Revised 2-4-19

qcd DENTAL BENEFITS

NLLEO-Dallas

Consumer Driven Choices	RED*	RED PLUS	WHITE**	BLUE
Monthly Rates			With Ortho	With Ortho
Employee Only **Employee + One** **Employee + Family**	**No Charge** **$5.00** **$5.00**	**$8.95** **$18.95** **$28.95**	**$21.95** **$44.95** **$65.95**	**$46.87** **$98.68** **$165.70**
	A Managed Cost Dental & Vision Benefit Program	A Limited Reimbursement Program	A Comprehensive Reimbursement Program	Traditional Dental Insurance
Calendar Year Deductible:	No Deductible	No Deductible	$50/$150 (Basic & Major)	$50/$150 (Basic & Major)
Calendar Year Max Benefit:	No Maximum	No Maximum	$1,500	$1,000
Reimbursement %	N/A	100% Class I - 2/yr	100%***	90th Percentile
PREVENTIVE SERVICES - CLASS I				
Waiting Period	**None**	**None**	**None**	**None**
Office Visit Routine Exams Cleaning X-rays Complete Series Fluoride Treatment Sealants Space Maintainers	**No Charge** See Reduced Fee Schedule (Approximately 50% Savings)	**No Charge** 100%*** of the Reimbursement Schedule QCD General Dentist Only See Reduced Fee Schedule (Approx. 50% Savings)	**No Charge In-Network** 100%*** of the Reimbursement Schedule QCD General Dentist Only See Reimbursement Schedule for Out-of-Network Benefits	100% of UCR
BASIC SERVICES - CLASS II				
Waiting Period	**None**	**None**	**3 Months**	**3 Months**
Extractions Fillings	See Reduced Fee Schedule (Approximately 50% Savings)	See Reduced Fee Schedule (Approximately 50% Savings)	100%*** of the Reimbursement Schedule QCD General Dentist Only See Reimbursement Schedule for Out-of-Network Benefits	80% of UCR
MAJOR SERVICES - CLASS III				
Waiting Period	**None**	**None**	**12 Months**	**12 Months**
Crowns Bridges Inlays/onlays Dentures Endo/Perio Oral Surgery	See Reduced Fee Schedule (Approximately 50% Savings)	See Reduced Fee Schedule (Approximately 50% Savings)	100%*** of the Reimbursement Schedule QCD General Dentist Only See Reimbursement Schedule for Out-of-Network Benefits	50% of UCR
ORTHODONTIA				
Waiting Period	**None**	**None**	**12 Months**	**12 Months**
Lifetime Maximum	None	None	Life Max $1,000	Life Max $1,000
Coverage	Children & Adults	Children & Adults	Children & Adult	Children Only
SPECIAL PROGRAM FEATURES				
	Household Coverage No Age or Relationship Restrictions	Benefit Level of a DHMO without the Operational Problems	No Frequency Limitations Credit Towards Waiting Periods Brand New Ortho Maximum	Use Any Dentist

QCD Clear Vision Discount Program (Included In All Dental Plans)	
Eye Examination	Spectacle Lenses (Uncoated Plastic)
Contact Lens Examination	Single $35.00
15% discount off Usual & Customary	Bifocal $55.00
15% discount off Usual & Customary	Trifocal $65.00
Frame	Lenicular $110.00
Priced up to $70 Retail = $40.00	Conventional
Priced over $70 Retail = $40.00	20% off Provider's Usual & Customary
10% off the amount over $70.00	Disposable/Planned Replacement
	10% off Provider's Usual & Customary

*	QCD "RED" Program is a managed cost dental and vision benefit program. The member pays at time of service according to the QCD Schedule of Program Fees (Approximately 50% Savings). Family coverage on RED Only includes everyone in the household regardless of age or relationship.
**	QCD " RED PLUS" and "WHITE" Program - Member pays a QCD provider at time of service per QCD Schedule of Program Fees and then submits a copy of the paid receipt for reimbursement - Claims paid in approximately 6-10 business days. Out-of-Network insurance reimbursements are per a set schedule and represent approximately 50% coverage.
***	QCD "WHITE" Program reimburses the member for any service performed by a QCD General Dentist and listed by code on the RED Schedule of Program Fees at 100% (After Deductibles). Lab fees are additional and not reimbursed.

Schedule of Programs Fees

qcd DENTAL BENEFITS

Procedure Number | Member Fee

DIAGNOSTIC DENTISTRY

D0120	PERIODICAL ORAL EXAMINATION	$9.00
D0140	LIMITED ORAL EXAMINATION, PROBLEM FOCUSED	$12.00
D0150	COMPREHENSIVE ORAL EXAMINATION	$18.00
D0210	INTRAORAL X - RAY COMPLETE SERIES	$28.00
D0460	PULP VITALITY TEST	$15.00
D9999	ASEPSIS FEE (INFECTION CONTROL)	$8.00
	ALL BITEWING / SINGLE FILM X-RAYS	20% DISCOUNT

PREVENTATIVE DENTISTRY

D1110	PROPHYLAXIS – ADULT	$24.00
D1120	PROPHYLAXIS – CHILD	$24.00
D1203	APPLICATION TOPICAL FLUORIDE – CHILD	$5.00
D1204	APPLICATION TOPICAL FLUORIDE – ADULT	$5.00
D1351	SEALANT-PER TOOTH	$14.00
D1510	SPACE MAINTAINER - FIXED UNILATERAL	$60.00
D1515	SPACE MAINTAINER - FIXED BILATERAL	$75.00

A specific preventative treatment may present unusual circumstances requiring an additional cost. Please consult the affiliated dentist as to the total procedure cost prior to treatment.

COSMETIC

ALL COSMETIC DENTISTRY ..... 20% DISCOUNT

RESTORATIVE DENTISTRY

D2140	AMALGAM - 1 SURFACE, PRIMARY OR PERMANENT	$28.00
D2150	AMALGAM - 2 SURFACES, PRIMARY OR PERMANENT	$36.00
D2160	AMALGAM - 3 SURFACES, PRIMARY OR PERMANENT	$46.00
D2161	AMALGAM - 4 OR MORE SURFACES, PRIMARY OR PERMANENT	$56.00
D2330	COMPOSITE RESIN - 1 SURFACE, ANTERIOR	$38.00
D2331	COMPOSTIE RESIN - 2 SURFACES, ANTERIOR	$46.00
D2332	COMPOSITE RESIN - 3 SURFACES, ANTERIOR	$56.00
D2335	COMPOSITE RESIN - 4 OR MORE SURFACES OR INVOLVING INCISAL ANGLE, ANTERIOR	$66.00
D2391	COMPOSITE RESIN - 1 SURFACE, POSTERIOR	$50.00
D2392	COMPOSITE RESIN - 2 SURFACES, POSTERIOR	$65.00
D2393	COMPOSTIE RESIN - 3 SURFACES, POSTERIOR	$85.00
D2394	COMPOSITE RESIN - 4 OR MORE SURFACES, POSTERIOR	$95.00
D2750	CROWN - PORCELAIN TO HIGH NOBLE METAL (GOLD AND LAB FEES ADDITIONAL)	$350.00
D2751	CROWN - PORCELAIN TO BASE METAL (LAB FEES ADDITIONAL)	$320.00
D2920	RECEMENT CROWN	$20.00
D2931	PREFABRICATED STAINLESS STEEL CROWN	$48.00
D2940	SEDATIVE FILLING	$16.00
D2950	CORE BUILDUP, (INCLUDING ANY PINS)	$55.00
D2951	PIN RETENTION – (PER TOOTH)	$20.00
D2952	CAST POST AND CORE IN ADDITION TO CROWN	$75.00
D2953	EACH ADDITIONAL CAST POST (SAME TOOTH)	$40.00
D2954	PREFAB POST / CORE IN ADDITION TO CROWN	$60.00
D2970	TEMPORARY CROWN (FRACTURED TOOTH)	$40.00

Procedure Number | Member Fee

ENDODONTICS

D3110	PULP CAP, DIRECT	$19.00
D3120	PULP CAP, INDIRECT	$24.00
D3220	PULPOTOMY	$35.00
D3310	ROOT CANAL, ANTERIOR	$159.00
D3320	ROOT CANAL, BICUSPID	$209.00
D3330	ROOT CANAL, MOLAR	$259.00
D3920	HEMISECTIO	$65.00

A specific root canal treatment or re-treatment may present unusual circumstances requiring additional cost. Please consult the affiliated dentist as to the total procedure cost prior to treatment.

