DELTA DENTAL®
Delta Dental Plan of Kansas

GROUP # 90604

Description OF Dental Care Coverage

CBIZ, INC.
Core Plan

Welcome to Delta Dental Plan of Kansas

Delta Dental Plan of Kansas, Inc. is a member of Delta Dental Plans Association, the leading and largest underwriter of group dental coverage in the United States. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to the overall well-being of every person.

You are free to go to any dentist of your choosing; however, there may be a difference in the amount of payment if the dentist is not a participating dentist with Delta Dental. Since over 80% of the dentists do contract with Delta Dental, the chances are excellent your dentist is already a member. If you have any questions about whether your dentist participates with Delta Dental, ask your dentist when making an appointment or contact the Customer Service staff at Delta Dental Plan of Kansas by calling (316) 264-4511 or toll free (800) 234-3375. You may also access our network, nationwide, through our website at www.deltadentalks.com.

It is our pleasure to be of service to you.

Summary of Dental Plan Benefits
CENTURY BUSINESS SERVICES, INCORPORATED
Group #90604

Maximum Contract Benefit Per Person

90604----Core Plan

The maximum benefit payment for all covered dental procedures for each Eligible Person in any one calendar year is One Thousand Dollars ($1,000.00).

Deductible Limitations

90604----Core Plan

Coverage for oral examinations, xrays, prophylaxis, fluoride treatments, space maintainers, and ancillary is not subject to any deductible amount. For all other benefits covered hereunder, during each calendar year Plan shall accrue no liability for any part of the first Fifty Dollars ($50.00) of covered procedures charged to or because of each Eligible Person for benefits provided to such person. After an Eligible Employee and his/her Eligible Dependents in any calendar year have each paid either the deductible amount described in the sentence preceding or have cumulatively paid charges for covered procedures in the amount of One Hundred Fifty Dollars ($150.00), the deductible requirements of the preceding sentence shall no longer be applicable for any benefits during that calendar year for such Eligible Employee or any Eligible Dependent of his/hers.

As a condition precedent for liability hereunder, Plan may require such reasonable evidence of the accrual and payment of the deductible amounts before described as Plan reasonably deems necessary.

% paid by Plan		Dental Services Covered
80%	I.	DIAGNOSTIC: Includes the following procedures necessary to assist the Dentist in evaluating the conditions existing and the dental care required: Oral examinations – two (2) times per calendar year. Diagnostic x-rays - bitewings two (2) times per calendar year for dependents under age twenty-five (25) and once each twelve (12) months for adult's age twenty-five (25) and over. Full mouth x-rays - once each thirty-six (36) months.
80%	II.	PREVENTIVE: Provides for the following: Prophylaxis (cleanings) - two (2) times per calendar year. Topical Fluoride - two (2) times per calendar year for dependent children under age nineteen (19). Space Maintainers - for dependent children under age nineteen (19) and only for premature loss of primary molars.
80%	III.	ANCILLARY: Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
80%	IV.	ORAL SURGERY: Provides for extractions and other oral surgery including pre and post-operative care.
80%	V.	REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations; composite (white) resin restorations on anterior (front) teeth, and stainless steel crowns for dependent children under age twelve (12).
80%	VI.	ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.
80%	VII.	PERIODONTICS: Includes procedures for the treatment of diseases of the tissues supporting the teeth.
40%	VIII.	SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual permanent crowns.
40%	IX.	PROSTHODONTICS: Includes bridges, partial and complete dentures, including repairs and adjustments.
NONE	X.	ORTHODONTICS:

Orthodontic appliances and treatment. NOTE: Consultations – unlimited number.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

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DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Eligible Employee by the Delta Dental Plan of Kansas, Inc., hereinafter referred to as "Plan", a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental coverage program and constitutes your summary of the Contract and contains the provisions of your dental coverage. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the Contract and then only if identified as a covered dental benefit in the Summary of Dental Plan Benefits. Certain restrictions may be applicable to your coverage. It is important to review the Exclusions and Limitations section of this document for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this booklet, appropriate modifications will be made in the benefits provided under the Contract.

HOW TO USE YOUR PLAN

Make an appointment with your Dentist. Tell the Dentist that you are covered by Delta Dental Plan of Kansas.

If the planned treatment involves prosthetic or orthodontic procedures, individual crowns (except stainless steel), gold restoration, surgical periodontics, endodontics or oral surgery, except for simple extraction of a single tooth, the Dentist should submit a treatment plan to Plan to determine how much of the bill will be paid by Plan and what your share of the cost will be. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of Plan's consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate Plan if you as an employee or dependent are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to Plan by the treating Dentist or a new treatment plan should be obtained and resubmitted to Plan.

PARTICIPATING DENTISTS

Before treatment is started, be sure to discuss with your Dentist the total amount of the bill and the portion, if any, you will be required to pay. Under the Contract you are free to go to the Dentist of your choice, however there may be a difference in the amount of payment which will be made by Plan if the Dentist chosen is not a Participating Dentist with Delta Dental at the time services are performed.

