

# SHELTON SCHOOL & EVALUATION CENTER



Consumer Driven Choices	RED PLUS	WHITE**	BLUE
<b>Monthly Rates</b>		With Ortho	With Ortho
Employee Only	<b>\$9.16</b>	<b>\$33.56</b>	<b>\$59.13</b>
Employee + Spouse	<b>\$17.36</b>	<b>\$74.26</b>	<b>\$118.25</b>
Employee + Child(ren)	<b>\$24.56</b>	<b>\$78.26</b>	<b>\$132.68</b>
Employee + Family	<b>\$27.66</b>	<b>\$116.76</b>	<b>\$210.54</b>
	A Limited Reimbursement Program	A Comprehensive Reimbursement Program	Traditional Dental Insurance
Calendar Year Deductible:	No Deductible	\$50/\$150 ( Basic & Major )	\$50/\$150 ( Basic & Major )
Calendar Year Max Benefit:	No Maximum	\$1,500	\$1,000
Reimbursement %	100% Class I - 2/yr	100%***	80th Percentile
<b>PREVENTIVE SERVICES - CLASS I</b>			
Waiting Period	<b>None</b>	<b>None</b>	<b>None</b>
Office Visit	<b>No Charge</b>	<b>No Charge In-Network</b>	
Routine Exams	100%**	100%*** In-Network	
Cleaning	100%**	QCD General Dentist Only	
X-rays Complete Series	100%**		100% of UCR
Sealants	See Schedule	See Reimbursement Schedule for	
Fluoride Treatment	100%**	Out-of-Network Benefits	
Space Maintainers	See Schedule		
<b>BASIC SERVICES - CLASS II</b>			
Waiting Period	<b>None</b>	<b>None</b>	<b>3 Months</b>
Extractions			
Fillings	See Reduced Fee Schedule (Approximately 50% Savings)	100%*** In-Network QCD General Dentist Only  See Reimbursement Schedule for Out-of-Network Benefits	80% of UCR
<b>MAJOR SERVICES - CLASS III</b>			
Waiting Period	<b>None</b>	<b>None</b>	<b>12 Months</b>
Crowns			
Bridges			
Inlays/onlays	See Reduced Fee Schedule (Approximately 50% Savings)	100%*** In-Network QCD General Dentist Only  See Reimbursement Schedule for Out-of-Network Benefits	50% of UCR
Dentures			
Endo/Perio			
Oral Surgery			
<b>ORTHODONTIA</b>			
Waiting Period	<b>None</b>	<b>None</b>	<b>12 Months</b>
Lifetime Maximum	None	Life Max \$1,000	Life Max \$1000
Coverage	20% Discount for Children & Adults	Children & Adults	Children Only up to age 19
<b>SPECIAL PROGRAM FEATURES</b>			
	Benefit Level of a DHMO without the Operational Problems	No Frequency Limitations No Waiting Periods	Use Any Dentist No Network Involved
<b>QCD Clear Vision Discount Program (Included In All Dental Plans)</b>			
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	Lenticular \$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 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 Schedule of Program Fees at 100% (After Deductibles). Lab fees are additional and not reimbursed.		

