ORANGE COUNTY FIRE AUTHORITY - RESERVE FIREFIGHTERS PROGRAM

DENTAL AND VISION BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

The Contract Administrator of this Plan is:

Zenith American
SOLUTIONS

INTRODUCTION

To Our Employees:

This booklet is a comprehensive summary of the dental and vision coverages which are effective as of **January 1, 1999. Orange County Fire Authority - Reserve Firefighters Program** is pleased to be able to offer this coverage to you.

Please review the contents of this booklet carefully. The dental and vision coverages of our Plan are self-funded so the Plan's success is dependent upon our wise choice and use of dental and vision services. With dental and vision costs always on the rise, cost-conscious use of dental and vision care will better assure our ability to continue to offer quality dental and vision coverage to our valuable employees.

In particular, we call the following items to your attention:

- Claims are handled by a Contract Administrator. Review the section entitled "Claims Procedures" within and send claims to:

  Zenith American Solutions
  1325 North Grand Avenue, #200
  Covina, CA 91724

- If you have claims questions, you may call: **(800) 877-2528**

THIS BOOKLET IS A SUMMARY ONLY.
THE ACTUAL GOVERNING PROVISIONS ARE CONTAINED IN
THE PLAN DOCUMENT AND INSURANCE POLICIES.

Solicitud de Informaciones En Español

(Spanish Language Offer of Assistance)

Este documento está escrito en ingles y contiene un resumen de los derechos y beneficios de su plan de seguro. Si ud. tiene dificultad en comprender cualquier parte de este documento, comuniquese con los administradores de la:

Zenith American Solutions
1325 North Grand Avenue, #200
Covina, CA 91724

El horario de la oficina es: las ocho de la mañana hasta las cuatro de la tarde, lunes a viernes. Ud. tambien puede llamar a la oficina del administrador del plan de seguro a estos telefonos: (800) 877-2528 para pedir ayuda.

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DENTAL SCHEDULE OF BENEFITS

PLAN MAXIMUMS

The maximum payable for eligible dental expenses will not exceed the maximums shown below.

Calendar Year Maximum Benefit---------- $1,500

Orthodontia Maximum Benefit---------- $1,000

DEDUCTIBLES

A Deductible is an amount which an Employee must contribute toward payment of eligible dental expenses.

Individual Deductible, per person, per Calendar Year.....$ 50

Deductible Carry-Over - Eligible Expense incurred in the last three (3) months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.

COINSURANCE SCHEDULE

Coinsurance is the percentage of eligible dental expenses which the Plan pays after any Deductible requirement has been satisfied. The Coinsurance percentages are as shown to the far right, below.

(continued on next page)

Dental Schedule of Benefits, *continued*

ELIGIBLE DENTAL EXPENSES	Employee Pays	Plan Pays
Preventive Care (Ded. Waived)	-0-	100%
Basic Services	10%	90%
Major Services NOTE: Prosthetics and gold restorations (inlays/onlays) are not covered until an individual has been covered under the Plan for at least six (6) consecutive months unless necessary to repair damage resulting from an Accidental Injury which occurs while covered.	30%	70%
Orthodontia	50%	50%

NOTE: THIS SCHEDULE IS A SUMMARY ONLY.
PLEASE REFER TO THE ELIGIBLE DENTAL EXPENSES
AND LIMITATIONS AND EXCLUSIONS SECTIONS
FOR MORE COMPLETE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed (where expense is expected to exceed $250), the Plan Sponsor requires that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental x-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending Dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request x-rays or additional information during the course of its review.

While failure to obtain a pre-treatment estimate might reduce Plan benefits, the estimate also serves a useful purpose. First, it gives the patient and the Dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and Dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most Dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimate.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A PRE-TREATMENT ESTIMATE IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME THE SERVICES ARE ACTUALLY INCURRED.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies listed below, which are incurred (i.e., the service is rendered or the supply is actually received or installed) while a person is covered hereunder, except as benefits may be extended under the **Extended Dental Benefits** provision.