Following treatment, the Attending Dentist's Statement should be forwarded by the Dentist to Plan. Plan will make direct payment to the Dentist, if he or she is a Participating Dentist, on each covered procedure on the basis of the Usual fee for services as filed with and accepted by Plan, Plan's maximum allowed fee, or the billed fee, whichever is less. Any amounts withheld from a Participating Dentist by Plan for reserves, research or other purposes shall be deemed to have been paid as part of the claim of the Participating Dentist. You will receive notice of Plan's payment and of the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist's usual billing procedure.

NON-PARTICIPATING DENTISTS

For dental benefits and services provided by a non-Participating Dentist, Plan will pay to the employee on each covered procedure the applicable co-percentage of the lesser of the actual fee charged or the average fee as determined from the filed fees of the Participating Dentists.

NO PRE-EXAMINATION

There are no pre-examination requirements for employees and dependents to be eligible for dental benefits.

EMERGENCY TREATMENT

Plan's group dental coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and patients should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours.

INQUIRIES/COMPLAINTS

Dentists and Eligible Persons are encouraged to contact Plan when they have a question concerning a particular claim. Such inquiry should be directed to the Customer Service Department of Delta Dental Plan of Kansas, Inc., in Wichita, Kansas, and should include all of the following information:

1. Employee group number and social security number.
2. Patient name and birth date.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.

Written inquiries are best submitted on the copy of the Notification of Benefits form.

Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511, or outside of the Wichita area, 1-800-234-3375.

Patients who have complaints about the Contract or about services provided by a Dentist under the Contract, are encouraged to write their complaints to Customer Service Department, Delta Dental Plan of Kansas, Inc., P.O. Box 49198, Wichita, Kansas 67201-9198.

Eligible Persons may also telephone the Customer Service Department using any of the numbers identified above. Complaints or inquiries may also be presented in person at the business office of Delta Dental Plan of Kansas, Inc., which is located at 1010 N. Main St., Wichita, Kansas 67203.

If necessary, additional information or documents may be requested for a full and fair review. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, patients will receive a written acknowledgement to their inquiries or complaints within 20 days of receipt unless referred to a review committee or other unusual circumstances arise, in which case the patient will be advised and an answer or decision should be received in writing within thirty (30) days.

REEVALUATION AND PEER REVIEW

If the Employer or Eligible Person does not agree with the determination of benefits and has additional information to supply, reevaluation may be requested by resubmitting a copy of the claim form, x-rays and clinical comments to the Customer Service Department, Delta Dental Plan of Kansas, Inc., P.O. Box 49198, Wichita, Kansas 67201-9198.

Reevaluation will be made by the consultant and staff and, in some cases, the Eligible Person may be examined clinically by a regional dental consultant. The Employer or Eligible Person may also request such an examination.

If a case cannot be resolved in this manner, the Employer or Eligible Person may request an evaluation by the applicable state dental association peer review system.

REGIONAL CONSULTANTS

As Plan is aware that the review of a claim form and x-rays may not be sufficient to come to a decision in all cases, Plan will rely on the council of regional dental consultants to examine patients clinically.

The treating Dentist is always notified by Plan if a patient is being selected for examination by a regional dental consultant. Routine pre- and post-treatment examinations are made to determine contractual benefits and to verify that the treatment was provided and meets the accepted standards of the profession. When appropriate, examinations may also be conducted at the request of the Eligible Person or a treating Dentist.

PLAN LIABILITY

Plan shall have no liability for any conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omission, or any other act, of any person, including but not limited to employees, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services, and shall also have no liability for any services or facilities which, for any reason, are unavailable to any Eligible Person.

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, Plan, upon its request, shall be entitled to receive from any attending or examining Dentist, or from hospitals in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, or treatment rendered to, an Eligible Person as is helpful in the administration of such claims. Plan, at its own expense, shall have the right and opportunity to cause any Eligible Person to be examined when and so often as it reasonably requires during the pending of a claim under this Contract and the right and opportunity to make an autopsy if it is not prohibited by law. The accepting by any Eligible Person of any benefit of coverage under this Contract constitutes the automatic and irrevocable consent by that Eligible Person for the release to Plan of any and all of the information and records before described, and a full waiver by that Eligible Person that any of such information and records that otherwise is privileged. Further, the providing by an attending or examining Dentist to an Eligible Person of any benefits covered under this Contract is a consent by that Dentist, upon request, to provide such information and records to Plan and the permitting by any hospital of the performance by any Dentist of any benefits covered hereunder in such hospital constitutes a consent by that hospital, upon request, to provide such information and records to Plan.

