DENTAL SERVICE CENTER
Post Office Box 3907 • Gardena, CA 90247-7599
Phone: 888·293·4903 • Fax: 310·323·7881

Welcome to the 2011-2012 Dental and Vision Care plan Enrollment Season!

Did you know you can get quality, affordable **dental and vision coverage** for yourself *and your family* and **children** can now be on your plan until age **26** with **no student verification**. Just enroll in any of the *voluntary* options below during this annual, limited **open enrollment period**. When we receive your enrollment **no later than June 10, 2011,** your coverage will take effect **on July 1, 2011.**

Choose a dental care plan from CIGNA and vision care coverage through VSP!

Maximize savings with the CIGNA Dental Care® (DHMO) plan.

Why pay more than you have to for dental care? The CIGNA DHMO plan has comprehensive coverage, including orthodontic coverage for both children and adults. With the DHMO plan, you choose a primary dentist from the network at enrollment. Specialty care is available with a referral approved for payment. No deductibles, no claim forms, no annual maximums! Keep in mind, there is no out-of-network coverage with a DHMO plan. Finding a DHMO network dentist is easy! Search online at **www.cigna.com** or call us for live customer service - 24/7 - at **1.800.CIGNA24** (1-800-244-6224).

Balance freedom and savings with the CIGNA Dental PPO (DPPO)!

As a DPPO customer, you may visit any licensed dentist, with no referrals required for specialty care. Choosing a CIGNA Core Network dentist (or specialist) will save you money on your dental bills because CIGNA Core Network dentists agree to offer discounts to CIGNA customers. And they cannot charge you more than their contracted rates for covered services. Finding a Core Network dentist is easy! Search online at **www.cigna.com** or call us for live customer service - 24/7 - at **1.800.CIGNA24** (1-800-244-6224).

Vision Service Plan (VSP) Signature Plan:

VSP is the largest vision care provider in the United States, with over 26,000 participating doctor locations. Visit **www.vsp.com** or call 1-800-877-7195 to locate a provider.

Inside this kit, you will find plan details, rates, payment options and enrollment forms for the ***NCBC*** Dental and Vision Care Plan options. Be sure to read the enclosed plan materials carefully before making a decision.

When you're ready to enroll, complete the enrollment form(s) for the coverage you want to have and use the enclosed envelope to return your form(s) to us. You must complete **separate enrollment forms** to enroll for both dental and vision coverage. You must also include **separate checks** for payment: each made payable to **"Dental Service Center".** You can send your first quarterly payment, or your entire annual premium amount. **We must receive your enrollment form(s) and check(s) no later than June 10, 2011 for coverage to begin on July 1, 2011.**

If you are requesting this kit after our initial open enrollment deadline, there are pro-rated rates and enrollment deadlines for the time you are requesting. Please see the rate sheet for details.

Questions? Just call us toll-free at **1-888-293-4903, option 4**.

To your good health,

DENTAL SERVICE CENTER

Important Information about
Selecting a CIGNA Dental Plan
Compare Plan features & Monthly Premiums!*

Cigna Dental Care (HMO)
Patient Charge Schedule W1-07
Minimize out-of-pocket expenses!

- Finding a Dental Care network dentist is easy: Call a representative at 1-800-CIGNA24 (1-800-244-6224) or use the dental office locator at www.cigna.com
- No claim forms to file
- No deductibles to meet, so your coverage starts right away.
- No Annual dollar maximums, so you don't have to postpone any treatment.
- Access to a large credentialed national network of independent dentists.
- Specialty care available, with a referral approved for payment.
- Out-of-network benefits are not available with the CIGNA Dental Care plan.

CIGNA Dental PPO
Visit any licensed dentist!

