



DENTAL SERVICE CENTER

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

April 2008

Welcome to the 2008-2009 Dental and Vision Care plan Enrollment Season! We are pleased to offer you *and your family* these high-quality insurance plans during this annual, limited open enrollment period now underway and concluding on **June 6, 2008**. You must enroll in order to have coverage in any of these plans for the next plan year. **Coverage will begin on July 1, 2008.**

Regular visits to the dentist may do more than brighten your smile.

Did you know that research has linked periodontal (gum) disease to complications leading to heart disease, stroke, diabetes, osteoporosis, respiratory infections, and other health issues? The good news is...gum disease is treatable!

The following dental options can help scheduling regular dental care more convenient and affordable. Be sure to read the enclosed plan materials carefully before making a decision.

Your voluntary dental plan options include:

CIGNA DENTAL HMO (HMO) By visiting a network dental care office, you will enjoy the maximum savings built into this low-cost HMO plan: no deductibles or dollar maximum; preventive care covered at 100%; and fixed co-payments for dental treatments. Additionally, this plan offers orthodontic coverage. Recently added coverages include brush biopsy and oral cancer screening. Referrals may be needed for specialty care.

CIGNA DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) This PPO plan allows you to visit any licensed dentist nationwide. Because of negotiated network discounts, you will save money by visiting a dentist in the CIGNA PPO network (one of the largest dental networks in the nation). Or, you may use your out-of-network benefits to visit a dentist not in the CIGNA network.

To find a CIGNA Dental HMO or PPO participating dentist near your home, visit www.cigna.com or call 1-800-CIGNA24 (1-800-244-6224).

In addition, we offer you the following Vision Care plan:

VISION SERVICE PLAN (VSP) VSP is the largest vision care provider in the United States, with over 24,000 participating doctor locations. Visit www.vsp.com or call 1-800-877-7195 to locate a provider.

Inside this kit, you will find descriptions and rates for your Dental and Vision Care Plan options. To begin coverage, just complete and return your enrollment form(s) for these plans included in the enclosed envelope along with separate check(s) (one for the dental plan and one for the vision plan, each made payable to "Dental Service Center") for each enrollment form. **We must receive your application and checks no later than June 6, 2008.** It is important to note that eligibility in these plan options is limited to this current annual open enrollment period.

If you have any questions, please contact us at our TOLL-FREE number 1-888-293-4903, option 4. **Note:** *if you are currently enrolled in one of our plans it is not necessary to fill out a new application unless you are adding a new plan or want to change your current plans. You will automatically receive your renewal billing for your current plan under separate cover.*

Wishing your good health,

Dental Service Center



Important Information about Selecting a CIGNA Dental Plan

Compare Plan features & Monthly Premiums!*

Cigna Dental Care (HMO)

Minimize out-of-pocket expenses!

- Finding a 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!

- 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 your choice.
- 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	23.75	47.68
Member + One	45.65	83.74
Member + Family	64.37	136.39

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



CIGNA
A Business of Caring.

CIGNA Dental Benefit Summary

Summary of Benefits

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

Benefits	CIGNA Dental Care HMO	CIGNA Dental PPO			
	W1-06 Patient Charge Schedule	In-Network		Out-of-network	
Calendar Year Maximum <i>(Class I, II and III expenses)</i>	No Dollar Maximum	\$1,500		\$1,500	
Annual Deductible Individual Family	None None	\$50 per person \$150 per family		\$50 per person \$150 per family	
Reimbursement Levels**	Reduced, fixed charges for covered services, with no waiting periods and no missing tooth limitations.	Based on Reduced Contracted Fees		Based on the 90 th percentile of UCR.	
	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
Class I – Preventive & Diagnostic Care Oral Exams Routine Cleanings Bitewing X-rays Fluoride Applications Sealants Space Maintainers (limited to non-orthodontic treatment)	See the following page for sample patient charges.	100%	No charge	80%	20%
Class II – Basic Restorative Care Fillings Full Mouth X-rays Panoramic X-rays Emergency Care to Relieve Pain Oral Surgery – Simple Extractions	See the following page for sample patient charges.	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 Dentures Denture Adjustments and Repairs Bridges Histopathologic Exams Periodontal Scaling and Root Planing Periodontal Maintenance (Cleaning) Anesthetics Repairs to Bridges, Crowns and Inlays	See the following page for sample patient charges.	50%*	50%*	50%*	50%*
Class IV – Orthodontia	See the following page for sample patient charges.	Not covered		Not covered	

Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$500 is proposed.

*Subject to annual deductible

**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 based on the 90th percentile of UCR, 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)



More reasons to SMILE

CIGNA Dental Care (HMO)