PERIODONTICS

D4210	GINGIVECTOMY/GINGIVOPLASTY –(PER QUADRANT)	$180.00
D4211	GINGIVECTOMY/GINGIVOPLASTY - (PER TOOTH)	$50.00
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - (PER QUADRANT)	$200.00
D4260	OSSEOUS SURGERY-(PER QUADRANT) (INCLUDING FLAP ENTRY AND CLOSURE)	$260.00
D4341	PERIODONTAL SCALING AND ROOT PLANING - (PER QUADRANT)	$75.00
D4355	FULL MOUTH DEBRIDEMENT	$70.00
D4910	PERIODONTAL MAINTENANCE PROCEDURES FOLLOWING ACTIVE THERAPY	$30.00

A specific periodontal treatment may present unusual circumstances requiring an additional cost. Please consult the affiliated dentist as to the total procedure cost prior to treatment.

PROSTHODONTICS – REMOVABLE

(LAB FEES ADDITIONAL COST)

D5110	COMPLETE UPPER DENTURE (INCLUDING SIX MONTHS POST CARE)	$400.00
D5120	COMPLETE LOWER DENTURE (INCLUDING SIX MONTHS POST CARE)	$400.00
D5130	IMMEDIATE UPPER	$420.00
D5140	IMMEDIATE LOWER	$420.00
D5211	UPPER PARTIAL DENTURE – RESIN BASE	$250.00
D5212	LOWER PARTIAL DENTURE – RESIN BASE	$250.00
D5213	UPPER PARTIAL – PREDOMINANTLY CAST BASE	$400.00
D5214	LOWER PARTIAL – PERDOMINANTLY CAST BASE	$400.00
D5410	ADJUST COMPLETE DENTURE	$15.00
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	$40.00
D5610	REPAIR RESIN DENTURE BASE	$35.00
D5630	REPAIR OR REPLACE BROKEN CLASP	$45.00
D5640	REPLACE BROKEN TEETH – (PER TOOTH)	$30.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	$45.00
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	$65.00
D5730	RELINE COMPLETE UPPER (CHAIRSIDE)	$75.00
D5731	RELINE COMPLETE LOWER (CHAIRSIDE)	$75.00
D5740	RELINE UPPER PARTIAL (CHAIRSIDE)	$75.00
D5741	RELINE LOWER PARTIAL (CHAIRSIDE)	$75.00
D5810	TEMPORARY COMPLETE UPPER DENTURE	$200.00
D5811	TEMPORARY COMPLETE LOWER DENTURE	$200.00
D5820	TEMPORARY PARTIAL - STAY PLATE UPPER	$180.00
D5821	TEMPORARY PARTIAL - STAY PLATE LOWER	$180.00

Schedule of Programs Fees (Continued)

qcd DENTAL BENEFITS

PROSTHODONTICS – FIXED BRIDGES

D6241	PONTIC-PORCELAIN FUSED TO BASE METAL	$320.00
D6751	CROWN-PORCELAIN FUSED TO BASE METAL	$320.00
D6791	CROWN-FULL CAST FUSED TO BASE METAL	$270.00
D6930	RECEMENT BRIDGE	$20.00
D6940	STRESS BREAKER	$90.00
D6950	PRECISION ATTACHMENT (EACH)	$225.00

A specific prosthodontic treatment may present unusual circumstances requiring an additional cost. If precious metal (gold) is desired, the cost will be additional to the crown cost. Please consult the affiliated dentist as to the total cost prior to treatment.

ORAL SURGERY

D7110	SINGLE TOOTH EXTRACTION	$36.00
D7120	EACH ADDITIONAL TOOTH	$34.00
D7130	ROOT REMOVAL – EXPOSED ROOTS	$48.00
D7210	SURGICAL EXTRACTION-ERUPTED	$68.00
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$78.00
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$109.00
D7240	REMOVAL OF IMPACTED TOOTH- COMPLETELY BONY	$129.00
D7241	REMOVAL OF IMPACTED TOOTH- COMPLETELY BONY, WITH UNUSUSAL SURGICAL COMPLICATIONS	$189.00
D7250	ROOT RECOVERY	$72.00
D7280	SURGICAL EXPOSURE PER TOOTH	$66.00
D7310	ALVEOLOPLASTY (PER QUADRANT WITH EXTRACTIONS)	$78.00
D7320	ALVEOLOPLASTY (PER QUADRANT WITHOUT EXTRACTIONS)	$84.00
D7960	FRENECTOMY	$99.00

A specific oral surgery procedure may present unusual circumstances requiring an additional cost. Please consult the affiliated dentist as to the total procedure cost prior to

ORTHODONTICS (QCD GENERAL DENTIST ONLY)

D8999	DIAGNOSTIC WORK UP RADIOGRAPHS, MODEL, RECORDS	$120.00
D8080	CHILD (QCD GENERAL DENTIST) CLASS I OR II FOR 24 MONTH TREATMENT	$2,200.00
D8090	ADULT (QCD GENERAL DENTIST) CLASS I OR II FOR 24 MONTH TREATMENT	$2,400.00
D8680	ORTHODONTIC RETENTION	$230.00

A special orthodontic treatment may present unusual circumstances requiring an additional cost. During the orthodontic consultation appointment, the affiliated dentist will explain all needed procedures, length of treatment, required fees and payment schedule.

GENERAL SERVICES

D9999	FAILED APPOINTMENT (WITHOUT 24 HOURS NOTICE)	$30.00
D9999	PALLATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES	$20.00
D9999	OFFICE VISIT-AFTER HOURS	$45.00

IMPORTANT NOTICE

THE QCD OF AMERICA® DENTAL BENEFIT PROGRAM DOES NO CONSTITUTE DENTAL INSURANCE AND IS NOT A HEALTH MAINTENANCE ORGANIZATION CONTRACT. QCD OF AMERICA® DOES NOT REIMBURSE THE AFFILIATED DENTIST OR IMDEMNIFY THE MEMBER FOR THE COST OF DENTAL SERVICES RECEIVED BY THE MEMBER.

SPECIALTY CARE SERVICES

All scheduled charges listed are for services rendered by a QCD OF AMERICA® affiliated general dentist. All treatments provided by a QCD OF AMERICA® affiliated specialty dentist (advanced degree) in Endodontics, Periodontics, Prosthodontics, Oral Surgery, Pediatric Dentistry or Orthodontics (Board Certified or Board Eligible only) will be charged at a 20% discount from the affiliated specialty dentist's usual and customary fee for the treatment.

OTHER PROCEDURES AND PAYMENT FOR SERVICES

Any procedure not listed on the QCD OF AMERICA® Schedule of Dental Program Fees is available at the dentist's usual and customary fee less a 20% discount – this includes all lab fees. All fees included in the Schedule of Dental Fees are for payment at the time of service. The member may negotiate payment terms with the affiliated dentist, however, an

ASEPSIS FEE

An asepsis fee of $8.00 per patient appointment is charged by all affiliated dentists to insure proper infection control for all QCD OF AMERICA® members.

QCD OF AMERICA® - EXCLUSIONS AND LIMITATIONS

1) THE FOLLOWING EXCLUSIONS AND LIMITATIONS APPLY:

   A) SERVICES COVERED UNDER WORKMEN'S COMPENSATION OR EMPLOYER'S LIABILITY LAWS;

   B) COST OF ANY DENTAL CARE COVERED BY ANY MEDICAL INSURANCE;

   C) SERVICES WHICH, IN THE OPIONION OF THE ATTENDING DENTIST, ARE NOT NECESSARY FOR THE PATIENT'S DENTAL HEALTH OR CANNOT BE PERFORMED BECAUSE OF THE GENERAL HEALTH OF THE PATIENT;

   D) GENERAL ANESTHESIA, I.V. SEDATION, HOSPITALIZAITON, AND HOSPITAL OR MEDICAL CHARGES OF ANY TYPE.

2) QCD OF AMERICA® MEMBER FEES APPLY TO SERVICES RENDERED BY AFFILIATED DENTAL OFFICES AND ARE SUBJECT TO CHANGE IN THE FUTURE.

3) QCD OF AMERICA® MEMBER FEES DO NOT APPLY TO WORK IN PROGRESS OR IF THE PATIENT'S MEMBERSHIP IS NO LONGER VALID.