- Finding a Core network dentist is easy: Call a representative at 1-800-CIGNA24 (1-800-244-6224) or use the dental office locator at www.cigna.com
- Save on out-of pocket expenses for treatment when you visit general dentist or specialists in our large national PPO network. Or, visit any dentist of you choose.
- In-network or not, you'll be reimbursed for all or part of the cost for covered procedures up to your annual dollar maximum, after meeting your deductible.
- Out of pocket expenses will be higher when you visit a non-network dentist.
- Most network dentist file claim forms for members; members must file claims for out-of-network care.
- Fast, accurate, convenient claims processing.
- No referral necessary to see a specialist.

Monthly Rate*	CIGNA Dental Care (HMO)	CIGNA Dental PPO
Member Only	24.84	47.68
Member + One	47.85	83.74
Member + Family	67.52	136.39

***Monthly rates are for comparison only. Premiums are paid annually or quarterly. Please refer to the Rate sheet included.**

More reasons to SMILE
CIGNA Dental Care (HMO)
Sample Patient Charges W1-07

This ***Overview*** shows you a sampling of covered services and what you will pay with your CIGNA Dental Care Plan compared to what you would pay without coverage. If you choose this HMO coverage a complete Patient Charge Schedule will be mailed to you after your enrollment.

Key Highlights of the CIGNA Dental Care Plan
This plan offers coverage for a wide range of services at a cost savings. Coverage includes:

- Preventive care (cleanings, x-rays, and more)
- Basic Care (fillings, basic restorative work)
- Major services (bridges, crowns, root canals and more)
- NO waiting periods
- NO deductibles
- NO dollar maximums
- NO claim forms

		What You'll Pay	
Code	Procedure Description	With CIGNA Dental Care	Without Dental Coverage*
D1110	Prophylaxis Cleaning – Adult (Limit 1 every 6 months)	$0.00	$87.40
D0150	Comprehensive Oral Evaluation – New or Established Patient	$0.00	$72.70
D1203	Topical Fluoride Application – Child (Up to 19th Birthday) (once in 6 months)	$0.00	$33.50
D0210	X-Rays – Complete Series (including bitewings) (Limit 1 every 3 years)	$0.00	$128.00
D1351	Sealant – Per Tooth	$15.00	$50.30
D2150	Amalgam – Two Surface, Primary or Permanent	$21.00	$139.30
D2330	Resin-Based Composite – One Surface, Anterior	$21.00	$138.40
D2160	Amalgam – Three Surfaces, Primary or Permanent	$26.00	$169.20
D2391	Resin-Based Composite – One Surface, Posterior	$42.00	$152.90
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	$315.00	$687.00
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	$505.00	$1,048.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	$470.00	$5,523.56
D8660	Pre-Orthodontic Treatment Visit	$61.00	$179.20
D8670	Periodic Orthodontic Treatment Visit - Child (Up to 19th Birthday) (As Part of Contract)	$2304.00	$3,874.23
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	$345.00	$578.50
D8999	Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	$175.00	$269.90
D4341	Periodontal Scaling and Root Planing, Four or More Teeth or bounded Teeth Spacers per quadrant (Limit 4 Quadrants per Consecutive 12 months)	$110.00	$224.00
D4910	Periodontal Maintenance Cleaning (Limit of 2 Within the First 12 Months After Active Therapy)	$78.00	$130.81
D7210	Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	$100.00	$238.45
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$50.00	$139.99
D7240	Removal of Impacted Tooth – Completely Bony	$220.00	$447.30
D7241	Removal of Impacted Tooth – Completely Bony, Unusual Complications	$220.00	$534.00
D5214	Lower Partial Denture –Metal (Including Clasps, Rests and Teeth)	$640.00	$1,414.00
D2750	Crown – Porcelain Fused to High Noble Metal	$460.00	$1,070.00
D6750	Crown – Porcelain Fused to High Noble Metal	$460.00	$1033.00
D6240	Pontic – Porcelain Fused to High Noble Metal	$460.00	$1,004.00
Grand Total		**$7098.00**	**$19,367.64**
Total Savings with CIGNA Dental Care		**$12,269.64**	

*Estimated cost without dental coverage are based on Connecticut General Life Insurance Company analysis on average charge for each dental procedure based on geographic distribution of CIGNA Dental Care membership and national claims analysis, prepared February 2011. Actual charges without dental coverage may differ from your area charges or local dentist's fees.