CONFIDENTIALITY:

Plan agrees that it has individual health information and other proprietary information (collectively, "Information") which is valuable, special, private and unique. The Plan will not divulge, disclose or communicate in any manner any Information to any third party without prior written consent of the Eligible Member. The Plan will protect the Information and treat it as strictly confidential. The Plan will abide by the requirements of 42 C.F.R. Part 160-164 (HIPAA) and all Standards for Privacy of Individually Identifiable Health Information. The Plan agrees that it will:

1) not use or further disclose the information other than as permitted or required by the Contract or as required by law;

2) use appropriate safeguards to prevent use or disclosure of Information other than as provided for by the Contract;

3) report to the Eligible Member any use or disclosure of the Information not provided for by its Contract of which it becomes aware;

4) ensure that any agents, including a subcontractor to whom it provides protected health Information received from or created by the business associate on behalf of the Eligible Member, agree to the same restrictions and conditions that apply to the business partner with respect to such Information;

5) make available protected health Information in accordance with 42 C.F.R. 164.526;

6) make available protected health Information for amendment and incorporate any amendments to protected health Information in accordance with 42 C.F.R. 164.526;

7) make available the Information required to provide an accounting of disclosures in accordance with 42 C.F.R. 164.528;

8) make its internal practices, books, and records related to the use and disclosure of protected health Information received from or created or received by the business associate on behalf of the Eligible Member available to the United States Secretary of Health and Human Services for the purpose of determining the compliance with 42 C.F.R. Part 160-164; and,

9) at the termination of the contract, if feasible, return or destroy all protected health Information received from or created or received by the business associate on behalf of the Eligible Member, the business partner still maintains in any form and retain no copies of such Information; or, if such return or destruction is not feasible, extend the protections of the contract to the Information and limit further uses and disclosures to those purposes that make the return or destruction of the Information infeasible.

A VIOLATION OF THIS SECTION SHALL BE A MATERIAL VIOLATION AND BREACH OF THIS CONTRACT.

MISREPRESENTATIONS

No statements made by the Employer or by an individual employee shall be deemed warranties, and no statement by the Employer or employee shall be used in defense of a claim or in any other dispute under the Contract, unless it is contained in a written instrument, a copy of which has been furnished to such Employer, employee or personal representative thereof and, if such statement was made in the application of this Description of Dental Care Coverage, which application or an exact copy thereof is included in or attached to this document.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Contract prior to the expiration of sixty (60) days after final notice of claims has been filed in accordance with the requirements of the Contract nor shall any action be brought after five (5) years from the date the claim for benefits was presented to Plan.

GOVERNING LAW:

This Contract shall be interpreted and enforced according to the laws of the State of Kansas, except to the extent such laws are preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

DEFINITIONS

For the purpose of this Description of Dental Care Coverage, the following definitions shall apply:

1. "Child" means in addition to the Eligible Employee's own or lawfully adopted child or children, any step-child residing with the Eligible Employee in a regular parent-child relationship. The term "Child" also includes any child, under the stated dependent age of this Contract, placed with the Eligible Employee for adoption and any child of the Eligible Employee who is recognized as an alternate recipient under a qualified medical child support order."

2. "Continuation Coverage" shall mean coverage under this Contract as that term is defined and used pursuant to Section 4980B of the Internal Revenue Code of 1986 as amended all of the requirements, definitions and specifications of said Section 4980B of the Internal Revenue Code of 1986 as amended necessary to qualifying this Contract to meet the conditions and requirements of said Section 4980B of the Internal Revenue Code of 1986 as amended being hereby adopted and incorporated by reference.

3. "Contract" means the agreement between Plan and Employer including the Application of the Employer for this Contract and the attached appendices, endorsements and riders, if any. The Contract constitutes the entire Contract between the parties.

4. "Contract Term" means the period commencing on the Effective Date hereof and terminating at 11:59 P.M. on the last day of the term of the Contract as specified in the Contract.

5. "Cosmetic", when describing dentistry, means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory.

6. "Dentist" means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.

7. "Effective Date" means the first day of the initial term of this Contract.

8. "Eligible Dependent" means the spouse and any of the other dependents of an Employee who meet the conditions of eligibility outlined in this Contract, and any spouse or dependent who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate monthly payment specified in Section 1.6, is received by Plan.

9. "Eligible Employee" means any employee of Employer who meets the conditions of eligibility outlined in this Contract, and any employee who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate monthly payment is received by Plan.

10. "Eligible Person" means an employee, spouse or a dependent who meets the conditions of eligibility outlined in this Contract, and a person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate monthly payment is received by Plan.

11. "Employer" means the corporation, partnership, sole proprietorship, limited liability company, association or any other organization which has hereby contracted with Delta Dental Plan of Kansas, Inc. to provide dental coverage for its employees or members.

12. "Participating Dentist" means any Dentist who has agreed to render services in accordance with terms and conditions established by Plan and has satisfied Plan that he or she is in compliance with such terms and conditions.

13. "Plan" means Delta Dental Plan of Kansas, Inc., which shall be the control plan, or any other Delta Dental Plan which has agreed to provide to Eligible Persons the benefits described in this Contract, or both, as applicable.

14. "Usual" fee shall be defined as the lowest fee charged or offered for a given service by an individual Dentist to any patient or prospective patient. The Usual fee shall not be affected by fees accepted for patients covered by programs funded by public or charity funds primarily intended to assist the poor or disadvantaged or those occasional instances where professional courtesy discounts are given or fees waived or discounted in cases of financial hardship.

