

**DENTAL**

**Save** on Preventive Procedures,  
Including Exams, X-rays and Cleanings

**Save** on Basic & Major Restorations  
Fillings, Crowns, Dentures available at deep savings

**Save** on Orthodontics  
Including Braces for both children and adults

**Over 70,000 participating providers nationwide**

**Includes all specialties:** All dentists must meet highly selective credentialing standards based on education, background, license standing and other requirements.

**Endodontics    Pedodontics**  
**Oral Surgery    Periodontics**  
**Orthodontics    Prosthodontics**

Members may visit any participating dentist on the plan and change providers at any time.

Specialty care included where available. (see website for details)

**PRESCRIPTION**

Discount Prescription card assures that members receive the lowest prices on most prescriptions at participating pharmacies.

A **savings of 15% - 60%** on generic prescriptions and a **savings of 15% - 25%** on brand name prescriptions from the nation's leading pharmacies.

Convenience of our mail-in order pharmacy.

**VISION**

Members have access to over **40,000 providers** including optometrists, ophthalmologists, opticians and leading optical retailers.

- Savings of 20% to 40%
- Unlimited frequency
- Choice of any available frame
- 20% off items not included
- Laser vision correction savings
- Replacement contact lens by mail

Mail completed application to:

FloridaHealthInsurance.com  
 John K Arnold  
 5415 Lake Howell Road, #325  
 Winter Park, FL 32792

Contact us at:

(888)592-0311  
 Fax: (407)386-7053  
 jka.cidental.com

† Please make Checks/Money Orders payable to **Careington International**.

| <b>Only Six Steps!</b>   |         |  |                                      |  |         |                                 |       |   |                     |  |                         |                      |                                 |
|--|---------|--|--------------------------------------|--|---------|---------------------------------|-------|---|---------------------|--|-------------------------|----------------------|---------------------------------|
| Please complete the following application.   |         |  |                                      |  |         |                                 |       |   |                     |  |                         |                      |                                 |
| 1. FILL OUT YOUR NAME<br>2. COMPLETE YOUR ADDRESS  |         |  |                                      | 3. LIST ADDITIONAL MEMBERS<br>4. SELECT PLAN |         |                                 |       | 5. CHOOSE PAYMENT METHOD<br>6. SIGN AND MAIL WITH PAYMENT |                     |  |                         |                      |                                 |
| 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  |                         | Birthday<br>/ /      |                                 |
|  | 4. Name |  | Birthday<br>/ /                      |  | 5. Name |                                 |       | Birthday<br>/ /   |                     | 6. Name  |                         | Birthday<br>/ /      |                                 |
| <input type="checkbox"/> I want to pay by <b>CHECK</b> or <b>MONEY ORDER</b> payable to <b>Careington International</b> on a:<br><input type="checkbox"/> Quarterly Basis – enclose payment for <b>3 months</b> with application.<br><input type="checkbox"/> Annual Basis – enclose payment for <b>12 months</b> with application   |         |  |                                      | <b>I would like to include: (check one)</b>  |         |                                 |       | <b>Amount to include with application, if you pay:</b>    |                     |  |                         |                      |                                 |
| <input type="checkbox"/> I want to pay <b>MONTHLY</b> by <b>BANK DRAFT</b> . I hereby authorize you to pay checks drawn on my account by <b>Careington International</b> , and payable to same, provided there are sufficient collected funds in said account to pay the same upon presentation. <b>Enclose a voided check AND a check for first month's fee payable to Careington International</b> |         |  |                                      | <input type="checkbox"/> Individual          |         | Monthly Rate<br>\$7.95          |       | non-refundable app fee<br>\$20.00                         |                     | Monthly *<br>\$27.95   |                         | Quarterly<br>\$43.85 | Annually (Save 10%)<br>\$105.86 |
|  |         |  |                                      | <input type="checkbox"/> Individual+1        |         | \$12.95                         |       | \$20.00   |                     | \$32.95  |                         | \$58.85              | \$159.86                        |
|  |         |  |                                      | <input type="checkbox"/> Family              |         | \$16.95                         |       | \$20.00   |                     | \$36.95  |                         | \$70.85              | \$203.06                        |
| <input type="checkbox"/> I want to pay by <b>CREDIT CARD</b> on a: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual   |         |  |                                      | Account Number                               |         |                                 |       |   |                     |  |                         |                      |                                 |
| <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover  |         |  |                                      | Name on Card                                 |         |                                 |       |   |                     | Exp. Date  |                         |                      |                                 |
| Signature X  |         |  |                                      |  | Date    |                                 |       | Effective Date<br>Please select one of the following:     |                     | <input type="checkbox"/> This Month<br><input type="checkbox"/> Next Month |                         |                      |                                 |
| For Office Use Only  |         |  | Sales Summary Number<br><b>76055</b> |  |         | Group Number<br><b>EMXQBI-R</b> |       |   | WA<br><b>JARNOZ</b> |  | Office<br><b>QUALBE</b> |                      |                                 |