CIGNA Dental PPO Benefit Summary

Summary of Benefits

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in and out of network.

Benefits	***In-Network***		***Out-of-network***	
Plan Year Maximum *(Class I, II and III expenses)*	**$1,500 per person**		**$1,500 per person**	
Annual Deductible Individual Family	**$50 per person** $150 per family		**$50 per person** $150 per family	
Reimbursement Levels**	Based on Reduced Contracted Fees		Based on Contracted Fee Schedule. Dentist may balance bill up to usual fees.	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I – Preventive & Diagnostic Care Oral Exams Routine Prophylaxis Cleanings Bitewing X-rays Fluoride Applications Sealants Space Maintainers (limited to non-orthodontic treatment)	**100%** **No Deductible**	**No charge**	**80%** **No Deductible**	**20%**
Class II – Basic Restorative Care Fillings Full Mouth X-rays Panoramic X-rays Emergency Care to Relieve Pain Oral Surgery – Simple Extractions	**80%**	**20%**	**50%**	**50%**
Class III – Major Restorative Care Root Canal Therapy Osseous Surgery Surgical Extraction of Impacted Teeth Oral Surgery – all except simple extractions Crowns Core Build-Up Dentures Denture Adjustments and Repairs Bridges Histopathologic Exams Periodontal Scaling and Root Planning Periodontal Maintenance (Cleaning) Anesthetics Repairs to Bridges, Crowns and Inlays	**50%**	**50%**	**50%**	**50%**
Class IV – Orthodontia	**Not covered**		**Not covered**	
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for 24 months; thereafter, considered a Class III expense.			

Pretreatment review is available on a voluntary basis when extensive dental work in excess of $500 is proposed.
**For services provided by CIGNA Dental PPO network dentist, CIGNA Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, CIGNA Dental will reimburse according to the Contracted Fee Schedule but the dentist may balance bill up to their usual fees.

To Locate a CIGNA Dentist, visit their web site www.cigna.com or call 1-800-CIGNA24 (1-800-244-6224)

Your VSP Vision Benefits Summary

Why enroll in a VSP® Vision Care plan? We'll help keep you and your eyes healthy. Plus, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

Value and Savings. You'll get great benefits on your exam and eyewear at an affordable price.

Personalized Care. You'll get quality care that focuses on your eyes and overall wellness with a WellVision Exam® from a VSP doctor. They'll look for vision problems and signs of other health conditions.

When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, you'll be 100% happy with your eyecare and eyewear from a VSP doctor or we'll make it right.

Eyewear. Choose the eyewear that's right for you and your budget. From classic styles to the latest designer fashions, you'll find hundreds of options for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider. To find a VSP doctor, visit **vsp.com** or call **800.877.7195.**

Enroll today. You'll be glad you did.

Once your plan is effective, register on **vsp.com** to view a complete description of your benefits. To use your vision coverage, simply tell your eyecare provider that you have VSP. No ID card is necessary.

Contact us. **vsp.com** | **800.877.7195**

Vision care for life

CAT#00610 JOB#3755CM 6/10

NCBC and VSP provide you with an affordable eyecare plan. Sign up for VSP today.

Doctor Network……………………….VSP Signature

Your Coverage with a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness

- $20 copay.................................. ***every 12 months***

Prescription Glasses

- $25 copay

Lenses.. ***every 12 months***

- *Single vision, lined bifocal, and lined trifocal lenses*
- *Polycarbonate lenses for dependent children*

Frame... ***every 24 months***

- *$120.00 allowance for a wide selection of frames*
- *20% off the amount over your allowance*

~OR~

Contact Lens Care

- **No copay** .... ***every 12 months***

$120.00 allowance for contacts and the contact lens exam (fitting and evaluation). If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained.