Preventive Services

Exams - Routine periodic oral examinations, limited to one (1) exam per 6-month period.

Fluoride Applications - Application of fluoride, limited to one (1) application per 12-month period.

Palliatives - Emergency treatment for the relief of dental pain when no other services, except X-rays, are performed.

Prophylaxis - Cleaning and polishing of the teeth (including periodontal prophylaxis), limited to one (1) cleaning per 6-month period.

Space Maintainers - Fixed appliances used to prevent abnormal movement of teeth as a result of premature loss.

X-rays - Dental X-rays for diagnostic purposes. Routine "full mouth" X-rays or a panoramic X-ray, limited to once per 24-month period. Routine bitewing X-rays, limited to one (1) set per 6-month period.

Basic Services

Anesthesia - General anesthesia when Medically Necessary and administered in connection with oral or dental surgery.

Endodontia - Endodontic services, including root canal therapy (except for final restoration), pulp capping, pulpotomy, apicoectomy and retrograde filling.

Extraction - Removal of a tooth from the oral cavity.

Eligible Dental Expenses, *continued*

Fillings (Non-Precious) - Amalgam, silicate, acrylic and plastic restorations but not including gold fillings.

Oral Surgery - Surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Pathology - Diagnostic laboratory services performed to assist in the diagnosis of oral disease.

Periodontia - Gingival curettage, osseous surgery, occlusal equilibration when no restoration is involved, periodontal scaling and root planing. See "Prophylaxis" in the list of Preventive Services for coverage for periodontal prophylaxis.

Stainless Steel Crowns

Major Services

Crowns - A gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations.

Inlays/ Onlays/ Gold Fillings - A gold or cast restoration when a tooth cannot be satisfactorily restored with a filling (amalgam, etc.) restoration.

Prosthetics - Full and partial dentures, fixed and removable bridgework and the addition of teeth to partial dentures or fixed bridgework. The allowance made for a prosthetic includes six (6) months of post-installation care (adjustments, repairs, etc.).

NOTE: See **Dental Limitations and Exclusions** for restrictions which may apply to the initial placement or replacement of prosthetics.

Repairs, Relines, Etc. - Repair, adjustment or relining of full or partial dentures and fixed bridgework when provided more than six (6) months following installation. Recementing of crowns, cast restorations or bridgework.

Eligible Dental Expenses, *continued*

Orthodontia
Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth to include:

initial consultation, models, x-rays and other diagnostic services;

comprehensive full-banded orthodontic treatment;

appliances (i.e., fixed or cemented appliances for tooth guidance and fixed or cemented appliances to control harmful habits).

Orthodontia services must be in accordance with a treatment plan that has been reviewed and approved by the Contract Administrator prior to the commencement of services (see **Dental Pre-treatment Estimate** section above).

Orthodontia benefits will begin upon submission of proof that the orthodontia appliances have been installed. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the remaining treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is shown in the "Plan Maximums" in the **Dental Schedule of Benefits.** This maximum applies to the entire period(s) a person is covered under the Plan.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Analgesia - Separate charges for pre-medication, local anesthesia, analgesia, or conscious sedation.

Appliances - Items intended for sport use, such as athletic mouthguards.

Congenital or Developmental Conditions - The treatment of congenital (hereditary) or developmental (following birth) malformations.

Cosmetic Dentistry - Treatment rendered for cosmetic purposes, except when necessitated by an Accidental Injury and then limited to services rendered while the individual is covered under the Plan and within two (2) years following the accident.

NOTE: A veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or a tooth-colored restoration is not covered on a tooth posterior to the second bicuspid but will be considered "cosmetic". The maximum allowance for restoration or replacement of such a tooth will be the allowance for a gold crown or pontic.

Crowns - Crowns placed for the purpose of periodontal splinting.

Customized Prosthetics - Precision or semi-precision attachments, overdentures, or customized prosthetics.

Discoloration Treatment - Any treatment to remove or lessen discoloration except in connection with endodontia.