EXCLUSIONS AND LIMITATIONS

1. **The Dental Benefits and Services Provided Shall <u>NOT</u> Include The Following:**

   a. Coverage for any patient who has been, but no longer is, an Eligible Person.

   b. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

   c. Benefits or services which are determined by Plan to be Cosmetic surgery; or, dentistry for Cosmetic reasons.

   d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the patient became an Eligible Person hereunder, except orthodontics, and then only if such orthodontic coverage was provided under the Employer's group dental program in effect immediately preceding the Effective Date and if orthodontic services are included as a covered dental benefit in the Summary of Dental Plan Benefits.

e. Prescription drugs, premedications and relative analgesia; hospital, healthcare facility, or laboratory charges; general anesthesia for restorative dentistry shown; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.

f. Benefits and services that are not necessary and customary as determined by the standards of generally accepted dental practice.

g. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

h. Benefits or services for control of harmful habits.

i. Treatment to correct congenital or developmental malformations.

j. Services performed for the purpose of full mouth reconstruction.

k. Dental care injuries or disease caused by riots or any form of civil disobedience if the Eligible Person was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; injuries intentionally self-inflicted; and injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting therefrom.

l. Treatment rendered outside of the United States or Canada unless claims are submitted in English and converted to U.S. Dollars.

m. Claims not submitted to Plan within six (6) months of the date of service provided, however, that if it was not reasonably possible to submit a claim within such six (6) months, such claim shall be excluded only if it is either not submitted to Plan as soon as it is reasonably possible or within one (1) year of the date of service, whichever is the earlier.

n. X-rays taken in conjunction with non-covered services such as, but not limited to, temporomandibular joint dysfunction (TMJ) cases.

o. Temporary services and procedures, including, but not limited to, temporary filling, sedative fillings and bases, temporary crowns and temporary prosthetic devices.

p. Any service which is not specifically provided under the Contract.

q. Gold restorations and individual crowns unless included as a covered dental benefit in the Summary of Dental Plan Benefits.

r. Crowns and endodontic treatment in conjunction with an overdenture.

s. Bridges and dentures, including repairs and adjustments, unless included as a covered dental benefit in the Summary of Dental Plan Benefits.

t. Replacement of lost or stolen dentures or charges for duplicate dentures.

u. Orthodontic procedures and procedures related to orthodontic services, such as, but not limited to, x-rays, extractions, orthodontics appliance repairs and adjustments, unless orthodontics specified as a covered benefit in the Summary of Dental Plan Benefits.

v. Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident to the extent such benefits and services are payable under any medical or dental expense payment provision (by whatever terminology used -- including such benefits mandated by law) of any automobile insurance policy. The excluded expenses cannot be used for any purpose under the Contract.

w. Any benefit, procedure or service, a motivating purpose for which is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, which prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

x. Dental benefits and services which are not completed.

y. Procedures for dental implants and associated services.

z. Diagnosis or treatment of temporomandibular joint dysfunction.

2. The Dental Benefits and Services Provided Shall Be Limited as Follows:

a. If there is selected a more expensive service or benefit than is needed, Plan will pay the applicable percentage of the fee for the service or benefit for which is needed to restore the tooth or dental arch to contour and function. The remainder of the fee is not a covered benefit and cannot be used for any purpose under the Plan.

b. Only the cost of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are a dental benefit under the Contract and then only if selected as a covered dental benefit in the Summary of Dental Benefits.

c. Some procedures and treatments may have specific age and frequency limitations. These limitations are identified in the Summary of Dental Benefits.

d. When services in progress are interrupted and completed later by another Dentist, Plan will review the claim to determine the allocation of payment to each Dentist.

e. Charges for services or supplies for which no charge is normally made or for which no charge would be made but for the Contract are not covered benefits.

f. Prophylaxis (including periodontal maintenance) and oral examinations may be subject to specific time and frequency limitations. Such limitations are identified in the Summary of Dental Benefits. Bitewing x-rays may be subject to specific age, time and frequency limitations. Such limitations are identified in the Summary of Dental Benefits.

g. Full mouth x-rays may be subject to specific time and frequency limitations. Such limitations are identified in the Summary of Dental Benefits. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.

h. Benefits for a seven (7) vertical bitewing series are not provided more frequently than once each two (2) years.

i. Payment is made for a surface only once within a twenty-four (24) month period regardless of the number or combinations of restorations placed therein.

j. Recementation of space maintainers are covered one (1) per lifetime.

k. Composite (white) fillings are only covered on anterior (front) teeth. If composite fillings are performed on posterior (back) teeth, Plan will benefit up to the maximum allowable for an equal surface amalgam (silver) filling and the remainder of the fee is not a covered benefit.

l. Veneers are considered to be optional treatment. Benefit payment will be made for the restorative procedure appropriate to the degree of tooth breakdown.

m. All inlays are benefited on the basis of the Participating Dentist's filed fee for an equal surface amalgam (silver restoration) with the patient being responsible for the difference in cost, if any.

n. Individual crowns are not a covered benefit unless specified as a covered dental benefit in the Summary of Dental Benefits. If a covered benefit:

(1) Individual crowns on the same tooth are a covered benefit only once in any five (5) year period unless it is needed because of injury. Said time period is to be measured from the date the crown was supplied to the Eligible Person whether or not the Contract was then effective.