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- *Average 35 - 40% savings on all non-covered lens options*
- *30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*

Contacts

- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction

- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*
- *After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor*

Monthly Rates Shown for Comparison Only

Employee Only	**$14.32**
Employee + One Dependent	**$22.88**
Employee + Family	**$33.58**

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam	*Up to $50.00*
Single vision lenses	*Up to $50.00*
Lined bifocal lenses	*Up to $75.00*
Lined trifocal lenses	*Up to $100.00*
Frame	*Up to $70.00*
Contacts	*Up to $105.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

NCBC

DENTAL and VISION CARE PLAN RATES

You must enroll for the full plan year through June 30, 2012

Send your completed enrollment form(s) and separate check(s) by June 10, 2011

- Child must be under the age of 26 and student verification is no longer required.
- Rates are payable **annually** by full payment or **quarterly** by automatic checking or savings account deductions (ACH). **Any** returned Check or ACH is subject to a $20.00 fee (See agreement below).
- **When quarterly automatic deductions are elected, the first quarterly payment for each coverage plan selected must be made with a separate check (payable to the Dental Service Center) submitted with each signed enrollment form.**
- To cancel coverage, **written notice** must be received by the Dental Service Center no later than the 5th of the month prior to the month the coverage will terminate. Once canceled, coverage under these plan options cannot be reinstated for **2 years**.

CIGNA Dental HMO W1-07	No dental offices in the following states: AK, DE, HI, ID ,ME, MT, ND, NH, NM, PR, RI, SD, VT, WV, WY		
	Payment Options:	**Quarterly**	**Annual**
	Member Only	$74.52	$298.08
	Member + One	$143.55	$574.20
	Member + Family	$202.56	$810.24

CIGNA Dental Preferred Provider Option (PPO) Core Network	**Available in all states.** NOTE: The $50 deductible and $1,500 maximum is based on the plan year.		
	Payment Options:	**Quarterly**	**Annual**
	Member Only	$143.04	$572.16
	Member + One	$251.22	$1004.88
	Member + Family	$409.17	$1636.68

VSP Vision Care Plan Signature Plan	**Available in all states.**		
	Payment Options:	**Quarterly**	**Annual**
	Member Only	$42.96	$171.84
	Member + One	$68.64	$274.56
	Member + Family	$100.74	$402.93

Authorization Agreement for Quarterly Automatic Checking or savings Account Deductions – By enrolling in any of the dental or vision care plans above, I indicate the following:

- I have a checking account at the financial institution named on the enclosed check and, for all debit entries, shall have funds sufficient to pay such entries. Electronic debit entries shall be initiated by Dental Service Center to pay dental and/or vision plan costs and other charges for the coverage plans selected and the entries shall constitute my receipt for the transaction (s).
- No payment to Dental Service Center shall be deemed to have been made unless and until Dental Service Center received actual credit. I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account.
- **I understand my direct electronic payment of the premium due will be debited on or about the 5th day of each month prior to the following calendar quarter for which premium is due. (For example the April-May-June quarterly premium will be deducted from my account on the 5th of March.).**
- Dental Service Center reserves the right to refund or terminate electronic payment services. This agreement is to remain in effect until Dental Service Center terminates it or receives written notification from the enrollee to terminate participation in the plan and Dental Service Center has sufficient time to act upon the request.

National Conference of Bankruptcy Clerks (NCBC) DENTAL PLAN

SELECT THE PLAN THAT'S RIGHT FOR YOU **PLEASE PRINT**

1. ☐ CIGNA DHMO *Please choose a dental office from the website www.cigna.com or 1-800-244-6224. Dental Office Code No.__________* ☐ CIGNA PPO

2. I am enrolling: ☐ Myself only ☐ Myself + One ☐ Myself + Family

LIST ONLY *THE MEMBERS WHO ARE TO BE INSURED BELOW*

Name: Last	First	Middle Initial	Social Security No.:
Address:			
City	State	Zip	
Telephone	Date of Birth	☐ Male ☐ Female	

Spouse: Last	First	Middle Initial	Social Security No.:
Date of Birth	☐ Male ☐ Female		