## TERMS & CONDITIONS

**Renewal Conditions:** By joining a plan, you are authorizing **Careington** to bill your credit card or checking account for the plan you have selected. This charge shall remain in force until you notify **Careington International Corporation** in writing of its cancellation. By joining, you indicate you have read the terms and conditions of the plan. This plan will automatically renew at the end of your membership term on an annual basis, and your credit card or bank account will be automatically charged or drafted for the appropriate amount.

**Termination Conditions:** **Careington** reserves the right to terminate plan members from its plan for any reason, including non-payment.

**Cancellation Conditions:** You have the right to cancel within the first 30 days after receipt of membership materials and receive a full refund, less the processing fee, if applicable. **FL Residents:** You have the right to cancel within the first 30 days after effective date. If for any reason during this time period you are dissatisfied with the plan and wish to cancel and obtain a refund, you must submit a written cancellation request. **Careington** will accept and cancel program memberships at any time during the membership period and will cease collecting membership fees in a reasonable amount of time, but no later than 30 days after receiving a cancellation notice. Please send a cancellation letter and a request for refund with your name and member number to Member Services, **Careington International Corporation**, P.O. Box 2568, Frisco, TX 75034 or fax to 888-335-7330. You may also submit cancellation by email: member@careington.com. If **Careington** is billing you quarterly, semi-annually or annually, **Careington** will, in the event of cancellation of the membership by either party, make a pro-rata reimbursement of the periodic charges to the member.

**Description of Services:** Please see the enclosed materials for a specific description of the programs that you have purchased.

**Limitations, Exclusions & Exceptions:** This program is a discount membership program offered by **Careington**. **Careington** is not a licensed insurer, health maintenance organization, or other underwriter of health care services. No portion of any provider's fees will be reimbursed or otherwise paid by **Careington**. **Careington** is not licensed to provide and does not provide medical services or items to individuals. You will receive discounts for medical services at certain health care providers who have contracted with the plan. You are obligated to pay for all health care services at the time of your appointment. Savings are based upon the provider's normal fees. Actual savings will vary depending upon location and specific services or products purchased. Please verify such services with each individual provider. The discounts contained herein may not be used in conjunction with any other discount plan or program. All listed or quoted prices are current prices by participating providers and subject to change without notice. Any procedures performed by a non-participating provider are not discounted. From time to time, certain providers may offer products or services to the general public at prices lower than the discounted prices available through this program. In such event, members will be charged the lowest price. Discounts on professional services are not available where prohibited by law. This plan does not discount all procedures. Providers are subject to change without notice and services may vary in some states. It is the member's responsibility to verify that the provider is a participant in the plan. At any time **Careington** has the right to eliminate a Participating Professional from the respective network in which they are associated and may substitute Provider networks at its sole discretion. **Careington** cannot guarantee the continued participation of any provider. If he or she leaves the plan, you will need to select another provider. Providers contracted by **Careington** are solely responsible for the professional advice and treatment rendered to members and **Careington** disclaims any liability with respect to such matters. Services and service providers may change or be discontinued at anytime with notice as required by law.

**Complaint Procedure:** If you would like to file a complaint or grievance regarding your plan membership, you must submit your grievance in writing to: **Careington International Corporation**, P.O. Box 2568, Frisco, TX 75034. All complaints or grievances are documented in the monthly Quality Assurance log along with the date and content of the complaint or grievance. Members have the right to request an appeal of the complaint and grievance resolution. Appeals will be sent to the Committee and will be entitled to a second review with different individuals. After completing the complaint resolution process and you remain dissatisfied, you may contact your state insurance department. **TX Residents:** All complaints will be completed within 72 hours of receipt with the exception of billing inquiries that require further research or documentation.

### **Disclosures:**

#### **THIS PLAN IS NOT INSURANCE. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN.\***

This plan does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00. 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. The plan does not make payments directly to the providers of medical services. 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. You may access a list of participating health care providers at this website. Upon request the plan will make available a written list of participating health care providers. 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 (nominal fee for MD residents is \$5). Discount Medical Plan Organization and administrator: **Careington International Corporation**, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-372-7615.

The program and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. This program is not available in Montana and Vermont. \*Medicare statement applies to MD residents when pharmacy discounts are part of program.