# Schedule of Programs Fees



Procedure Number	Member Fee	Procedure Number	Member Fee
<b>DIAGNOSTIC DENTISTRY</b>		<b>ENDODONTICS</b>	
D0120	PERIODICAL ORAL EXAMINATION .....\$9.00	D3110	PULP CAP, DIRECT.....\$19.00
D0140	LIMITED ORAL EXAMINATION, PROBLEM FOCUSED .....\$12.00	D3120	PULP CAP, INDIRECT .....\$24.00
D0150	COMPREHENSIVE ORAL EXAMINATION .....\$18.00	D3220	PULPOTOMY.....\$35.00
D0210	INTRAORAL X - RAY COMPLETE SERIES .....\$28.00	D3310	ROOT CANAL, ANTERIOR.....\$159.00
D0460	PULP VITALITY TEST.....\$15.00	D3320	ROOT CANAL, BICUSPID.....\$209.00
D9999	ASEPSIS FEE (INFECTION CONTROL) .....\$8.00	D3330	ROOT CANAL, MOLAR.....\$259.00
	ALL BITEWING / SINGLE FILM X-RAYS.....20% DISCOUNT	D3920	HEMISECTIO.....\$65.00
<b>PREVENTATIVE DENTISTRY</b>		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.	
D1110	PROPHYLAXIS – ADULT .....\$24.00	<b>PERIODONTICS</b>	
D1120	PROPHYLAXIS – CHILD .....\$24.00	D4210	GINGIVECTOMY/GINGIVOPLASTY –(PER QUADRANT)....\$180.00
D1203	APPLICATION TOPICAL FLUORIDE – CHILD.....\$5.00	D4211	GINGIVECTOMY/GINGIVOPLASTY - (PER TOOTH).....\$50.00
D1204	APPLICATION TOPICAL FLUORIDE – ADULT .....\$5.00	D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - (PER QUADRANT) .....\$200.00
D1351	SEALANT-PER TOOTH .....\$14.00	D4260	OSSEOUS SURGERY-(PER QUADRANT) (INCLUDING FLAP ENTRY AND CLOSURE) .....\$260.00
D1510	SPACE MAINTAINER - FIXED UNILATERAL .....\$60.00	D4341	PERIODONTAL SCALING AND ROOT PLANING - (PER QUADRANT).....\$75.00
D1515	SPACE MAINTAINER - FIXED BILATERAL .....\$75.00	D4355	FULL MOUTH DEBRIDEMENT .....\$70.00
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.		D4910	PERIODONTAL MAINTENANCE PROCEDURES FOLLOWING ACTIVE THERAPY .....\$30.00
<b>COSMETIC</b>		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.	
	ALL COSMETIC DENTISTRY .....20% DISCOUNT	<b>PROSTHODONTICS – REMOVABLE</b>	
<b>RESTORATIVE DENTISTRY</b>		(LAB FEES ADDITIONAL COST)	
D2140	AMALGAM - 1 SURFACE, PRIMARY OR PERMANENT .....\$28.00	D5110	COMPLETE UPPER DENTURE (INCLUDING SIX MONTHS POST CARE) .....\$400.00
D2150	AMALGAM - 2 SURFACES, PRIMARY OR PERMANENT .....\$36.00	D5120	COMPLETE LOWER DENTURE (INCLUDING SIX MONTHS POST CARE) .....\$400.00
D2160	AMALGAM - 3 SURFACES, PRIMARY OR PERMANENT .....\$46.00	D5130	IMMEDIATE UPPER.....\$420.00
D2161	AMALGAM - 4 OR MORE SURFACES, PRIMARY OR PERMANENT .....\$56.00	D5140	IMMEDIATE LOWER.....\$420.00
D2330	COMPOSITE RESIN - 1 SURFACE, ANTERIOR .....\$38.00	D5211	UPPER PARTIAL DENTURE – RESIN BASE.....\$250.00
D2331	COMPOSITE RESIN - 2 SURFACES, ANTERIOR.....\$46.00	D5212	LOWER PARTIAL DENTURE – RESIN BASE.....\$250.00
D2332	COMPOSITE RESIN - 3 SURFACES, ANTERIOR.....\$56.00	D5213	UPPER PARTIAL – PREDOMINANTLY CAST BASE .....\$400.00
D2335	COMPOSITE RESIN - 4 OR MORE SURFACES OR INVOLVING INCISAL ANGLE, ANTERIOR .....\$66.00	D5214	LOWER PARTIAL – PREDOMINANTLY CAST BASE .....\$400.00
D2391	COMPOSITE RESIN - 1 SURFACE, POSTERIOR.....\$50.00	D5410	ADJUST COMPLETE DENTURE .....\$15.00
D2392	COMPOSITE RESIN - 2 SURFACES, POSTERIOR.....\$65.00	D5510	REPAIR BROKEN COMPLETE DENTURE BASE .....\$40.00
D2393	COMPOSITE RESIN - 3 SURFACES, POSTERIOR.....\$85.00	D5610	REPAIR RESIN DENTURE BASE .....\$35.00
D2394	COMPOSITE RESIN - 4 OR MORE SURFACES, POSTERIOR.....\$95.00	D5630	REPAIR OR REPLACE BROKEN CLASP.....\$45.00
D2750	CROWN - PORCELAIN TO HIGH NOBLE METAL (GOLD AND LAB FEES ADDITIONAL) .....\$350.00	D5640	REPLACE BROKEN TEETH – (PER TOOTH) .....\$30.00
D2751	CROWN - PORCELAIN TO BASE METAL (LAB FEES ADDITIONAL) .....\$320.00	D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE .....\$45.00
D2920	CEMENT CROWN .....\$20.00	D5660	ADD CLASP TO EXISTING PARTIAL DENTURE .....\$65.00
D2931	PREFABRICATED STAINLESS STEEL CROWN .....\$48.00	D5730	RELINE COMPLETE UPPER (CHAIRSIDE) .....\$75.00
D2940	SEDATIVE FILLING .....\$16.00	D5731	RELINE COMPLETE LOWER (CHAIRSIDE).....\$75.00
D2950	CORE BUILDUP, (INCLUDING ANY PINS) .....\$55.00	D5740	RELINE UPPER PARTIAL (CHAIRSIDE) .....\$75.00
D2951	PIN RETENTION – (PER TOOTH) .....\$20.00	D5741	RELINE LOWER PARTIAL (CHAIRSIDE).....\$75.00
D2952	CAST POST AND CORE IN ADDITION TO CROWN .....\$75.00	D5810	TEMPORARY COMPLETE UPPER DENTURE.....\$200.00
D2953	EACH ADDITIONAL CAST POST (SAME TOOTH) .....\$40.00	D5811	TEMPORARY COMPLETE LOWER DENTURE .....\$200.00
D2954	PREFAB POST / CORE IN ADDITION TO CROWN .....\$60.00	D5820	TEMPORARY PARTIAL - STAY PLATE UPPER.....\$180.00
D2970	TEMPORARY CROWN (FRACTURED TOOTH) .....\$40.00	D5821	TEMPORARY PARTIAL - STAY PLATE LOWER.....\$180.00