If more children, enclose information on a separate sheet of paper. **Child must be under the age of 26.**

Child: Last	First	Middle Initial	Social Security No.:
Date of Birth	☐ Male ☐ Female		
Child: Last	First	Middle Initial	Social Security No:
Date of Birth	☐ Male ☐ Female		
Child: Last	First	Middle Initial	Social Security No:
Date of Birth	☐ Male ☐ Female		

3. PAYMENT OPTION – SEPARATE CHECKS REQUIRED FOR EACH ENROLLMENT FORM

☐ **Annual Check** – Enclosed is my annual payment made payable to: **Dental Service Center**

☐ **Quarterly Automatic Deduction—Enclosed is my check to cover the first quarter's** premium for the option I selected above. I authorize Dental Service Center to deduct subsequent quarterly payments from my checking account referenced on the enclosed check. I have read and agree to the Authorization Agreement enclosed in this kit. **I understand future deductions will be taken the 5th of each month prior to the following calendar quarter for which premiums is due. (For example the October, November, December quarterly premium will be taken on the 5th of September.)**

____ ______________

Authorized Signature for Automatic Deductions Date

4. I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form. I authorize any participating dental office to release dental records and billing information to CIGNA Dental Health for purposes of plan administration.

5. I understand that if I cancel this coverage, I must do so in **writing** and submit it by the **5th** of the month prior to the effective cancellation month date. I must wait **2 years** before I can re-enroll.

____ ______________

Authorized Signature Date

DENTAL SERVICE CENTER
P. O. Box 3907, Gardena CA 90247-7599
Telephone (888) 293-4903

1. Original to Dental Service Center 2. Copy for your files

National Conference of Bankruptcy Clerks (NCBC) VISION CARE PLAN

SELECT THE COVERAGE TYPE THAT'S RIGHT FOR YOU **PLEASE PRINT**

1. I am enrolling**:** ☐ Myself only ☐ Myself + One ☐ Myself + Family

LIST ONLY *THE MEMBERS WHO ARE TO BE INSURED BLEOW*

Name: Last	First	Middle Initial	Social Security No.:
Address:			
City	State		Zip
Telephone	Date of Birth		☐ Male ☐ Female

Spouse: Last	First	Middle Initial	Social Security No.:
Date of Birth	☐ Male ☐ Female		

If more children, enclose information on a separate sheet of paper. **Child must be under the age of 26**.

Child: Last	First	Middle Initial	Social Security No.:
Date of Birth	☐ Male ☐ Female		
Child: Last	First	Middle Initial	Social Security No:
Date of Birth	☐ Male ☐ Female		
Child: Last	First	Middle Initial	Social Security No:
Date of Birth	☐ Male ☐ Female		

2. PAYMENT OPTION - SEPARATE CHECKS REQUIRED FOR EACH ENROLLMENT FORM

☐ **Annual Check** – Enclosed is my annual payment made payable to: **Dental Service Center**

☐ **Quarterly Automatic Deduction**—I have **enclosed a payment** for the **first quarter** and I authorize Dental Service Center to deduct subsequent quarterly payments from my checking account referenced on the enclosed check. I have read and agree to the Authorization Agreement enclosed in this kit. **I understand future deductions will be taken on the 5th of each month prior to the following calendar quarter for which premium is due. (For example October, November, December quarterly premium will be taken on the 5th of September.)**

____ ________________
Authorized Signature for Automatic Deductions Date

3. I accept the coverage/insurance benefits provided by this group vision plan and authorize the processing of my enrollment in the vision plan. I authorize any participating vision office to release vision records and billing information to VSP for purposes of plan administration.

4. I understand that if I cancel this coverage, I must do so in **writing** and submit it by the **5th** of the month prior to the effective cancellation month date. I must wait **2 years** before I can re-enroll.

____ ________________
Authorized Signature Date

DENTAL SERVICE CENTER
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1. Original to Dental Service Center 2. Copy for your files