(2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not covered benefits for any person under twelve (12) years of age.

(3) Recementation of a crown may be allowed for payment only once in a twelve (12) consecutive month period.

(4) Only two (2) repairs per crown will be allowed in a twelve (12) month time period.

(5) Stainless steel crowns are limited to once in a twenty-four (24) month period when placed on dependent children. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection will apply.

(6) Coverage for core/crown build-ups, including pins is limited to permanent teeth having insufficient tooth structure.

o. Prosthetic appliances are not a covered benefit unless specified as a covered dental benefit in the Summary of Dental Benefits. If a covered benefit:

(1) Not more than one full upper and one full lower denture shall be constructed under the Contract in any five (5) year period for any one Eligible Person. Said time period is to be measured from the date the denture was last supplied to the Eligible Person whether or not the Contract was then effective.

(2) A partial denture, fixed bridge, or removable bridge may not be provided under the Contract for any Eligible Person more often than once in any five (5) year period. Said time period is to be measured from the date the denture or bridge was last supplied to the Eligible Person whether or not the Contract was then effective.

(3) Denture reline and rebase (jumps) is a covered benefit only once in any thirty-six (36) month period for any one Eligible Person.

(4) Denture adjustments are a covered benefit only two (2) times in any twelve (12) month period for any one Eligible Person.

(5) No replacement will be made of any existing denture that in the opinion of Plan's consultants is satisfactory or can be made satisfactory.

(6) Crowns when used for abutment purposes are covered at the same co-payment percentage as provided under this agreement for bridges and complete and partial dentures.

(7) Recementation of a bridge may be allowed for payment only once in a twelve (12) consecutive month period.

(8) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial towards the procedure submitted. If a fixed bridge or other more expensive procedure is selected, the remainder of fee is not a covered benefit.

(9) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

(10) Benefits for tissue conditioning are limited to no more than two (2) per arch per thirty-six (36) months.

p. Endodontic procedures are not covered benefits unless specified as a covered dental benefit in the Summary of Dental Benefits. When covered, payment for root canal therapy is limited to only once in any twenty-four (24) month period.

q. Periodontic procedures are not covered benefits unless specified as a covered dental benefit in the Summary of Dental Benefits. When covered, payment is limited to only once in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis which is benefited as a prophylaxis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is covered once in any six (6) month period; and crown lengthening which carries no limitation.

r. Payment for anesthesia and IV (intravenous) sedation is allowed only for covered surgical extractions and is limited to a maximum of ninety (90) minutes, per episode.

s. Orthodontic services are not covered benefits unless specified as a covered dental benefit in the Summary of Dental Benefits. If a covered benefit:

(1) The obligation of Plan ceases with payment to the date of termination if the treatment plan is terminated for any reason or the Eligible Person is no longer eligible for benefits before completion of the case.

(2) Treatment may be terminated by the dentist, by written notification to Plan and to the Patient, for lack of patient interest and cooperation.

(3) Related services for orthodontic purposes, such as but not limited to, x-rays, extractions, space maintainers, and study models, shall be payable at the orthodontic co-payment percentage as specified in the Summary of Dental Benefits.

(4) Plan will not pay for the repair or replacement of an orthodontic appliance.

t. Maximum Payment:

(1) Anything contained in the Contract or any appendix to the contrary notwithstanding, the maximum benefit payable in any one calendar year or contract term, as applicable, or any portion thereof, shall be the amount indicated in the Summary of Dental Benefits.

(2) If orthodontics are a covered benefit, payment for orthodontic benefits shall be limited to the maximum per patient specified in the Summary of Dental Benefits. Payment for orthodontic benefits shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of treatment.

(3) If a deductible amount is specified in the Summary of Dental Benefits, Plan shall not be obligated to pay for, or otherwise discharge, in whole or in part, the first fees, up to the deductible amount.

ELIGIBILITY OF EMPLOYEES AND THEIR DEPENDENTS

1. Eligible Employee:

To qualify for benefits as an Eligible Employee hereunder, an individual must meet on of the following requirements:

a. Be a full-time employee or former employee of an Employer who is:

1. actively employed to work for Employer a regularly scheduled twenty-five (25) hours per week for at least nine (9) months in a calendar year.;

2. be on paid sick leave from such employment;

3. be on any other approved leave of absence from such active employment; or

4. be on Continuation Coverage.

b. Be a member in good standing of an organization, association or union which has contracted with Plan to provide dental coverage for its members, under the rules of the organization, association or union.

c. Be an employee under the requirements of sub-paragraph (a) of this section which meets the requirements of sub-paragraph (b) of this section.

2. Commencement of Coverage for Employee:

Coverage hereunder shall begin for an Eligible Employee as is specified in the Summary of Dental Plan Benefits.