4) QCD OF AMERICA® ASSUMES NO RESPONSIBILITY OR LIABILITY FOR SERVICES RENDERED BY AFFILIATED DENTISTS.

5) ANY QCD OF AMERICA® MEMBER ACCEPTED FOR ORTHODONTIC TREATMENT MUST REMAIN A MEMBER OF THE PLAN FOR THE COMPLETE DURATION OF THE TREATMENT OR RISK ADDITIONAL CHARGES BY THE AFFILAITED DENTIST.

6) ANY PROCEDURE MAY PRESENT UNUSUAL CIRCUMSTANCES REQUIRING AN ADDITIONAL COST. PLEASE CONSULT THE AFFILIATED DENTIST AS TO THE TOTAL TREATMENT COST PRIOR TO ANY SERVICE BEING RENDERED.

QCD WHITE Program Reimbursement Schedule

WE WILL PAY, SUBJECT TO DEDUCTIBLE AND CO-INSURANCE, FOR THE PROCEDURES AND SERVICES LISTED IN THE SCHEDULE OF ELIGIBLE EXPENSES, NOT TO EXCEED THE LESSER OF THE ACTUAL CHARGE OR THE SCHEDULED BENEFIT FOR SUCH PROCEDURE OR SERVICE.

Maximum Limit:
Eligible Expenses for:
Class I, II, III — **Combined $1,500 per calendar year**

Percentage Payable, after Deductible
Eligible Expenses for:
Class I, II, III — **100% of Scheduled Benefit**

Deductible Amount Each Calendar Year

Eligible Expenses for	Each Person	Each Family
Class I	$0	$0
Class II & III	$50	$150

Waiting Period For:

Class I	NONE
Class II	3 Months
Class III	12 Months

SCHEDULE OF ELIGIBLE EXPENSES

CLASS I (or A) - PREVENTATIVE & DIAGNOSTIC

Code	Procedure	Scheduled Benefit
D0120	Periodical Oral Evaluation	$9
D0140	Limited Oral Evaluation	$12
D0145	Oral Evaluation For Patient < 3 yrs	$18
D0150	Comprehensive Oral Evaluation	$18
D0160	Detailed and Extensive Oral Evaluation	$30
D0170	Re-Evaluation – Limited	$26
D0210	Intraoral – Complete Series	$28
D0220	Intraoral – Periapical First Film	$12
D0230	Intraoral-Periapical Each Additional Film	$9
D0240	Intaoral-Occlusal Film	$18
D0250	Extraoral-First Film	$24
D0260	Extraoral-Each Additional Film	$23
D0270	Bitewing – Single Film	$14
D0272	Bitewings-Two Films	$21
D0273	Bitewings- Three Films	$25
D0274	Bitewings-Four Films	$29
D0277	Vertical Bitewings-7 To 8 Films	$45
D0330	Panoramic Film	$53
D0340	Cephalometric Film	$66
D0350	Oral/Facial Images	$29
D0460	Pulp Vitality Tests	$15
D0470	Diagnostic Casts	$30

Code	Procedure	Scheduled Benefit
D0472	Accession of Tissue, Exam & Report	$30
D0473	Accession of Tissue, Exam & Report	$50
D0474	Accssion Incl Assessof Surgical Margins	$50
D0480	Processing /Interpret Cytologic Smears	$40
D0999	Unspecified Diagnostic Proc, by Report	$8
D1110	Prophylaxis-Adult	$36
D1120	Prophylaxis-Child	$29
D1201	Topical App Flouride w/Phophylaxis-Child	$39
D1203	Topical Application Flouride-Child	$10
D1204	Topical Application Flouride-Adult	$10
D1205	Topical App Flouride w/Phophylaxis-Adult	$46
D1206	Topical Flouride Varnish	$10
D1351	Sealant-Per Tooth	$14
D1510	Space Maintainer-Fixed Unilateral	$60
D1515	Space Maintainer-Fixed Bilateral	$75
D1520	Space Maintainer-Removable Unilateral	$150
D1525	Space Maintainer-Removable Bilateral	$150
D1550	Recementation of Space Maintainer	$37
D1999	Infection Control	$8
D9110	Emergency Palliative Treatment	$41
D9310	Consultation, Second Opinion	$50
D9440	Office Visit After Hours	$45

CLASS II (or B) - BASIC RESTORATIVE

Code	Procedure	Scheduled Benefit
D2140	One Surface Amalgam – Permanent	**$28**
D2150	Two Surface Amalgam – Permanent	**$36**
D2160	Three Surface Amalgam – Permanent	**$46**
D2161	Four + Surface Amalgam – Permanent	**$56**
D2330	One Surface Resin – Anterior	**$38**
D2331	Two Surface Resin – Anterior	**$46**
D2332	Three Surface Resin – Anterior	**$56**
D2335	Four + Surface or Incisal Resin – Anterior	**$66**
D2391	Resin Composite – 1 Surface Posterior	**$50**
D2392	Resin Composite – 2 Surface Posterior	**$65**
D2393	Resin Composite – 3 Surface Posterior	**$85**
D2394	Resin Composite – 4+ Surface Posterior	**$95**
D3110	Pulp Cap-Direct (Excludes Final Restor)	**$19**
D3120	Pulp Cap-Indirect (Excludes Final Restor)	**$24**
D3220	Vital Pulpotomy – Primary Teeth Only	**$35**
D3221	Gross Pulpal Debridement	**$77**
D3230	Pulpal Therapy – Anterior Primary	**$74**
D3240	Pulpal Therapy – Posterier Primary	**$80**
D3310	Root Canal – Anterior	**$185**
D3320	Root Canal – Bicuspid	**$209**
D3330	Root Canal – Molar	**$259**
D3331	Treat Root Canal Obstruction; Non-Surg	**$160**
D3332	Incomplete Endodontic Therapy	**$256**
D3333	Internal Root Repair - Perforation Defects	**$50**
D3346	Retreat Root Canal Therapy - Anterior	**$399**
D3347	Retreat Root Canal Therapy - Bicuspid	**$400**
D3348	Retreat Root Canal Therapy – Molar	**$400**
D3351	Apexification/Recalcification - Initial Visit	**$50**
D3352	Apexification/Recalcification - Interim	**$35**
D3353	Apexificauon/Recalcification - Final Visit	**$50**
D3410	Apicoectomy – Anterior	**$339**
D3421	Apicoectomy – Bicuspid	**$370**
D3425	Apicoectomy – Molar	**$400**
D3426	Apicoectomy – Additional Root	**$140**
D3430	Retrograde Filling	**$103**
D3450	Root Amputation	**$208**
D3460	Endodontic Endosseous Implant	**$100**
D3470	Intentional Reimplantation	**$125**
D3920	Hemisection Not Incl Root Canal Therapy	**$65**
D4210	Gingivectomy – Per Quadrant	**$180**
D4211	Gingivectomy – Per Tooth	**$50**
D4240	Gingival Flap Surgery	**$200**
D4245	Apically Positioned Flap	**$100**
D4249	Clinical Crown Lengthening - Hard Tissue	**$125**
D4260	Osseous Surgery – Per Quadrant	**$260**
D4261	Osseous Surgery – 1-3 Teeth	**$32**
D4263	Bone Replace Graft-1st Site In Quadrant	**$30**
D4264	Bone Replace Graft-Each Addl Site/Quad	**$30**
D4268	Surgical Revision Procedure, Per Tooth	**$100**
D4270	Pedicle Soft Tissue Graft Procedure	**$387**