Excess Care - Services which exceed those necessary to achieve an acceptable level of dental care. If the Plan Sponsor determines that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, benefits will be provided for the least costly procedure(s) which would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Dental Limitations and Exclusions, *continued*

Excess Charges - Charges in excess of the Usual, Customary and Reasonable charge for dental services or supplies.

Experimental Procedures - Services which are considered experimental or which are not approved by the American Dental Association.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Implants - Implants (materials implanted into or on bone or soft tissue) or the removal of implants.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by other than a Dentist (D.D.S. or D.M.D.) or a dental hygienist or x-ray technician under the supervision of a Dentist.

Oral Hygiene Counseling, Etc. - Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, waterpiks, and mouthwashes.

Personalization or Characterization of Dentures

Prior to Effective Date - Charges for courses of treatment which were begun prior to the Employee's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.

Replacements - Replacement of a prosthesis which, in the dentist's opinion, is or can be made satisfactory.

Replacement of a prostheses (other than a crown necessary for restorative purposes only) for which benefits were paid under the Plan if the existing appliance is less than five (5) years old, unless:

replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth;

the existing prosthesis is a stayplate or similar temporary partial prosthesis and is being replaced by a permanent prosthesis; or

the prosthesis, while in the oral cavity, has been damaged beyond repair as the result of an Accidental Injury occurring while the individual is covered under the Plan.

Sealants - Materials applied to the teeth to seal developmental imperfections, such as pits and fissures.

Splinting - Appliances and restorations for splinting teeth.

Temporary Full Prosthetics - A temporary full prosthesis.

Temporomandibular Joint Dysfunction / Maxillofacial Surgery - Any charges for jaw (mandibular) augmentation or reduction procedures; or procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome, including the correction of abnormal positioning and relationship of teeth.

Vertical Dimension - Procedures which are performed solely to increase vertical dimension.

- *(See also* ***General Exclusions*** *section)* -

EXTENDED DENTAL BENEFITS

Benefits will be extended for one (1) month beyond an Employee's termination date for the following services and supplies, provided such services would have been covered under the Plan if the coverage had remained in force:

an appliance, or modification of one, for which an impression was taken prior to the date of termination;

a crown, bridge or gold restoration for which the tooth was prepared prior to the date of termination;

root canal therapy, provided the pulp chamber was opened prior to the date of termination.

VISION SCHEDULE OF BENEFITS

The Plan will provide benefits, up to the amounts shown at the far right, for the vision services and supplies which are listed below. Benefits are paid at 100% (not to exceed actual charges) and there is no Deductible requirement.

ELIGIBLE VISION EXPENSES	**Plan Pays**
Examination, up to	$50
Contacts (in lieu of glasses), up to Necessary Elective	 $300 $120
Frames, per pair up to	$75
Lenses for Glasses, per pair: Single Vision Bifocal Trifocal Lenticular	 $70 $80 $120 $150

NOTE: THIS SCHEDULE IS A SUMMARY ONLY. PLEASE REFER TO THE ELIGIBLE VISION EXPENSES AND LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE COMPLETE INFORMATION.

ELIGIBLE VISION EXPENSES

The following is a complete list of Eligible Expenses under this section. Any such services or supplies must be rendered or ordered by a licensed ophthalmologist or optometrist.

Contacts - The benefit for contact lenses (hard, soft or disposables) renews every Calendar Year. The allowance for "necessary" contacts will be paid if contact lenses are necessary after cataract surgery or if visual acuity is not correctable to 20/70 in the better eye except through the use of contact lenses.

Examination - One complete visual examination, including refraction, is covered in any Calendar Year.

Frames - One pair of frames is covered in any Calendar Year.

Lenses for Glasses - One pair of lenses for glasses is covered in any Calendar Year.

VISION LIMITATIONS AND EXCLUSIONS

Except as expressly stated below, no vision coverage will be provided for:

Medical or Surgical Treatment of the Eye

No Prescription Change - Glasses purchased when the lens prescription has not changed.

Non-Professional Care - Visual examination performed other than by a licensed ophthalmologist or optometrist.