3. Eligible Dependent:

To be eligible for benefits hereunder a dependent or former dependent must satisfy one of the following requirements:

a. Be the lawful spouse of an Eligible Employee; or where required by federal, state or local law, a Domestic Partner of an Eligible Employee.

b. Be an unmarried child under the age of twenty-five (25) years of an Eligible Employee, and principally dependent upon that Eligible Employee for support;

c. Be a handicapped child of the Eligible Employee. A handicapped child is an unmarried child who is incapable of earning his or her own living because of mental retardation or physical handicap and who is principally dependent upon the Eligible Employee for support at the time the child would otherwise cease to be eligible because of age. Such child shall continue to be an Eligible Dependent for the duration of the incapacity, provided his or her status as an Eligible Dependent does not terminate for any other reason and proof of incapacity is furnished to Plan within thirty one (31) days after the child attains the age which would otherwise be disqualifying. Such proof of incapacity must thereafter be furnished from time to time as is reasonably required by Plan;

d. Be on Continuation Coverage.

e. No person may be insured both as an employee and as a dependent and no person will be considered as a dependent of more than one employee. Eligible Dependents do not include another employee of the Employer insured under any employer-sponsored program providing dental expense coverage. A Child who may be otherwise eligible as a dependent under more than one dental plan sponsored by the Employer shall be covered under the program of the employee as determined by the Contract.

f. Notwithstanding anything above, any Child with respect to which there is a court decree which would otherwise establish financial responsibility of the dental care expenses of the Child will be considered an Eligible Dependent.

4. Commencement of Coverage for Dependent:

Coverage hereunder shall begin for the dependent of an Eligible Employee on the first day that the coverage commences for the Eligible Employee or the first day of the month following the month in which the dependent becomes an Eligible Dependent, whichever is later.

5. Termination of Benefits:

a. If at any time an employee who has been an Eligible Employee satisfies none of the requirements described above to be an Eligible Employee, coverage under the Contract shall terminate for such employee, and each dependent of such employee, in the following manner:

(1) if the employee qualifies for and timely elects Continuation Coverage, he or she shall continue to be covered under the Contract for the period required by Section 4980B of the Internal Revenue Code of 1986 as amended, and thereupon the coverage shall terminate.

(2) if the employee fails to qualify for or timely elect Continuation Coverage, coverage shall terminate at the end of the premium period in which the Eligible Employee first ceases to be an Eligible Employee.

b. If at any time, other than that described in subparagraph (a) of this paragraph, a person who has been an Eligible Dependent satisfies none of the requirements described above to be an Eligible Dependent, coverage under the Contract shall terminate in the following manner:

(1) if the dependent qualifies for and timely elects Continuation Coverage, he or she shall continue to be covered under the Contract for the period required by Section 4980B of the Internal Revenue Code of 1986 as amended, and thereupon the coverage shall terminate.

(2) if the dependent fails to qualify or timely elect Continuation Coverage, coverage shall terminate at the end of premium period in which the Eligible Employee upon whom such person is dependent ceased to be an Eligible Employee or at the time such dependent satisfies none of the requirements to be an Eligible Dependent, whichever occurs first.

c. At termination of coverage under this Plan, operative procedures then in progress which are completed within thirty (30) days of the termination of coverage and submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges and are considered in progress only if all procedures for commencement of lab work have been completed.

6. Non-Duplication of Benefits:

For purposes of this section entitled Non-Duplication of Benefits, "This Plan" means that portion of the Contract which provides the benefits that are subject to this provision. "This Plan" will not duplicate benefits for dental care service for which Eligible Persons are entitled under any of the following plans:

Group, blanket, or franchise insurance.

Group practice, individual practice, and other prepayment of coverage on a group basis. (This includes group contracts issued by Plan).

Labor-management trusted plans.

Union Welfare plans.

Employee benefit organization programs.

Coverage under government programs.

(1) This provision shall apply to determining the benefits as to a person covered under "This Plan" for any Claim Determination Period, if for the covered services incurred as to such person during such period, the sum of;

(a) the benefits that would be payable under "This Plan" in the absence of this provision, and;

(b) the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose of this provision would exceed such Covered Services. Claim Determination Period means calendar year.

(2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under "This Plan" in the absence of this provision for the Covered Services incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Covered Services under all other plans, except as provided in paragraph (3) below, shall not

exceed the total of such Covered Services. Benefits payable under another plan include benefits that would have been payable had claim been duly made therefore.

(3) If another plan which is involved in paragraph (2) above and which contains a provision coordinating its benefits with those of "This Plan" would, according to its rules, determine its benefits after the benefits of "This Plan" have been determined, and the rules would require "This Plan" to determine its benefits before such other plan, the benefits of such other plan will be ignored for the purposes of determining the benefits under "This Plan".

To avoid duplicate benefit payment, one plan will be "Primary" and the others will be "Secondary".

(1) When "This Plan" is Primary, benefits will be paid without regard to other coverage.