Code	Procedure	Scheduled Benefit
D4271	Free Soft Tissue Graft Procedure	**$398**
D4273	Subepithelial Connective Tissue Graft	**$400**
D4274	Distal Or Proximal Wedge Procedure	**$100**
D4341	Scaling and Root Planing –Per Quadrant	**$75**
D4342	Scaling and Root Planing – 1-3 Teeth	**$32**
D4355	Periodontal Debridement (Full Mouth)	**$70**
D4910	Periodontal Maintenance Procedure	**$30**
D5410	Denture Adjustment – Upper	**$15**
D5411	Denture Adjustment – Lower	**$32**
D5421	Partial Adjustment – Upper	**$32**
D5422	Partial Adjustment – Lower	**$32**
D5510	Repair Denture Base	**$40**
D5520	Repair Teeth – Per Tooth	**$53**
D5610	Repair Partial Base	**$35**
D5620	Repair Partial Framework	**$74**
D5630	Repair Broken Clasp	**$45**
D5640	Replace Teeth – Per Tooth	**$30**
D5650	Add Tooth to Existing Partial Denture	**$45**
D5660	Add Clasp to Existing Partial Denture	**$65**
D5710	Rebase Complete Denture – Upper	**$235**
D5711	Rebase Complete Denture – Lower	**$224**
D5720	Rebase Partial Denture – Upper	**$222**
D5721	Rebase Partial Denture – Lower	**$222**
D5730	Reline Upper Denture	**$75**
D5731	Reline Lower Denture	**$75**
D5740	Reline Upper Partial Denture	**$75**
D5741	Reline Lower Partial Denture	**$75**
D5750	Reline Upper Denture (Lab)	**$177**
D5751	Reline Lower Denture (Lab)	**$177**
D5760	Reline Upper Partial Denture (Lab)	**$174**
D5761	Reline Lower Partial Denture (Lab)	**$174**
D6930	Bridge Recementation	**$20**
D6940	Stress Breaker	**$90**
D6950	Precision Attachment	**$225**
D6970	Cast Post & Core + Fixed Partial Retainer	**$161**
D6971	Cast Post, Part of Fixed Partial Denture	**$141**
D6972	Crwod Resin (Plus Fixed Partial Retainer)	**$131**
D6973	Core Build-up for Retainer (Incl Any Pins)	**$105**
D6980	Fixed Partial Denture Repair	**$50**
D7110	Simple Extraction	**$36**
D7120	Additional Extraction	**$34**
D7130	Root Removal Exposed	**$48**
D7140	Extraction, Erupted Tooth, Exposed Root	**$48**
D7210	Surgical Extraction	**$68**
D7220	Impacted (Soft Tissue)	**$78**
D7230	Impacted (Partial Bony)	**$109**
D7240	Impacted (Complete Bony)	**$129**
D7241	Impacted (Complete Bony) Unusual Circum	**$189**
D7250	Surgical Removal of Root	**$72**
D7270	Tooth Relmplantation	**$100**

CLASS II (or B) - BASIC RESTORATIVE (Continued)

Code	Procedure	Scheduled Benefit
D7280	Surgical Access of an Unerupted Tooth	**$65**
D7281	Surgical Exposure of Impacted/Unerupted	**$100**
D7285	Biopsy of Oral Tissue – Hard Bone/Tooth	**$30**
D7286	Biopsy of Soft Oral Tissue	**$30**
D7290	Surgical Repositioning of Teeth	**$100**
D7310	Alveolectomy (w/extraction) – per quadrant	**$78**
D7311	Alveoloplasty (w/extraction) – 1-3 Teeth	**$39**
D7320	Alveolectomy (w/o extraction) – per quad	**$84**
D7321	Alveoloplasty (w/o extraction) – 1-3 Teeth	**$42**
D7340	Vestibuloplasty- Ridge Extent	**$75**
D7350	Incision & Drainage of Abscess – Intraoral	**$200**
D7410	Radical Excision- Lesion up to 1.25cm	**$75**
D7440	Malignant Tumor Excision- Up to 1.25cm	**$50**
D7441	Malignant Tumor Excision- > 1.25cm	**$50**
D7450	Remove Odontogenic Cyst Or Tumor	**$50**
D7451	Remove Odontogenic Cyst Or Tumor	**$50**
D7460	Removal Of Nonodontogenic Cyst/Tumor	**$50**
D7461	Removal Of Nonodontogenic Cyst/Tumor	**$50**
D7465	Destruction Of Lesion(s)-Physical or Chem	**$50**
D7471	Removal Of Exostosis - Per Site	**$50**

Code	Procedure	Scheduled Benefit
D7510	Intraoral Incision and Drainage of Abscess	**$30**
D7520	Extraoral Incision and Drainage of Abscess	**$30**
D7530	Foreign Body Removal Skin/Subcutaneous	**$75**
D7540	Foreign Body Removal-Reaction-Producing	**$150**
D7550	Sequestrectomy For Osteomyeliti	**$30**
D7560	Maxillary Sinusotomy-Remove Tooth Frag	**$130**
D7610	Maxilla-Open Reduction	**$130**
D7620	Maxilla – Closed Reduction	**$175**
D7630	Mandible – Open Reduction	**$140**
D7640	Mandible – Open Reduction	**$175**
D7650	Malar And/Or Zygomatic Arch - Open	**$135**
D7660	Malar And/Or Zygomatic Arch - Closed	**$175**
D7670	Alveolus – Stabilization Of Teeth, Closed	**$135**
D7680	Facial Bones - Complicated Reduction	**$135**
D7910	Suture Of Recent Small Wounds up to 5 cm	**$75**
D7911	Complicated Suture - Up To 5 Cm	**$75**
D7912	Complicated Suture – Greater Than 5 Cm	**$75**
D7960	Frenulectomy (Frenectomy Or Frenotomy)	**$99**
D7970	Excision Of Hyperplastic Tissue - Per Arch	**$75**
D7971	Excision Of Pericoronal Gingiva	**$75**

CLASS III (or C) - MAJOR RESTORATIVE

Code	Procedure	Scheduled Benefit
D0502	Other Oral Pathology Procedures	**$50**
D2410	Gold Foil - One Surface	**$80**
D2420	Gold Foil -Two Surfaces	**$130**
D2430	Gold Foil - Three Surfaces	**$200**
D2510	Inlay-Metallic - One Surface	**$215**
D2520	Inlay-Metallic - Two Surfaces	**$244**
D2530	Inlay-Metallic - Three Or More Surfaces	**$281**
D2542	Onlay-Metallic-Two Surfaces	**$275**
D2543	Onlay-Metallic-Three Surfaces	**$288**
D2544	Onlay-Metallic-Four Or More Surfaces	**$300**
D2610	Inlay-Porcelain/Ceramic-One Surface	**$253**
D2620	Inlay-Porcelain/Ceramic-Two Surfaces	**$267**
D2630	Inlay-Porcelain/Ceramic-Three or More	**$284**
D2642	Onlay - Procelain/Ceramic – Two Surfaces	**$276**
D2643	Onlay - Procelain/Ceramic– Three Surfaces	**$298**
D2644	Onlay - Procelain/Ceramic - Four Or More	**$316**
D2650	Inlay-Resin-Based Composite-One Surface	**$166**
D2651	Inlay-Resin-Based Composite-Two Surfaces	**$198**
D2652	Inlay-Resin-Based Composite-Three+	**$208**
D2662	Onlay - Resin-Based Composite - 2 Surfaces	**$180**
D2663	Onlay - Resin-Based Composite– 3 Surfaces	**$212**
D2664	Onlay-Resin-Based Composite– 4+ Surf	**$227**
D2710	Crown-Resin (Laboratory)	**$128**
D2720	Crown-Resin With High Noble Metal	**$316**
D2721	Crown-Resin w/Predominantly Base Metal	**$296**

Code	Procedure	Scheduled Benefit
D2722	Crown-Resin With Noble Metal	**$302**
D2740	Crown-Porcelain/Ceramic Substrate	**$324**
D2750	Crown-Porcelain Fused to High Noble Mtl	**$350**
D2751	Crown-Porcelain Fused To Base Metal	**$320**
D2752	Crown-Porcelain Fused To Noble Metal	**$335**
D2780	Crown-3/4 Cast High Noble Metal	**$307**
D2781	Crown-3/4 Cast Predominantly Base Metal	**$289**
D2782	Crown-3/4 Cast Noble Metal	**$298**
D2783	Crown-3/4 Porcelain/Ceramic	**$315**
D2790	Crown-Full Cast High Noble Metal	**$335**
D2791	Crown-Full Cast Predominantly Base Metal	**$292**
D2792	Crown-Full Cast Noble Metal	**$298**
D2910	Recement Inlay	**$23**
D2920	Recement Crown	**$20**
D2930	Prefab Stainless Steel Crown-Primary Tooth	**$65**
D2931	Prefab Stainless Steel Crown-Perm Tooth	**$48**
D2932	Prefabricated Resin Crown	**$80**
D2933	Prefab Stainless Steel Crown w/Resin	**$90**
D2940	Sedative Filling	**$16**
D2950	Core Buildup, Including Any Pins	**$55**
D2951	Pin Retention - Per Tooth	**$20**
D2952	Cast Post And Core In Addition To Crown	**$75**
D2953	Ech Additional Cast Post (Same Tooth)	**$40**
D2954	Prefab Post &Core In Addition To Crown	**$60**
D2960	Labial Veneer (Resin Laminate) - Chairside	**$193**