Orthoptics - Services or supplies in connection with orthoptics, visual training or other special procedures.

Non-Prescription Lenses - Lenses which do not correct refractive error (plano lenses) or which are not obtained upon prescription by an ophthalmologist, optometrist or optician.

Prior to Effective Date - Any material furnished as the result of an eye refraction which began before the individual's effective date of coverage under the Plan.

Radial Keratotomy - Surgery to correct refractive error.

Replacement - Replacement of lost or broken lenses or frames (except in accordance with the allowable frequencies above).

Safety Lenses or Goggles

Sunglasses - Sunglasses (tint other than No. 1 or 2) or photo-sensitive lenses.

*(See also **General Exclusions** section)*

GENERAL EXCLUSIONS

No benefits will be payable under the Plan for:

Criminal Activities - Any injury resulting from or occurring during the Employee's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which an Employee is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies not specifically listed in the Plan Document as Eligible Expenses are NOT covered under the Plan.

Other Coverage - Services or supplies for which an Employee is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).

Outside United States - Charges incurred outside of the United States if the Employee traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.

General Exclusions, *continued*

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Employee is eligible for benefits under the plan which this Plan replaces.

Relative or Resident Care - Any service rendered to an Employee by a relative (i.e., a spouse, a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Employee's household.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction which occurred while sane or insane and regardless of whether the Covered Person was aware of or in control of his or her actions.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

War or Active Duty - Conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country.

Work-Related Conditions - Any condition for which the Employee has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However, if the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

COORDINATION OF BENEFITS (COB)

Benefits provided under the Plan are subject to an industry-standard Coordination of Benefits (COB) provision. The full terms of the provision are not included in this booklet but are in the Plan Document.

Briefly, the intent of COB is to avoid a duplication of benefits when an individual has coverage under more than one plan, such as often occurs when both a husband and wife are employed. In such an instance, the two (or more) plans will determine, between them, who will provide benefits on a "primary" basis and who will provide "secondary" benefits.

For COB purposes an "Other Plan" will include:

group, blanket or franchise coverage, whether insured or uninsured;

group prepayment plans (HMOs and EPOs); group

Blue Cross and Blue Shield coverages;

any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs, such as CHAMPUS/CHAMPVA, and any coverage required or provided by a statute, including Medicare. For purposes of implementing this provision, eligibility alone will constitute coverage.

To assure prompt claims handling, Claimants with more than one plan of coverage should be certain to provide other coverage details (name of carrier, claims-paying address, policy no., etc.) when filing claims.

SUBROGATION

(Acts of Third Parties)

If a Covered Person incurs charges for treatment of an injury, sickness or other condition which is caused by the act or omission of another person or another party, the Plan Sponsor will provide the benefits of the Plan only on condition that the Covered Person will agree in writing:

to advise the Plan Sponsor of a claim or suit against a third person or coverage carrier within 60 days of such action;

to provide the Plan with an assignment of benefits to the extent of benefits provided under the Plan; and

to reimburse the Plan to the extent of benefits provided, immediately upon collection of damages by him, whether by legal action, settlement or otherwise.

Upon conditional payment of the Plan benefits, the Plan Sponsor will file the assignment of benefits with the person or party whose act(s) caused the injuries, his agent, insurers, the court, or the provider(s) of the services.

The Plan Sponsor will also be entitled to file a lien against the proceeds of any settlement or judgment which results from the Covered Person's claim or suit. The amount of the lien will equal the payments made by the Plan. Notice of such lien will be filed with the person or party whose act(s) caused the injuries, his agent, insurers, the court, or the provider(s) of the services.

NOTE: The payment to the Plan required under this provision shall not exceed the lesser of: (1) the proceeds of any such recovery after deducting reasonable and necessary expenditures in effecting such recovery, including attorney's fees, or (2) the total benefits paid by the Plan.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements
In order to be eligible to participate in the coverages of the Plan, an Employee must be in active employment for the Employer, performing all customary duties of his occupation at his usual place of employment.

