

**Night and Day Dental's health care savings plan is designed to provide affordability and greater access to quality dental care. Your benefits are only available at Night and Day Dental.**

### Benefits of our health care savings plan:

- \* No yearly maximums
- \* No deductibles
- \* No claim forms
- \* No pre-authorization requirements
- \* No pre-existing condition limitation
- \* Immediate eligibility (no waiting periods)
- \* Automatic renewal with credit card on file

Benefit	Annual Membership Fee*
Individual	\$275
Dual**	\$525
Family of 3	\$750
Family***	\$950

\* Membership fees will be reviewed annually and are subject to change

\*\* The dual plan is for husband/wife or parent/child

\*\*\* The family plan is for an immediate family of four. Each additional child is \$175.00. The family plan includes children until the age of 18 or under the age of 23 if enrolled full time in college.

**Health care savings plan members receive a 100% discount on the following services:**

- Comprehensive new patient exam (initial visit)
- Periodic exam (2 per year)
- Limited emergency exam (1 per year)
- X-rays (1 set per year)
- Routine cleanings (2 per year)
- Fluoride (once per year)

**Health care savings plan members receive a 20% discount on the following services:**

- Sealants
- Periodontal (deep) cleaning
- ZOOM bleaching
- Fillings
- Crowns
- Dentures and Partialals
- Oral Surgery
- Root Canals

## Example of Savings

Service	Standard Fees - Individual	Savings Plan - Individual	Standard Fees - Family of 4	Savings Plan - Family of 4
New Patient Exam (1)	\$118	\$0	\$472	\$0
Periodic Exam (1)	\$84	\$0	\$336	\$0
Limited Exam (1)	\$100	\$0	\$400	\$0
New Patient X-rays (4 BW and 3 PA's)	\$204	\$0	\$816	\$0
Panoramic X-ray (1)	\$128	\$0	\$512	\$0
Routine Cleanings (2)	\$262	\$0	\$1048	\$0
Benefit Fee	-	\$275	-	\$950
<b>Total Cost:</b>	\$896	\$275	\$3,584	\$950
<b>Savings:</b>		\$621 !		\$2,634 !

### Exclusions and Limitations:

- \* The program is a discount plan, not a dental insurance plan
- \* The plan cannot be used:
  - \* In conjunction with another dental insurance plan
  - \* For services for injuries covered under workman's compensation
  - \* For treatment which, in sole opinion of the treating dentist, lies outside the realm of their capability
  - \* For referrals to specialists
  - \* For hospitalization or hospital charges of any kind
  - \* For costs of dental care which are covered under automobile medical
- \* This plan is honored only at the location of the office at which you purchased it. This plan cannot be used for services received at any other office. Cannot be combined with any other offers.
- \* This program is non-refundable



# Oral Health Care Savings Plan

Date:	
Name:	DOB:                      SSN:
Spouse's name:	DOB:                      SSN:
Child's name:	DOB:                      SSN:
Child's name:	DOB:                      SSN:
Child's name:	DOB:                      SSN:
Type of Plan:    Single: _____    Dual: _____    Family of 3: _____    Family: _____	
Make checks payable to: Night and Day Dental	
Credit card number:	Credit Card Expiration date:
_____	Month _____ Year _____
Night and Day Dental is authorized to issue a charge memo to my credit card account:	
Authorized Signature:	Date:
_____	_____
<b>Auto renewal entitles you to a 5% discount off the renewal of the annual membership fee</b>	
_____ I would like Night and Day Dental to keep my signature on file and auto-renew my plan membership annually at the the anniversary date	
Authorized Signature:	Date:
_____	_____