CLASS III (or C) - MAJOR RESTORATIVE (Continued)

Code	Procedure	Scheduled Benefit
D2961	Labial Veneer (Resin Laminate) – Lab	**$215**
D2962	Labial Veneer (Porcelain Laminate) – Lab	**$234**
D2970	Temporary Crown (Fractured Tooth)	**$40**
D2980	Crown Repair, By Report	**$60**
D5110	Complete Denture – Maxillary	**$400**
D5120	Complete Denture – Mandibular	**$400**
D5130	Immediate Denture – Maxillary	**$420**
D5140	Immediate Denture – Mandibular	**$420**
D5211	Maxillary Partial Denture – Resin Base	**$250**
D5212	Mandibular Partial Denture – Resin Base	**$250**
D5213	Maxillary Partial Denture – Cast Metal	**$400**
D5214	Mandibular Partial Denture – Cast Metal	**$400**
D5225	Maxillary Partial Denture – Flexible Base	**$400**
D5226	Mandibular Partial Denture – Flexible Base	**$400**
D5281	Removable Unilateral Partial Denture	**$233**
D5810	Temporary Complete Upper Denture	**$200**
D5811	Temporary Complete Lower Denture	**$200**
D5820	Interim Partial Denture (Maxillary)	**$180**
D5821	Interim Partial Denture (Mandibular)	**$180**
D5850	Tissue Conditioning, Maxillary	**$35**
D5851	Tissue Conditioning, Mandibular	**$35**
D5860	Overdenture - Complete, By Report	**$200**
D5861	Overdenture - Partial, By Report	**$200**
D6210	Pontic - Cast High Noble Metal	**$276**
D6211	Pontic - Cast Predominantly Base Metal	**$258**
D6212	Pontic - Cast Noble Metal	**$269**
D6240	Pontic -Porcelain Fused to High Noble Met	**$330**
D6241	Pontic - Porcelain Fused to Base Metal	**$320**
D6242	Pontic - Porcelain Fused To Noble Metal	**$265**
D6245	Pontic - Porcelain/Ceramic	**$281**
D6250	Pontic - Resin With High Noble Metal	**$269**
D6251	Pontic - Resin With Predom Base Metal	**$248**
D6252	Pontic - Resin With Noble Metal	**$256**
D6519	Inlay/Onlay – Porcelain/Ceramic	**$255**
D6520	Inlay - Metallic – Two Surfaces	**$237**
D6530	Inlay - Metallic – Three Or More Surfaces	**$272**
D6543	Onlay - Metallic – Three Surfaces	**$279**
D6544	Onlay - Metallic – Four Or More Surfaces	**$291**

Code	Procedure	Scheduled Benefit
D6545	Retainer-Cast Metal-Resin Fixed Prosthesis	**$114**
D6548	Retainer-Porcelain/Ceramic-Resin Bonded	**$126**
D6600	Inlay -Porcelain/Ceramic-Two Surfaces	**$255**
D6601	Inlay- Porcelain/Ceramic-Three Surfaces	**$255**
D6602	Inlay -High Noble Metal, Two Surfaces	**$255**
D6603	Inlay- High Noble Metal,Three or More Surfaces	**$255**
D6604	Inlay -Base Metal, Two Surfaces	**$255**
D6605	Inlay -Base Metal, Three or More Surfaces	**$255**
D6606	Inlay-Noble Metal, Two Surfaces	**$237**
D6607	Inlay -Noble Metal, Three or More Surfaces	**$272**
D6608	Onlay -Porcelain/Ceramic Two Surfaces	**$272**
D6609	Onlay -Porcelain/Ceramic Three or More Surfaces	**$272**
D6610	Onlay-High Noble Metal Two Surfaces	**$272**
D6611	Onlay High Noble Metal Three or More Surfaces	**$272**
D6612	Onlay Noble Metal Two Surfaces	**$272**
D6613	Onlay Base Metal, Three or More Surfaces	**$272**
D6614	Onlay Noble Metal, Two Surfaces	**$272**
D6615	Onlay Noble Metal, Three or More Surfaces	**$272**
D6720	Crown - Resin With High Noble Metal	**$303**
D6721	Crown - Resin With Predom Base Metal	**$288**
D6722	Crown - Resin With Noble Metal	**$293**
D6740	Crown - Porcelain/Ceramic	**$319**
D6750	Crown-Porcelain Fused to High Noble Met	**$205**
D6751	Crown - Porcelain Fused to Base Metal	**$320**
D6752	Crown - Porcelain Fused to Noble Metal	**$345**
D6780	Crown - 3/4 Cast High Noble Metal	**$293**
D6781	Crown - 3/4 Cast Predominantly Base Met	**$293**
D6782	Crown - 3/4 Cast Noble Metal	**$272**
D6783	Crown - 3/4 Porcelain/Ceramic	**$302**
D6790	Crown - Full Cast High Noble Metal	**$300**
D6791	Crown – Full Cast Predom Base Metal	**$270**
D6792	Crown – Full Cast Noble Metal	**$295**
D9220	General Anesthesia - First 30 Minutes	**$83**
D9221	General Anesthesia - Each Addl 15 Minutes	**$35**
D9241	Intravenous Sedation/Analgesia- 1st 30 Min	**$65**
D9242	Intravenous Sedation- Each Addl 15 Min	**$27**
D9930	Post-Surgical Complication Treatment	**$50**

Out of Pocket Comparison

Code	Procedure	National Average	Red	Red Plus	White	Blue
CLASS I						
D0150	Comprehensive Exam	$40	$18	$0	$0	$0
D0210	Intraoral X-Ray	$104	$28	$0	$0	$0
D1110	Adult Cleaning	$75	$24	$0	$0	$0
D1120	Child Cleaning	$53	$24	$0	$0	$0
CLASS II						
D2140	Amalgam 1 Surface	$121	$28	$28	$0	$24
D7110	Simple Extraction	$123	$38	$38	$0	$24
CLASS III						
D3310	Anterior Root Canal	$542	$185	$185	$0	$271
D2750	Crown Porcelain Fused to High Noble Metal	$838	$350	$350	$0	$419
D2950	Core Buildup		$55	$55	$0	
D2952	Cast Post and Core		$75	$75	$0	
D2970	Temporary Crown Lab Fees Additional		$40	$40	$0	
D5110	Complete Upper Denture Lab Fees Additional	$1,252	$400	$400	$0	$626

- The actual out-of-pocket cost may vary if specialty care dentists are used.
- Lab fees are additional and are not reimbursed by the scheduled insurance plan.
- All procedures listed by ADA code on the QCD “RED” Schedule of Program Fees performed by a QCD Affiliated General Dentist are reimbursed by the scheduled insurance plan at 100% (after deductibles). Includes Class I, II, III.

Claims Information

Fax, mail or email

Complete Itemized Bill to:

QCD of America, INC.
1664 Keller Parkway. Suite 101

Keller, Texas 76248

Fax: 972-726-8559

Email: dorish@qcdofamerica.com

Customer Service

800-229-0304

Dental Networks

Available at www.QCDofAmerica.com

Vision Networks

Available at www.davisvision.com

The **Red** Program

A managed cost dental and vision benefit program

qcd DENTAL BENEFITS

No claim forms, no deductibles and no coverage maximums

Use a QCD affiliated dentist of choice

Pay at time of service according to the QCD schedule of program fees, saving approximately 50% at time of service

Coverage for pre-existing conditions and orthodontic coverage for adults and children

Family coverage defined as entire household regardless of age or relationship

Discount vision benefit included

Sample Dental Procedure	Fee Paid With QCD of America	National Average Dental Fees	Savings with QCD of America
Oral Exam	$9	$40	78%
Full Mouth X-Ray	$28	$104	73%
Teeth Cleaning	$24	$75	68%
Amalgam (1 Surface)	$28	$121	77%
Simple Extraction	$36	$123	71%
Root Canal (1 Canal)	$185	$542	66%
Porcelain w/Metal Crowns (lab fees additional)	$350	$838	59%
Complete Upper or Lower Denture (lab fees additional)	$400	$1,252	69%

1. A fee of $8.00 is charged per appointment for infection control costs. There will be an additional charge for all lab fees less a 20% discount.
2. The schedule represents a sample of highly utilized dental procedures. The average costs are estimated from data gathered in a 2010 Survey of Sample Average National Dental Fees.