An Employee will be deemed in "active employment" on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Effective Date
Eligible Employees who are in active employment and enrolled on the effective date of the Plan Document and who were validly covered under the Employer's plan(s) of coverage which this Plan replaces will be covered on the Plan Document's effective date. All other Employees will be effective as below.

The Employee coverages of the Plan are provided on a non-contributory basis (that is, the Employer pays entire Employee cost of coverage). An eligible Employee's coverage is effective, subject to completion of the enrollment form, upon completion of a waiting period to the first of the month following his completion of thirty (30) days of continuous active employment.

If an Employee is absent from active status when his coverage would otherwise become effective, coverage will be delayed under the day he returns to active employment.

Reinstatement / Rehire
If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines, and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated. No waiting period requirement will be applied.

Eligibility and Effective Dates, *continued*

In accordance with Federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan. Neither the waiting period requirement nor any Plan limitations with reference to pre-existing conditions will apply. However, this provision is intended to comply with the minimum requirements of the Veteran's Re-employment Rights Law and, if it is in conflict or incomplete in any way, such law will prevail.

Adjustments for Prior Coverage

If these Coverages are an immediate replacement of prior coverage(s) offered by the Plan Sponsor, they are intended to replace the prior coverage(s) and, except to the extent that benefits are expressly modified, it is not intended that benefits will be reduced or increased for an Employee who was covered under the prior coverage(s) on the day of discontinuance and who is eligible as an active enrollee under the Plan Document on its effective date. Any deductibles satisfied or benefits paid with respect to such Employees under the prior coverage(s) will be deemed to be Deductibles satisfied or benefits paid under the Plan Document. Any contiguous periods an Employee was covered under a prior coverage(s) of the Plan Sponsor will be deemed to be time covered under the Plan Document for purposes of any time-covered requirements of the Plan.

TERMINATION OF COVERAGE

An Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan;

termination of Employee's eligibility or termination of participation in the Plan by the Employee;

the date the Employee becomes a full-time member of the armed forces of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year. For active duty in the military services of the United States such date will be the date of active duty on his/her "activation Orders." However, if the U.S. active duty call-up is for less than 30 days and is then extended, Plan coverage will continue until 12:00 midnight on the 30th day of active duty;

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer - except when coverage is extended under the terms of any **Extension of Coverage** provision.

NOTE: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

EXTENSION OF COVERAGE DURING ABSENCE FROM WORK

If an Employee fails to continue in active employment during an approved leave of absence or disability due to sickness or injury, the Employee may be permitted to continue health coverages for himself though Employee could be required to **pay the full cost of coverage during such absence.** Any such plan of extended coverage offered by the Employer must be administered on a basis which precludes individual selection. However, the maximum continuation period commencing with the cessation of active employment of an Employee will be to the last day of the third full month of the leave;

This extension will automatically and immediately cease on the earliest of the following dates:

the end of the period for which the last contribution was paid, if such contribution is required; or

the date of termination of this Plan.

CLAIMS PROCEDURES

Proof of Loss
Written proof covering the details of loss for which a claim is made must be furnished to the Contract Administrator within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event except in the absence of legal capacity of the Claimant, later than twelve (12) months from the date on which covered charges were incurred.

Claims should be submitted as soon as possible after expenses are incurred to:

Zenith American Solutions
1325 North Grand Avenue, #200
Covina, CA 91724

Assignments to Providers
All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to providers of service will be honored, and (2) the Plan may pay benefits directly to providers of service unless the Employee requests otherwise, in writing, within the time limits for filing proof of loss.

NOTE: Benefit payments on behalf of an Employee who is also covered by a State's Medicaid program will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Employee, as created by an assignment of rights made by the Employee or his beneficiary as may be required by the State Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the State's having paid Medicaid benefits that were payable under the Plan.

Claims Denials and Appeal Procedures
If the Contract Administrator or the Plan Sponsor determines that a claim should be wholly or partially denied, the Claimant will be given written notification of such denial. This notice will include:

the reason(s) for the denial;

specific reference to the Plan provision(s) on which the denial is based.

