were inserted, whichever is earlier.

Amount of Benefits: The amount of Benefits payable shall be equal to 50% of Covered Expenses up to the maximum amount shown in the Schedule of Dental Benefits.

Expenses Incurred: An expense shall be considered incurred as follows:

- A)** For insertion of active appliances, on the date of insertion;
- B)** For a service rendered to a person who does not pursue a Program, on the date the service is rendered; and
- C)** or a person who pursues a Program, at the end of each calendar month of a Program, but not beyond the date the Program ends.

With the exception of fees for the initial insertion of active appliances, Covered Expenses and Benefits for a Program shall be based on the estimated cost of the Covered Person's Program and shall be prorated monthly over the estimated length of the Program, but not for more than a total of twenty-four (24) consecutive months. The last monthly payment for a Program may be changed if the estimated and actual cost of the Program differ.

If a person's Coverage terminates during the course of his Program, his total benefit shall be equal to the sum of only those monthly Benefits which came due while he was Covered.

DENTAL EXCLUSIONS AND LIMITATIONS

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

- 1) Any procedures performed during the first 12 months that a late entrant is covered under this Plan.
- 2) Any treatment that is for cosmetic purposes or for the correction of congenital malformations.
- 3) 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.
- 4) 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).
- 5) Any prosthetic appliance installed or delivered more than 30 days after the person's coverage terminates.
- 6) The replacement of lost or stolen appliances.
- 7) 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.
- 8) 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.
- 9) The completion of claim forms, or missed appointments.
- 10) Injury arising out of or in the course of any employment for wage or profit.
- 11) Sickness for which a person is entitled to or eligible for benefits under any worker's compensation act or similar legislation.
- 12) 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.
- 13) War injuries.
- 14) Services not recommended by a licensed dentist or not required for Necessary Care and Treatment, as defined in the Plan Document.
- 15) Dental care that does not meet the standards established by the American Dental Association.
- 16) Services or supplies of the type intended for sport or home use.
- 17) For education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
- 18) For charges which exceed Reasonable and Customary rates.
- 19) Overdentures, including root canal therapy and supportive restorations.
- 20) Orthodontic services rendered to a person before such person has been covered under this Plan for at least twelve (12) consecutive months.
- 21) 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.

- 22) Services rendered or supplies, including drugs and medicines, furnished by a hospital or other facility.
- 23) 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.

Contact Lenses

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

BENEFIT LIMIT

- 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.

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.

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.

NOTE: The following exclusions became effective on June 1, 2001:

- 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 AIG Life Insurance Company, One Alico Plaza, Wilmington, Delaware 19801.

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

Also included are a benefit for accidental death of a covered dependent, a Seat Belt Benefit, benefits in connection with injury resulting in certain types of paralysis, and a schedule of benefits in connection with accidental dismemberment.

All benefits are subject to the terms, provisions, conditions and exclusions of the group insurance policy. For more information, call the Human Resources Office – Benefits Section at (915) 546-2218 with questions or to obtain a copy of the group insurance certificate.

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;
- 3) Administered during the 30-day period immediately following a covered person's effective date of coverage under the Plan;
- 4) 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.

SURVIVOR BENEFIT

If a Covered Member dies as a result of accidental bodily injury sustained while performing his duties as a peace officer. 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 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."

FILING OF CLAIMS

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

**The County of El Paso
through its third party administrator
Access Administrators, Inc.
7430 Remcon Circle Bldg C
El Paso, Texas 79912**

Claims filing need to be sent to:

**Access Administrators, Inc.
P.O. Box 12609
El Paso, Texas 79913**

Customer Service Information:

**Access Administrators
(915) 581-8182
(800) 854-2339
www.ahs-access.com**

**County of El Paso
500 E. San Antonio Ave, Ste. 302
El Paso, Texas 79901
(915) 546-2218**

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 Access Administrators, Inc. 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 Access Administrators, Inc. at the address shown above.

Claim forms are available through the Human Resources Department – Benefits Section and Access Administrators, Inc.

Other Claims

For information on filing other claims, such as for blood benefits, accidental death and dismemberment benefits or, if applicable, vision benefits, call Human Resources or Access Administrators, Inc. 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

Dependents means your spouse or any unmarried child under 19 years of age or under 24 years of age if attending school or college regularly and dependent on you for most of his/her support. A child shall be considered attending school or college regularly for 120 days immediately following completion of a semester at a school or college, or until covered under another group health plan, whichever comes first. "Dependent" does not include anyone eligible to participate in this plan as a member or who is on active duty with any armed forces. "Child" means your natural child, legally adopted child, a child being placed for adoption* by you or your Covered spouse on or after August 10, 1993, and any other child who depends on you for most of his/her support, lives with you in a regular parent-child relationship and for whom, except in the case of a stepchild, you have obtained, through a court of law, legal guardianship.

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

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 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.

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

The initial determination as to your eligibility for benefits and the amount of your payments will be made by Access Administrators, Inc. Should any request for benefits be wholly or partially denied, Access Administrators, Inc. will provide you with a statement explaining the reasons for denial.

The El Paso County Health and Benefits Risk Pool Board has been appointed to administer the operation of the Plan. If you are dissatisfied with the determination by Access Administrators Inc. you have the right to appeal the claim to the Risk Pool Board. Your questions and comments, in writing, should be directed to the Human Resources – Benefits Section Office who will in turn instruct you on the appeal process and the time limits available for an appeal. All correspondence will be kept confidential as allowed by law. The Risk Pool Board will meet during its monthly public meeting and make a final determination as to your claim and provide you with written notice of its decision and the reason for the decision within 60 days or no longer than 120 days from the date of the request. Any appeal concerning the denial of a claim must be submitted within 60 days after you receive written notice of the denial.

REVIEW AND APPEAL OF CLAIMS PROCEDURE

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;
- 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.

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 Commissioners Court of the County of El Paso.

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 Member's 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 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 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 County of El Paso, Texas or such other persons or entities as the County 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.

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 EPSOA Supplemental Benefits 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 EPSOA Supplemental Benefits Plan.

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, constitutes 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

EPSOA Supplemental Benefits Plan

2) NAME AND ADDRESS OF PLAN ADMINISTRATOR AND PLAN SPONSOR

The County of El Paso Texas
500 E. San Antonio Ave.
El Paso, Texas 79901
(915) 546-2218

3) FEDERAL IDENTIFICATION NUMBER

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 the following 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 the Plan Administrator.)

7) TRUSTEES:

El Paso County Commissioners Court

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 the County of El Paso.

10) 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.

11) STATEMENT OF ERISA RIGHTS:

As a Participant in the EPSOA Supplemental Benefits Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the following:

- to examine without charge, at the Plan Administrator's office and at other specified locations, all plan documents including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports or plan descriptions.
- to obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- to receive a summary of the Plan's annual financial report.

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate the Plan, known as Fiduciaries," have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, any sponsoring organization, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. If your claim for a Benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. 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, you should contact the nearest Area Office of the U.S. Labor-management Services Administration, Department of Labor, listed in the 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.