

The CMC Total-Care Plan includes discount health and medical services from nearly 500,000 physicians, hospitals, clinics, dentists, optometrists and many other ancillary types of service providers.

**Plus, you and your entire family will receive:**

- Comprehensive Dental Care Savings
- Comprehensive Vision Care Savings including LASIK Surgery
- Comprehensive Prescription Drug Savings

**That's not all...**

The CMC Total-Care Plan offers additional savings averaging from 20 to 45% with service to millions of patients annually. There are over 350,000 medical doctors including:

- Family Practice • Internal Medicine • Cardiology • Radiology
- Neurology • Oncology • Orthopedic • Pediatric • OB/GYN • Allergy

**We're still not finished...there's more!**

CMC Total-Care Plan also provides:

- 24 hour toll-free nurse on call
- Chiropractic Care Savings
- Free Access to Medical Information Library on 1,200 subjects

### See how much you can save in one year!

| Service Product | Regular Cost | Your Sample Cost | Your Savings | Your Annual Savings |
|-----------------|--------------|------------------|--------------|---------------------|
| Doctor Visits   | \$120        | \$90             | \$30 / visit | \$120               |
| Prescriptions   | \$100        | \$80             | \$20 / month | \$240               |
| New Glasses     | \$285        | \$185            | \$100 / pair | \$100               |
| Dental Visits   | \$110        | \$55             | \$55 / visit | \$110               |
| Chiropractor    | \$50         | \$35             | \$15 / month | \$180               |

Sample Annual Total-Care Savings per Person: \$750

**and remember...** With CMC Total-Care Plan you have...

- 45-day satisfaction guarantee
- Free customer support service

**✂ Please complete and detach the following application:**

|  |                      |                             |                     |                         |                 |                       |                 |
|--|----------------------|-----------------------------|---------------------|-------------------------|-----------------|-----------------------|-----------------|
| Name   |                      | Birthday<br>/ /             | Email               |                         | Spouse's Name   |                       | Birthday<br>/ / |
| Home Address (Incl. Apt. #)  |                      |                             | City                | State                   | Zip             | Home Phone (incl. AC) |                 |
| <b>List of Members to Include</b>  | 1. Name              | Birthday<br>/ /             | 2. Name             |                         | Birthday<br>/ / | 3. Name               |                 |
|  | 4. Name              | Birthday<br>/ /             | 5. Name             |                         | Birthday<br>/ / | 6. Name               |                 |
| Sponsoring Employer / Association:   |                      |                             |                     |                         |                 |                       |                 |
| I would like to include (check one): <input type="checkbox"/> Myself only \$19.95 <input type="checkbox"/> Me and one \$24.95 <input type="checkbox"/> My Family \$29.95 |                      |                             |                     |                         |                 |                       |                 |
| <b>I want to pay MONTHLY by PAYROLL DEDUCTION.</b> I authorize my employer to deduct from my earnings the necessary contribution, if required of me.                     |                      |                             |                     |                         |                 |                       |                 |
| Signature <b>X</b>   |                      |                             |                     | Date                    |                 |                       |                 |
| For Office Use Only  | Sales Summary Number | Group Number<br><b>ZTOT</b> | WA<br><b>JAMILZ</b> | Office<br><b>QUALBE</b> | Effective Date  |                       |                 |

1. **THIS PLAN IS NOT INSURANCE. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN.\***
2. The plan provides discounts at certain health care providers for medical services. The range of discounts will vary depending on the type of provider and service.
3. The plan does not make payments directly to the providers of medical services.
4. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount medical plan organization.
5. Before purchase, you may access a list of participating health care providers at CareingtonProviders.com. Upon request the plan will make available a written list of participating health care providers.
6. You have the right to cancel within the first 30 days after receipt of membership materials and receive a full refund, less a nominal processing fee.
7. Discount Medical Plan Organization and administrator: **Careington International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034; phone (800)372-7615.**

**Note to Texas Consumers:** Regulated by the Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711; telephone (800)803-9202 or (512)463-6599 website: [www.license.state.tx.us/complaints](http://www.license.state.tx.us/complaints). The program and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. \*Medicare statement applies to Maryland residents when pharmacy discounts are part of program. This program is not available in Vermont and Montana.