(2) When "This Plan" is Secondary, the benefits under Contract may be reduced. The benefits for Covered Services will be no more than the balance of charges remaining after the benefits of other plans are applied to Covered Services.

A "Covered Service" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made or service provided, recognizing services covered in scope by either plan within general compartmental categories of dental services. When the benefits are provided in the form of services, the cost value of these services will be used to determine the amount of benefits received.

Under Contract, "This Plan" is Secondary when;

(1) The Eligible Person is covered as a dependent under Contract but is covered as an employee under another plan; or

(2) The benefits of "This Plan" which covers the person on whose expense the claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in the calendar year, shall be determined before the benefits of another plan which covers such person as a dependent of a person whose date of birth, excluding the year of birth, occurs later in a calendar year, except for cases of a person for whom a claim is made as a dependent child whose parents are separated or divorced. However, if the other plan does not have the provisions of the preceding sentence regarding dependents, which would result either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of the immediately preceding sentence shall not apply and the rule set forth in the plan which does not have the provisions of the immediately preceding sentence shall determine the order of benefits.

(a) When the parents are separated or divorced and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody of the child will be Primary and the plan which covers the child as a dependent of the parent without custody will be Secondary;

(b) When the parents are divorced and the parent with the custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody shall be Primary and the plan that covers the child as a dependent of the step-parent will be Secondary, and both such plans shall be Primary to a plan which covers that child as a dependent of the parent without custody.

Notwithstanding (a) and (b) above, if there is a Court decree which would otherwise establish financial responsibility for the dental care expenses with respect to the child, the plan which covers the child as a dependent of the parent with such financial responsibility if such plan has actual knowledge of the terms of such Court decree, shall be Primary as it relates to any other plan which covers the child as a dependent child.

When rules (1) and (2) do not establish an order of benefit determination, the benefits of a plan which has covered the person of whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that;

(c) the benefits of a plan covering the person on whose expenses the claim is based as a laid-off or a retired employee, or dependent of such person, shall be determined after the benefit of any other plan covering such person as an employee, or dependent of such person; and

(d) if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (c) shall not apply.

Benefits of other plans which will be applied to Covered Services under this provision include all benefits which would be payable if the Eligible Person made claim for them.

To determine the applicability and implementing of the terms of the Contract or any provisions or similar purpose of any other plan, Plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which Plan deems to be necessary for such purposes. Any person claiming benefits under the Contract shall furnish to Plan such information as may be necessary to implement this provision.

Whenever payments which should have been made under the Contract in accordance with the preceding provisions have been made under any other plan or plans, Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts Plan shall determine to be warranted in order to satisfy the intent of these provisions, and the amounts so paid shall be deemed to be benefits paid under the Contract and, to the extent of such payments, Plan shall be fully discharged from liability under the Contract.

Whenever payments have been made by Plan with respect to covered benefits in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, Plan shall have the right to recover such payments, to the extent of such excess, from among such one or more of the following, as Plan shall determine:

Any person to or for or with respect to whom such payments were made, any other insurance companies and any other organizations.

ERISA Information

Plan Sponsor: Century Business Services, Inc.
6840 Rockside Woods Boulevard South
Suite 330
Cleveland, OH 44131
(216) 447-9000

Employer Identification Number (EIN): 22-2769024

Plan Administrator: Same as Plan Sponsor

Designated Agent for service of legal process: Same as Plan Sponsor

Plan Contributions: Employer and Employee, jointly

Dental Claims Administrator: Delta Dental Plan of Kansas, Inc.
P.O. Box 49198
Wichita, KS 67201-9198

Appeal Procedure

If a claim is denied in whole or in part as recommended by the *Dental Claims Administrator* the following claims appeal procedure shall be observed:

(a) The *claimant*, or the *claimant*'s duly authorized representative, may appeal the denial by submitting to the *Plan Administrator* or the *Dental Claims Administrator* a written request for review of the claim within 60 days after receiving written notice of such denial from the *Dental Claims Administrator*. Failure by the *claimant* to submit a request for review within 60 days after receiving the denial of benefits shall constitute a waiver by the *claimant* of the right to appeal the decision. The *Plan Administrator* or the *Dental Claims Administrator* shall, upon the *claimant*'s request, give the *claimant* an opportunity to review pertinent documents, other than legally privileged documents, in preparing such request for review.

(b) The request for review must be in writing and shall be addressed as follows:
Delta Dental Plan of Kansas, Inc.
P.O. Box 49198
Wichita, KS 67201-9198

(c) The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the *claimant* deems pertinent. The *Plan Administrator* or the *Dental Claims Administrator* may require the *claimant* to submit, at the expense of the *claimant*, such additional facts, documents or other material as are necessary or advisable in conducting the review.

(d) The *Dental Claims Administrator* shall act upon each request for review within 60 days after receipt thereof unless special circumstances require further time for processing, but in no event shall the recommendation or review be rendered more than 120 days after the *Dental Claim Administrator* receives the request for review. Written notice of an extension of time beyond 60 days shall be furnished to the *claimant* prior to the commencement of the extension.