- After you sign and turn in your enrollment form, QCD will send you a membership card
- Select any dentist in the QCD Affiliated Dentist Team and make an appointment
- Be sure to identify yourself as a QCD member and the reduced fee schedule will apply to all charges
- Please call the Client Services Department at 972.726.0444 or 800.229.0304 for assistance
- Additional information may be obtained from the website at www.QCDofAmerica.com

The **RED PLUS** Program

A limited reimbursement plan

The program features all of the benefits of the QCD RED managed cost dental & vision benefit program

No deductibles or maximums of coverage

Member pays at time of service according to the QCD schedule of program fees – approximately 50% savings at time of service

Coverage for all pre-existing conditions and orthodontic coverage for adults and children

The RED PLUS program includes reimbursement for limited preventive and diagnostic procedures

Send your bill to QCD for your limited reimbursement to be paid within 6-10 business days

The Following Procedures are reimbursed to the "RED PLUS" Program Member:

Twice Per Calendar Year

Code	Procedures	Scheduled Benefit
D0120	Periodical Oral Evaluation	$9
D0140	Problem Focused Exam	$12
D0150	Comprehensive Oral Exam	$18
D1110	Prophylaxis - Adult	$36
D1120	Prophylaxis - Child	$29
D1203	Fluoride - topical - child	$10
D1204	Fluoride - topical - adult	$10
D0999	Asepsis infection control	$8

Once Per Calendar Year

Code	Procedure	Scheduled Benefit
D0272	Bitewings - Two Films	$21
D0274	Bitewings - Four Films	$29
D0210	Intraoral - Complete Series	$28

Once Every Three Years

Code	Procedure	Scheduled Benefit
D0330	Panoramic Film	$53.00

The **White** Program

A comprehensive reimbursement plan

qcd DENTAL BENEFITS

Use your QCD affiliated dentist of choice and pay per RED schedule saving 50%

Get your bill complete with procedure codes

Send your bill to QCD for reimbursement within 6-10 business days

$1,500 reimbursement maximum per calendar year per plan member

Any service performed by a QCD General Dentist and listed by code on the RED schedule of program fees is reimbursed at 100% (after deductibles)

Represents approximately 93% of paid claims and includes major services

Virtually eliminates out-of-pocket costs

Out-of-network benefits paid to member

Credit towards waiting periods applied

Child and adult orthodontics included with a brand new $1,000 life maximum

Make your co-payment – Get your co-payment reimbursed (100% in most cases)

CODE	PROCEDURE	QCD PROGRAM CHARGE	INSURANCE PAYMENT	ESTIMATED OUT-OF-POCKET
[CLASS I]				
D0150	Comprehensive Exam	$18	$18	$0
D0210	Intraoral X-ray	$28	$28	$0
D1110	Adult Cleaning	$24	$24	$0
D1120	Child Cleaning	$24	$24	$0
D1203	Fluoride Child	$5	$5	$0
D1351	Sealant Tooth	$14	$14	$0
[CLASS II]				$0
D2140	Amalgam 1 Surface	$28	$28	$0
D2330	Comp. Resin 1 Surface	$38	$38	$0
D3310	Anterior Root Canal	$185	$185	$0
D3320	Bicuspid Root Canal	$209	$209	$0
D4210	Gingivectomy Per Quad	$180	$180	$0
[CLASS III]				$0
D2750	Crown Porcelain Fused to High Noble Metal	$350	$350	$0
D2950	Core Buildup	$55	$55	$0
D2952	Cast Post & Core	$75	$75	$0
D2970	Temporary Crown	$40	$40	$0
D5110	Complete Upper Denture	$400	$400	$0

- The actual out-of-pocket cost may vary if specialty care dentists are used
- Lab fees are additional and are not reimbursed by the scheduled insurance plan
- All procedures listed by ADA code on the QCD "RED" schedule of program fees and performed by a QCD affiliated General Dentists are reimbursed by the scheduled insurance plan at 100% of the reimbursment schedule(after deductibles). Includes Class I, II, and III.

The **BLUE** Program

An insurance plan

Traditional dental insurance

No network – use any dentist

Full benefits are paid to any dentist

Pays $1,000 per calendar year

Credit towards waiting periods applied

Child orthodontics included with $1,000 life maximum

CLASS	BENEFIT BEGINS	COVERAGE	DEDUCTIBLE (per person)	COINSURANCE (plan pays)
Class I Preventive Dental Services	Immediately	Exams, X-Rays, Cleanings	$0**	100%
Class II Basic Dental Services	After 3 Months of Coverage	Fillings Extractions	$50**	80%
Class III Major Dental Services	After 12 Months of Coverage	Bridges, Crowns, Dentures, Oral Surgery, Periodontal, Root Canals	$50**	50%

*Reasonable and customary fees are charges that do not exceed the general level of charges being made by other providers of dental services in the geographic area where the charge is incurred.

**Combined Class II and III deductible. Deductible has been waived for Class I services

Orthodontia

Lifetime Maximum Limit	$500 Per Calendar Year/$1,000 Lifetime	
Percentage Payable, after Deductible	50% of Usual & Customary Rate	
Deductible Amount Each Calendar Year	None	
Waiting Period	White/12 Month	Blue/12 Month

Code	Procedure	Scheduled Benefit
D8010	Initial Consultation	Usual, Customary & Reasonable
D8020	Diagnostic Evaluation (including x-rays)	Usual, Customary & Reasonable
D8030	Orthodontic Treatment of the Adolescent	Usual, Customary & Reasonable
D8080	24 Month Treatment	Usual, Customary & Reasonable
D8210	Retainers (Each)	Usual, Customary & Reasonable
D8680	Orthodontic Retention	Usual, Customary & Reasonable
D8999	Diagnostic Work Up Radiographs, Model,	Usual, Customary & Reasonable

Orthodontic Dental Services

We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this Certificate. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the Effect of Prior Plan provision. We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

We will pay the co-insurance percentage amount shown in the Schedule after any required deductible for orthodontic services has been satisfied for the Certificate Year. The maximum benefit payable to each covered dependent child, while insured under the policy, for orthodontic services is shown in the Schedule. Those who receive orthodontic coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

We will make a payment for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in equal quarterly installments over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and quarterly installments will be determined as follows:

1. We will determine the lesser of the Reasonable and Customary charge and the orthodontist's fee and multiply that amount by the co-insurance rate shown in the Schedule.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule will be the maximum benefit payable. An initial amount of 25% of the maximum benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.
3. The remaining 75% of the maximum benefit payable will be divided by the number of quarters that orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of orthodontic treatment. The subsequent quarterly payments will be made only if Your dependent remains insured under this Certificate and provides proof to Us that orthodontic treatment continues. If orthodontic treatment continues after the maximum benefit payable has been paid, no further benefits will be paid.

Blue plan benefits are limited to Children Only Under the Age of 19.

BLUE PLAN - EXCLUSIONS AND LIMITATIONS FROM COVERAGE

Benefits will not be paid for dental expenses arising from or in connection with:

1. Treatment, services or supplies which:
   - A. Are not Medically Necessary;
   - B. Are not prescribed by a Dentist;
   - C. Are determined to be Experimental/Investigational in nature by Us;
   - D. Are received without charge or legal obligation to pay;
   - E. Would not routinely be paid in the absence of insurance;
   - F. Are not Covered Procedures.
2. Intentionally Self-inflicted injuries.
3. War or an act of war, whether or not declared.
4. A Covered Person's commission of a felony or an assault on another person.
5. Riot, nuclear accident, or a major disaster when the Insured is an active participant.
6. Employment; whether caused by, related to, or as a condition of employment, including self-employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges.
7. Treatment which began, before the Covered Person's Effective Date of coverage or after the Covered Person's termination of coverage.
8. Congenital or development malformations existing when the Covered Person's coverage became effective under this Certificate.
9. Cosmetic procedures, unless the coverage is elected by the Policyholder and the required premium is paid.
10. Implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments, unless the coverage is elected by the Policyholder and the required premium is paid.
11. Periodontal splinting.
12. Porcelain on crowns, or pontics posterior to the 2nd bicuspid.
13. Replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any 5 year period.
14. Relining of dentures more often than once in any 2 year period.
15. Lost, stolen, or missing dentures or bridges or for duplicates.
16. Fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of coverage under this Certificate. Benefits may be payable for bridgework required for loss of teeth while covered under this Certificate, if such bridgework is not an abutment for non-covered bridgework.
17. Prescription Drugs and analgesia pre-medication.
18. Telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending Dentist statements, and any other services or supplies which are not part of the direct treatment of the Covered Person.
19. Dental education or training programs including oral hygiene or plaque control programs.
20. Counseling on diet and nutrition.
21. Military service, including service in a military reserve unit.
22. Orthodontia, unless this coverage is elected by the Policyholder and the required premium is paid.
23. Prosthodontics, unless this coverage is elected by the Policyholder and the required premium is paid.
24. Charges payable under any medical insurance.
25. Charges made by any government entity unless the Covered Person is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made.
26. Use of materials, other than fluorides or sealants, to prevent tooth decay.
27. Bite registrations.
28. Bacteriologic cultures in connection with a covered dental service.
29. Therapeutic injections administered by a Dentist.
30. Cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling).
31. Replacement of 3rd molars.
32. Composites on teeth posterior to the 2nd bicuspid.
33. Crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.
34. Temporomandibular joint syndrome.

qcd WELLNESS PROGRAM

QCD of America Discount Prescription Card

www.QCDofAmerica.com

Save up to 80% on your prescriptions and your pet's prescriptions. Simply present this card at a network pharmacy.

