

**DENTAL**

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

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

**Save** on Orthodontics, including braces for children and adults

**Over 70,000 participating providers nationwide**

- |                                  |                         |
|----------------------------------|-------------------------|
| <b>Includes all specialties:</b> | All dentists must meet  |
| ✓ <b>Endodontics</b>             | highly selective        |
| ✓ <b>Oral Surgery</b>            | credentialing standards |
| ✓ <b>Orthodontics</b>            | based on education,     |
| ✓ <b>Pedodontics</b>             | background, license     |
| ✓ <b>Periodontics</b>            | standing and other      |
| ✓ <b>Prosthodontics</b>          | requirements.           |

**DENTAL (cont.)**

Members may visit any participating dentist on the plan  
Specialty care included where available. (see website for details)

**VISION**

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

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

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

Name		Birthday / /	Email		Spouse's Name		Birthday / /
Home Address (Incl. Apt. #)			City	State	Zip	Home Phone (incl. AC)	
<b>List of Members to Include</b>	1. Name	Birthday / /	2. Name		Birthday / /	3. Name	
	4. Name	Birthday / /	5. Name		Birthday / /	6. Name	
Sponsoring Employer / Association:							
I would like to include (check one): <input type="checkbox"/> Myself only \$6.95 <input type="checkbox"/> Me and one \$11.95 <input type="checkbox"/> My Family \$15.95							
<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 X				Date			
For Office Use Only	Sales Summary Number	Group Number <b>ZDEM</b>	WA <b>JHOSFZ</b>	Office <b>QUALBE</b>	Effective Date		

**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.