(e) In the event the *Plan Administrator* confirms the denial of the claim for benefits in whole or in part, written notice of the *Plan Administrator's* decision shall be given to the *claimant*. Such notice shall be written in a manner calculated to be understood by the *claimant* and shall contain the specific reasons for the denial.

(f) In the event the *claimant* remains aggrieved after receiving notice of the *Plan Administrator's* decision to confirm the denial, the *claimant* may again appeal the denial. The procedure outlined in parts (a) through (e) above shall also apply to the second appeal.

STATEMENT OF ERISA RIGHTS

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

Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as work sites and union halls, 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 and *Plan* descriptions.

Obtain copies of all *Plan* documents and other *Plan* information upon written request to the *Plan Administrator*. The administrator may make a reasonable charge for the copies.

Receive a summary of the *Plan's* annual financial report if the *Plan* covers 100 or more *Participants*. The *Plan Administrator* is required by law to furnish each *Participant* with a copy of this summary annual report.

In addition to creating rights for *Plan Participants*, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *Plan Participants* and beneficiaries. No one, including your *Employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

If your claim for a welfare 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* reviewed and your claim reconsidered.

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 administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or federal court. If it should happen that the *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 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.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

The following provisions are only applicable to *Employers* with 20 or more *employees*.

A *Participant's* participation in the *Plan* may be continued if:

(a) the *Participant* notifies the *Employer* within 60 days of the *qualifying event* of the desire to continue participation, and

(b) the entire cost, at the group rate, is paid by, or on behalf of, the *Participant* continuing participation.

Qualifying event means any event that results in a loss of participation in the *Plan* for which continuance under the Special Federal Continuance Provisions is available.

This continuance is subject to all other terms and conditions of the *Plan*.

Continuance for Participants

A *Participant*, including any *covered dependents*, may continue participation in the *Plan* if the *Participant* stops *active work* due to any of the following *qualifying events*:

(a) the *Participant's* employment ends for any reason except gross misconduct;

(b) the *Participant* retires;

(c) the *Participant's* work hours are reduced to less than *full-time*; or.

The *Participant's* continued participation in the *Plan*, including participation for any *covered dependents*, will end on the earliest of:

(a) the date the *Participant* fails to make any required contribution;

(b) the date the *Participant* becomes covered under any *other group dental expense coverage*. The *Participant's* participation may be continued if the new group dental plan excludes or limits a current condition as a pre-existing condition or for a specific waiting period. Continued participation will end when the *Participant* satisfies the new plan's pre-existing limitation or waiting period;

(c) the date the *Plan* ends; or

(d) 18 months after the date continuance began, or 29 months after the date continuance began, if, before the end of the 18-month period the *Participant* or a *covered dependent* are determined to have been disabled for Social Security benefits when the continuance began.

Continuance for Dependent Children

Participation under the *Plan* for a *covered dependent* child may be continued if the child ceases to be an *eligible dependent* due to any of the following *qualifying events*:

(a) the child ceases to be dependent upon the *Participant*;

(b) the child ceases to be a full-time student in an accredited school;

(c) the child attains the age limit for dependent participation as described in the Eligible Dependents provision;

(d) the child gets married;

(e) the *Participant* dies; or

(f) the *Participant* divorces or legally separates from his spouse.

Continuance for Dependent Spouses

Participation under the *Plan* for a *covered dependent* spouse may be continued if he ceases to be an *eligible dependent* due to any of the following *qualifying events*:

(a) the dependent spouse becomes divorced or legally separated from the Participant; or

(b) the *Participant* dies.

When Continuance for Dependents Ends

Continued participation under the *Plan* for dependents will end on the earliest of:

(a) the date any required contribution is not made by, or on behalf of, the *covered dependent*;

(b) the date the *covered dependent* becomes covered under any *other group dental expense coverage*. The dependent's participation under the *Plan* may be continued if the new group dental plan excludes or limits a current condition as a pre-existing condition or for a specific waiting period. Continued coverage will end when the dependent satisfies the new plan's pre-existing limitation or waiting period;

(c) the date the *Plan* ends; or

(d) 36 months after the date continuance began.

Retired Participants

A *Participant* who is retired from *active work* with the *Employer* and any *covered dependents* may continue participation under the *Plan* when the *Employer* files a Chapter 11 Bankruptcy Petition. Participation under the *Plan* may continue for the *Participant* and any *covered dependents* for the lifetime of the retired *Participant*. The *Participant's covered dependents* may continue participation under the *Plan* for an additional period of 36 months after the *Participant's* death. If the spouse of a deceased *Participant* is participating under the *Plan* as a *covered dependent* at the time the *Employer* files a Chapter 11 Bankruptcy Petition, the spouse may continue participation under the *Plan* for the remainder of his lifetime. The *Participant* and any *covered dependents* must make any required contributions to continue participation under the *Plan*.

Additional Continuance Provisions

If more than one *qualifying event* occurs to one person, that person's participation will not continue, under this provision, for more than 36 months after the first *qualifying event* occurred.

Delta Dental Plan of Kansas

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