No Fees
No Expiration Date

Pre-Activated Card
Use it over and over!

- ✓ **Up to 80% on generic medications**
- ✓ **Up to 20% on name brand prescriptions**
- ✓ **Up to 80% on your PET'S medications too!**
- ✓ **Unlike many other programs and discounts,QCD Wellness Rx Card is FREE to people of ALL AGES**
- ✓ **This is NOT an insurance program or membership club Your FREE discount drug card simply entitles you to a discount off the purchase price of prescription drugs**

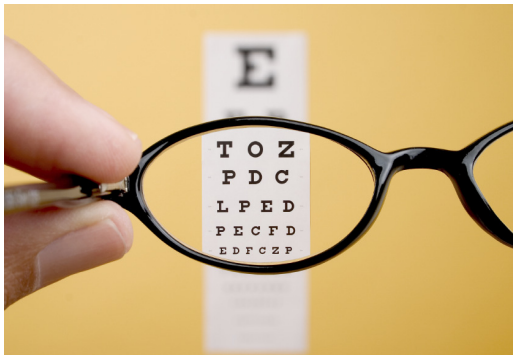
Clear Vision Discount Program

Davis Vision is pleased to provide you with a no-cost, traditional vision Discount Program that provides significant discounts on eye exams, lenses, frames and additional eyewear options. For more details, see the Accessing Provider Information section on the reverse side.

The Discount Program entitles you to the following discounts off usual and customary fees:

Comprehensive Eye Exam		
Complete Eye Examination	15% Discount off Usual & Customary	
Contact Lens Examination	15% Discount off Usual & Customary	
Frame/[1]	**Patient Price**	**Average Discount**
Priced up to $70 Retail	$40	40%
Priced over $70 Retail	$40 plus 10% off the amount over $70	28%
Spectacle Lenses (Uncoated Plastic)		
Single	$35	30%
Bifocal	$55	27%
Trifocal	$65	28%
Lenticular	$110	31%
Lens Options (Add to Lens Prices Above)/[2]		
Standard Progressive	$75	50%
Premium Progressive	$125	35%-60%
Glass Lenses	$18	40%
Polycarbonate Lenses	$30	50%
Blended Invisible Bifocals	$20	60%
Intermediate Vision Lenses	$30	80%
Scratch Resistant Coating	$20	33%-66%
Standard Anti-Reflective Coating	$45	20%
Ultraviolet Coating	$15	25%
Solid Tint	$10	30%
Gradient Tint	$12	20%
Photochromic Lenses	$35	20%-45%
Plastic Photosensitive Lenses	$65	35%-55%
High Index Lenses	$55	40%
Polarized Lenses	$75	20%
Contact Lenses (in lieu of eyeglasses)		
Conventional	20% off Provider's Usual & Customary	20%
Disposable/Planned Replacement	10% off Provider's Usual & Customary	10%
Value-Added Features		
Lens 1-2-3!® Membership	Free Membership	Up to 50%
Laser Vision Correction Discount	Up to 25% off Provider's U & C[/3]	Up to 25%

1/ At Wal-Mart locations, members will receive Wal-Mart's everyday low price on frame and contact lens purchases.
2/ Special lens designs, materials, powers, and frames may require additional cost.
3/ Or receive an additional 5% discount on any advertised specials-whichever is lower.



Clear Vision Discount Program Highlights

Vision Plan: Clear Vision Discount Plan **Control Code:** 2959 **Co-payment:** N/A, discount plan is 100% member paid at the time of service

Eye Examination – Members will receive a 15% discount on their comprehensive eye examination including dilation (when professionally indicated).

Eyewear (Frames and Spectacle Lenses or Contact Lenses) – Members will be entitled to substantial and verifiable savings on all of their eyewear needs. Discounts are uniform nationally and represent pricing well below Average Retail Prices. These discounts are based on published industry standard costs, not markdowns from artificially inflated prices.

Significant Savings – Client surveys indicate that programs providing discounts off retail prices of eyeglasses are subject to abuse due to the high associated markups of over 300% throughout the optical industry. Consequently, these programs do not result in a true "value-add" for the beneficiary. The proposed fixed-fee discounted pricing schedule provides both verifiable savings and benefit uniformity for all members from coast to coast.

Additional Value-Added Features – The Clear Vision Discount Program also offers significant discounts on replacement contact lenses and laser vision correction at no additional cost.

- Lens 123® is a mail order program that allows you to enjoy the guaranteed lowest prices on replacement contact lenses—save up to 60% off retail prices. Members can conveniently call 1-800-LENS123 with a current prescription for this value-added service. The Lens 123® contact lens replacement program is endorsed by the industry's major manufacturers.
- Davis Vision's Laser Vision Correction program provides substantial discounts on laser vision correction procedures. Members are entitled to savings of up to 25% off usual and customary fees or a 5% discount off a center's advertised special through a network of preeminent physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.) See below for information on finding a participating laser vision provider near you.

Accessing a Provider – Contact a Davis Vision representative at 1-888-897-9347 or simply log on to www.davisvision.com, choose "Find a Provider" and use your control code 2959

Customer Service -To speak with a customer service representative, call Davis Vision Customer Service at 1877-923-2847. Enter Client Control Number 2959 when prompted. At the main menu, press "0". Our representatives are available to assist you from 8 a.m. to 11 p.m. ET Monday through Friday, 9 a.m. to 4 p.m. ET Saturday and 12 p.m. to 4 p.m. ET Sunday.

DAVIS VISION
EYECARE REFRAMED℠

qcd DENTAL BENEFITS

Your Davis Vision Plan Benefits

Healthy eyes and clear vision are an important part of your overall health and quality of life. With the rising cost of eyewear you can't afford not to be covered through a managed vision care plan. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection (not available for fashion plan).

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and enter Client Code **2960** for Fashion Vision Plan, **2965** for Designer Vision Plan or **2971** for Designer Gold Vision Plan to locate a provider near you.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Lower costs and more benefits! *See the savings!*

SERVICES	WITHOUT DAVIS VISION	WITH DAVIS VISION		
		Fashion Vision Plan	Designer Vision Plan	Designer Gold Vision Plan
Eye Examination	$103	$10	$10	$10
Lenses				
Bifocals	$116	$25	$25	$25
Scratch-Resistant Coating	$25	$0	$0	$0
Transitions®/1	$110	$70	$65	$65
Frame	$160	$40	$16	$0
TOTAL COST	$514	$145	$116	$100
TOTAL SAVINGS		$369	$398	$414

Contact your Human Resources department today to enroll.

For more details about the plan, Just log on to the Open Enrollment section of our Member site at **davisvision.com** or call **1.877.923.2847** and enter Client Code **2960** for Fashion Vision Plan, **2965** for Designer Vision Plan or **2971** for Designer Gold Vision Plan.