A Claimant may request a review of his claim, provided such request is filed in writing to the Contract Administrator (at the address shown above) within 60 days after the date his claim is denied.

At such time as the Claimant requests a review of the denied claim, he may review any pertinent documents and should submit issues and comments in writing.

The Plan Sponsor will make a decision with regard to such claim not later than 60 days after the receipt of the request for review, unless special circumstances require an extension of time. If such an extension is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial 60-day period. The extension notice will explain the special circumstances requiring an extension and the date the Plan Sponsor expects to render the final decision.

The decision on review will be in writing, will include the specific reason(s) for the decision and will reference the pertinent provisions on which the decision is based.

DEFINITIONS

When capitalized within the text of this booklet, the following terms will have the meanings shown below. Other capitalized terms may be defined in the Plan Document.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1.

Claimant - Any Employee for whom a claim is submitted for benefits under the Plan.

Coinsurance - see the **Dental Schedule of Benefits** and **Vision Schedule of Benefits** for information

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Deductible - see the **Dental Schedule of Benefits and Vision Schedule of Benefits** for information

Dentist - An individual who is duly licensed to practice dentistry or perform oral surgery in the State where the dental service is performed and who is operating within the scope of his license. A physician (M.D.) will be considered to be a Dentist when he performs any dental services within the operating scope of his license.

Eligible Expense(s) - Expense which is (1) covered by a specific benefit provision of the Plan Document and (2) incurred while the person is covered by the Plan Document.

Employee - see **Eligibility and Effective Dates** section

Employer - An Employer participating in the Plan.

Fiduciary - A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Plan - The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Employees, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Usual, Customary and Reasonable - A charge made by a provider which does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of dental or vision conditions comparable in severity and nature to the dental or vision condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

GENERAL PLAN INFORMATION

Name of Plan:	**Orange County Fire Authority - Reserve Firefighters Program Dental and Vision Benefit Plan**
Plan Sponsor:	**Orange County Fire Authority – Reserve Firefighters Program**
Address:	**1 Fire Authority Road Irvine, CA 92614 / or PO Box 57115 Irvine CA 92619-7115**
Business Phone Number:	**(714) 573-6817**
Participating Employer:	**Orange County Fire Authority – Reserve Firefighters Program**
Plan Benefits:	**Dental and Vision Coverages**
Contract Administrator:	**Zenith American Solutions**
Address:	**1325 North Grand Avenue, #200 Covina, CA 91724**
Customer Service Number:	**(800) 877-2528**

Funding - Sources and Uses

Contribution Determinations
The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer(s) and the amount to be contributed (if any) by each Employee.

Employer contributions and those paid by Employee, if any, will be placed in a special account or accounts administered by the Contract Administrator to provide the non-insured benefits under the Plan.

Plan Funded Benefits
The contributions will be applied to provide the benefits under the Plan.

Administration Expenses
Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of an administration agreement between the Plan Sponsor and the Contract Administrator(s).

Taxes
Any premium or other taxes which may be imposed by any State or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent with applicable law.

Administrative Provisions

Administration
Certain benefits of the Plan are administered by Contract Administrator(s) under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator(s).

Amendment or Termination of the Plan
The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right:

to determine eligibility for benefits or to construe the terms of the Plan;

to alter or postpone the method of payment of any benefit; and

to amend any provision of these administrative provisions; and

to make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

Legal Actions
No Employee or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document. No action may be brought for benefits provided by the Plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Plan and then action may only be brought within one year after the date of such decision.

Misuse of Identification Card
If an Employee permits any other person to use any identification card issued, the Plan Sponsor may give Employee written notice that his coverage will be terminated at the end of 31 days from the date written notice is given.

Reimbursements
Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights

against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Substitution
The Plan Sponsor will be substituted for all rights of an Employee to recover attorney fees against any adverse party. Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

Type of Plan
This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible Employees of the Employer(s).

NOTES