Sample Patient Charges W1-06

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

Code	Procedure Description	What You'll Pay	
		With CIGNA Dental Care	Without Dental Coverage*
D1110	Cleaning – Adult (Limit 1 every 6 months)	\$0.00	\$73.00
D0150	Comprehensive Oral Evaluation – New or Established Patient	\$0.00	\$59.00
D1203	Topical Fluoride Application – Child (Up to 19 th Birthday) (once in 6 months)	\$0.00	\$27.00
D0210	X-Rays – Complete Series (including bitewings) (Limit 1 every 3 years)	\$0.00	\$100.00
D1351	Sealant – Per Tooth	\$15.00	\$43.00
D2150	Amalgam – Two Surface, Primary or Permanent	\$20.00	\$117.00
D2330	Resin-Based Composite – One Surface, Anterior	\$20.00	\$118.00
D2160	Amalgam – Three Surfaces, Primary or Permanent	\$25.00	\$142.00
D2391	Resin-Based Composite – One Surface, Posterior	\$40.00	\$128.00
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$285.00	\$595.00
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$455.00	\$868.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	\$425.00	\$1104.00
D8660	Pre-Orthodontic Treatment Visit	\$55.00	\$85.00
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)	\$2100.00	\$3565.00
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$315.00	\$496.00
D8999	Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	\$160.00	\$242.00
D4341	Periodontal Scaling and Root Planing, Four or More Teeth or bounded Teeth Spacers per quadrant (Limit 4 Quadrants per Consecutive 12 months)	\$100.00	\$184.00
D4910	Periodontal Maintenance (Limit of 2 Within the First 12 Months After Active Therapy)	\$70.00	\$128.09
D7210	Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	\$90.00	\$207.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$45.00	\$119.00
D7240	Removal of Impacted Tooth – Completely Bony	\$200.00	\$378.00
D7241	Removal of Impacted Tooth – Completely Bony, Unusual Complications	\$200.00	\$442.00
D5214	Lower Partial Denture –Metal (Including Clasps, Rests and Teeth)	\$585.00	\$1197.00
D2750	Crown – Porcelain Fused to High Noble Metal	\$450.00	\$859.00
D6750	Crown – Porcelain Fused to High Noble Metal	\$450.00	\$844.00
D6240	Pontic – Porcelain Fused to High Noble Metal	\$450.00	\$835.00
Grand Total		\$6555.00	\$12955.09
Total Savings with CIGNA Dental Care		\$6400.09	

*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 March 2006. Actual charges without dental coverage may differ from your area charges or local dentist's fees.

Your vision. Our passion.



Where will your eyes take you today?

Whether it's a day in the life or a day to remember, you'll get the personalized eyecare you deserve with VSP. We help millions of people see well, stay healthy and fulfill their potential.

Value, choice, doctors.

Enrolling in VSP is an easy way to make your life a little better. Here's a snapshot of what you'll enjoy:

- affordable benefits with great savings
- a WellVision ExamSM focused on your health
- plenty of eyewear choices you'll love
- VSP doctors nearby with flexible schedules that work for you

Satisfaction?
You bet. You'll be 100% happy or we'll make it right.

Still not decided?

Find doctors in your neighborhood at vsp.com or call us at 800-877-7195. We'd love to talk with you. Once you're signed up, your great benefits are a snap to use.

Enroll today. You'll be glad you did.



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

Your Coverage from a VSP Doctor

Exam covered in fullevery 12 months

Prescription Glasses

Lenses covered in fullevery 12 months

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

Frameevery 24 months

- Frame of your choice covered up to \$ 120.
- Plus, 20% off any out-of-pocket costs.

~OR~

Contact Lens Careevery 12 months

When you choose contacts instead of glasses, your \$105 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. 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 contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or vsp.com.

Advantages of Coverage

Without coverage, an exam and prescription glasses can cost \$300 or more. With VSP coverage, you'll save. Plus, with pre-tax payroll deductions, you'll be budgeting for your eyecare while reducing your taxable income.

Your Copays

Exam\$20.00
 Prescription Glasses\$25.00
 Contacts No copay applies

Extra Discounts and Savings

Glasses and Sunglasses

- Average 30% savings on lens options such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional glasses and sunglasses, including lens options*

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 from contracted facilities
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

* Available from any VSP doctor within 12 months of your last eye exam

Monthly Rates Shown for Comparison Only

Employee Only\$13.42
 Employee + One Dependent\$21.39
 Employee + Family\$31.34

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call us first at 800-877-7195.

Out-of-Network Reimbursement Amounts:

Exam Up to \$45.00
 Lenses:
 Single Vision Up to \$45.00
 Lined Bifocal Up to \$65.00
 Lined Trifocal Up to \$85.00
 Frame Up to \$47.00
 Contacts Up to \$105.00

VSP guarantees service from VSP network 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.

DENTAL and VISION CARE PLAN RATES

You must enroll for the full plan year through June 30, 2009

Send your completed enrollment form(s) and separate check(s) by June 6, 2008

- Child must be under the age of 25 and a full time student. It is **required** proof of 12 units or more for children 19-25 from their School and **must** be sent with the application to be enrolled.
- 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	No dental offices in the following states: AK, DE, HI, ID ,ME, MT, ND, NH, NM, NV, RI, SD, VT, WV, WY		
	Payment Options:	Quarterly	Annual
	Member Only	71.25	285.00
	Member + One	136.95	547.80
	Member + Family	193.11	772.44

CIGNA Dental Preferred Provider Option (PPO)	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	Available in all states.		
	Payment Options:	Quarterly	Annual
	Member Only	40.26	161.04
	Member + One	64.17	256.68
	Member + Family	94.02	376.08

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	<input type="checkbox"/> Male	<input type="checkbox"/> Female

Spouse: Last	First	Middle Initial	Social Security No.:

Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

If more children, enclose information on a separate sheet of paper. **Child must be under the age of 25 and a full time student, proof is required.**

Child: Last	First	Middle Initial	Social Security No.:

Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

Child: Last	First	Middle Initial	Social Security No.:

Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

Child: Last	First	Middle Initial	Social Security No.:

Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> 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

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 BELOW

Name: Last	First	Middle Initial	Social Security No.:
Address:			
City	State		Zip
Telephone	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Spouse: Last	First	Middle Initial	Social Security No.:
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		

If more children, enclose information on a separate sheet of paper. **Child must be under the age of 25 and a full time student, proof is required.**

Child: Last	First	Middle Initial	Social Security No.:
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child: Last	First	Middle Initial	Social Security No.:
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child: Last	First	Middle Initial	Social Security No.:
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> 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

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