Employee Rates	MONTHLY			ANNUALLY		
	Fashion	Designer	Designer Gold	Fashion	Designer	Designer Gold
Employee	$7.95	$9.95	$11.95	$95.40	$119.40	$143.40
Employee plus One	$14.95	$19.95	$24.95	$179.40	$239.40	$299.40
Employee plus Family	$19.95	$24.95	$29.95	$239.40	$299.40	$359.40

1/ Transitions® is a registered trademark of Transitions Optical Inc.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

OE00488 5/15/17

Plan Coverage & Cost Comparison

In-Network Benefits		Davis Vision Plan		
		Fashion Plan	Designer Plan	Designer Gold Plan
Frequency (once every)	Eye Examination	12 months	12 months	12 months
	Contact Lens Evaluation & Fitting	12 months	12 months	12 months
	Frame	24 months	24 months	24 months
	Spectacle Lenses	12 months	12 months	12 months
	Contact Lenses (in lieu of eyeglasses)	12 months	12 months	12 months
Copay	Eye Examination	$10	$10	$10
	Spectacle Lenses	$25	$25	$25
	Contact Lens Evaluation, Fitting & Follow up Care	$0	$0	$0
	Contact Lens	$0	$25	$25
Frames	Any frame in the provider's office	$100 allowance Plus 20% off balance [2]	$130 allowance Plus 20% off balance [2]	$150 allowance Plus 20% off balance [2]
	Davis Vision's Frame Collection[3] (in lieu of Allowance)			
	Fashion frame	Included	Included	Included
	Designer frame	$15	Included	Included
	Premier frame	$40	$25	$25
Spectacle Lenses	Single Vision, Lined Bifocal or Trifocal	Included	Included	Included
	Gradient Tint	$15	Included	Included
	Solid Tint	$15	Included	Included
	Scratch-Resistant Coating	Included	Included	Included
	Polycarbonate Lenses	$35	$0 or $30[4]	Included
	Ultraviolet Coating	$15	$12	Included
	Intermediate-Vision Lenses	$30	$30	Included
	Standard Anti-Reflective (AR) Coating	$40	$35	$35
	Premium AR Coating	$55	$48	$48
	Ultra AR Coating	$69	$60	$60
	Standard Progressive Lenses	$65	$50	Included
	Premium Progressives	$105	$90	$40
	Ultra Progressives	$140	$140	$90
	High-Index Lenses	$60	$55	$55
	Polarized Lenses	$75	$75	$75
	Plastic Photosensitive Lenses	$70	$65	$65
	Scratch Protection Plan (Single Vision | Multifocal)	$20 | $40	$20 | $40	$20 | $40
Contacts	Contact Lens Evaluation & Fitting			
	- Collection Contacts	N/A	Included	Included
	- Standard Lens Type	15% discount[2]	15% discount[2]	Included
	- Specialty Lens Type	15% discount[2]	15% discount[2]	$60 allowance with 15% off balance
	Non-Collection Contact Lenses	$100 allowance Plus 20% off balance [2]	$130 allowance Plus 20% off balance [2]	$150 allowance Plus 20% off balance [2]
	Davis Vision's Contact Lens Collection[3]			
	Disposable	N/A	4 boxes/multi-packs	8 boxes/multi-packs
	Planned Replacements	N/A	2 boxes/multi-packs	4 boxes/multi-packs
	Medically Necessary (with prior approval)	Included	Included	Included
Out-of-Network Reimbursement Schedule				
	Eye Examination	Up to $30	Up to $30	Up to $40
	Frames	Up to $30	Up to $30	Up to $60
	Spectacle Lenses (Single Vision | Bifocal/Progressive lenses | Trifocal | Lenticular)	Up to $25 | $35 | $45 | $60	Up to $25 | $35 | $45 | $60	Up to $35 | $45 | $60 | $80
	Contact Lenses (Elective | Medically Necessary)	Up to $75 | Up to $225	Up to $75 | Up to $225	Up to $150 | Up to $225

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site and click "Find a Provider" for a provider, including:

Visionworks

[1] At Walmart or Sam's Club locations, members will receive Walmart's/Sam's Club everyday low price on eye examination, frame and contact lens purchases.
[2] At Walmart or Sam's Club locations, members will receive the full allowances toward Walmart's/Sam's Club everyday low prices. Additional discounts not applicable.
[3] Collection is available at most participating independent provider offices. Collection is subject to change. All contact lenses in Collection are single vision spherical lenses.
[4] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

DC Administrators Online

Log In Online to View Claim EOB's

1. Log in to the online portal under "Group Member Access" & enter your Group ID: DALLP
2. Under Plan Participants, select the Claims tab
3. Select a Patient from the drop down menu
4. Click on any claim number to view the Explanation of Benefits (EOB)
5. EOB's remain accessible through the secure website, but you may also print a copy for your records

CALL 1-844-257-0684 WITH QUESTIONS

You now have accress to your dental plan information. As a new member with DC Administrators, we want to help you understand the tools you have to help you get the most from your dental plan.

To increase your access to timely information, **DC Administrators provides online access to your dental plan. The information provided includes Viewing & Submission of Claims, Explanation of Benefits, Printing ID cards, Accumulators list and more.**

Below are simple instructions for accessing your dental plan information online.

- **Go to www.QCDofAmerica.com**
- **On the home page click on Group Member Access & enter your Group ID- DALLP**
- **Login using the following data under Plan Participants:**
  - **Username: Member ID (on your card) or SSN**
  - **Password: Date of Birth (mmddyyyy)**

If you do not have internet access, please contact our customer service team at 1-844-257-0684.

We look forward to serving you!

The Red Program

Group Enrollment

Please complete all information and sign. Please print all information.

SUBSCRIBER INFORMATION

☐ New QCD Member ☐ Existing QCD Member making changes

Last Name	First Name	MI	Date of Birth
Address	City	State	Zip
Social Security Number	Telephone		
Company Name	Effective Date	Hire Date	

COVERAGE SELECTED

☐ Employee Only
☐ Employee and One
☐ Employee and Family

DEPENDENT INFORMATION

Social Security Number	Last Name	First Name	MI	Date of Birth	Gender	Relationship

I hereby make application for membership in QCD of America® (QCD). I agree to hold QCD harmless from any liability for negligence on the part of the Affiliated Dentist. I further release QCD from and waive any claims for negligent referral, negligent certification or similar claim. I hereby authorize my employer to make payroll deductions, if required, for the coverage selected. The QCD of America Dental and Vision Benefit Program is not an insurance plan and does not constitute insurance coverage.

Date _____ Applicant Signature _____

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
ONE MOODY PLAZA, GALVESTON, TEXAS

DENTAL ENROLLMENT FORM

PLEASE PRINT IN SPACE PROVIDED

RED PLUS ☐ WHITE ☐ BLUE ☐

EMPLOYER INFORMATION					
EMPLOYER NAME			LOCATION		GROUP NO.
[EMPLOYEE][APPLICANT]					
LAST NAME		FIRST NAME			M.I.
STREET ADDRESS		CITY		STATE	ZIP
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ( )			BIRTH DATE / /
SEX MALE ☐ FEMALE ☐	EMPLOYMENT DATE MM / DD / YY	MARITAL STATUS SINGLE ☐ MARRIED ☐	OCCUPATION/TITLE		EMPLOYMENT STATUS ACTIVE ☐ INACTIVE ☐

COVERAGE – Check Those That Apply

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE:____________

DEPENDENT INFORMATION			
SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE?____________________
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:

____

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN
REASON FOR REFUSAL:____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group dental plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage, treatments, and services I may receive may be distributed and disclosed to my employer. I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE
SIGNATURE OF [EMPLOYEE][APPLICANT]	

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
ONE MOODY PLAZA, GALVESTON, TEXAS

VISION ENROLLMENT FORM

PLEASE PRINT IN SPACE PROVIDED

☐ FASHION VISION ☐ DESIGNER VISION ☐ DESIGNER GOLD VISION

EMPLOYER INFORMATION

EMPLOYER NAME	LOCATION	GROUP NO.

[EMPLOYEE][APPLICANT]

LAST NAME	FIRST NAME		M.I.
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )		BIRTH DATE / /

SEX	EMPLOYMENT DATE	MARITAL STATUS	OCCUPATION/TITLE	EMPLOYMENT STATUS
MALE ☐ FEMALE ☐	MM DD YY / /	SINGLE ☐ MARRIED ☐		ACTIVE ☐ INACTIVE ☐

COVERAGE – Check Those That Apply

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE:___________

DEPENDENT INFORMATION

SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No

WILL YOU OR ANY DEPENDENT HAVE OTHER VISION INSURANCE COVERAGE?____________________
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:
____

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN
REASON FOR REFUSAL:____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group vision plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage, treatments, and services I may receive may be distributed and disclosed to my employer. I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE

SIGNATURE OF [EMPLOYEE][APPLICANT]