# Schedule of Programs Fees (Continued)



PROSTHODONTICS – FIXED BRIDGES	SPECIALTY CARE SERVICES
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	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.
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.	OTHER PROCEDURES AND PAYMENT FOR SERVICES
ORAL SURGERY	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
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 UNUSUAL 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	ASEPSIS FEE
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	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.
ORTHODONTICS (QCD GENERAL DENTIST ONLY)	QCD OF AMERICA® - EXCLUSIONS AND LIMITATIONS
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	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.
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.	

# 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

The Following Procedures are reimbursed to the "RED PLUS" Program Member within 6-10 Business Days:

## 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



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

No waiting periods for any new or existing employees

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

Out-of-network benefits paid to member

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

CODE	PROCEDURE	QCD PROGRAM CHARGE	INSURANCE PAYMENT	ESTIMATED OUT-OF-POCKET
<b>[CLASS I]</b>				
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
<b>[CLASS II]</b>				\$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
<b>[CLASS III]</b>				\$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% (after deductibles). Includes Class I, II, and III.

# QCD White 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

NONE

Class III

NONE

## 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	Unspecified Preventive	\$8
D9110	Emergency Palliative Treatment	\$41
D9310	Consultation, Second Opinion	\$50
D9999	Infection Control	\$8

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 – Posterior 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	Apexification/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 Reimplantation	\$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
D5863	Overdenture Complete Max	\$200
D5864	Overdenture Partial Max	\$200
D5865	Overdenture Complete Man	\$200
D5866	Overdenture Partial Man	\$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

Code	Procedure	Scheduled Benefit
D6530	Inlay - Metallic – Three Or More Surfaces	\$272
D6543	Onlay - Metallic – Three Surfaces	\$279
D6544	Onlay - Metallic – Four Or More Surfaces	\$291
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
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- 1 <sup>st</sup> 30 Min	\$65
D9242	Intravenous Sedation- Each Addl 15 Min	\$27
D9930	Post-Surgical Complication Treatment	\$50

# 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

## 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 2<sup>nd</sup> 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 3<sup>rd</sup> molars.
32. Composites on teeth posterior to the 2<sup>nd</sup> 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.

# 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/No Waiting Period	Blue/12 Months

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.

Benefits are limited to Children Only Under the Age of 19 on the Blue Plan.

## Fax, mail or email

Complete Itemized Bill to:

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

Keller, Texas 76248

Fax: 972-726-8559

Email: [dorish@qcdofamerica.com](mailto:dorish@qcdofamerica.com)

## Customer Service

800-229-0304

## Dental Networks

Available at [www.QCDofAmerica.com](http://www.QCDofAmerica.com)

## Vision Networks

Available at [www.davisvision.com](http://www.davisvision.com)

## 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: SHSC2
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 access 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.

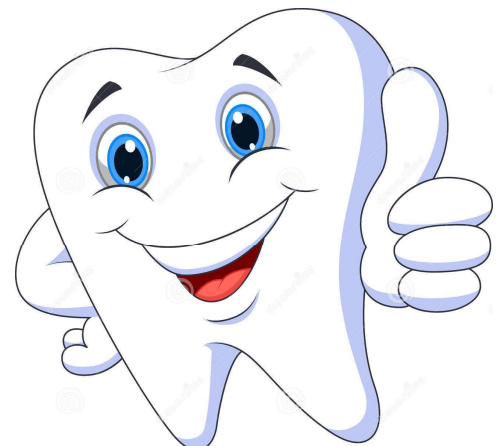
To increase your access to timely information, **DC Administrators provides online access to your dental plan. The information provided includes Viewing & Submission of Claims, Explanation of Benefits, Printing ID cards, Accumulators list and more.**

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

- Go to [www.QCDofAmerica.com](http://www.QCDofAmerica.com)
- On the home page click on Group Member Access & enter your Group ID- **SHSC2**
- 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!**



# 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:

<b>Comprehensive Eye Exam</b>		
Complete Eye Examination	15% Discount off Usual & Customary	
Contact Lens Examination	15% Discount off Usual & Customary	
<b>Frame<sup>1</sup></b>	<b>Patient Price</b>	<b>Average Discount</b>
Priced up to \$70 Retail	\$40	40%
Priced over \$70 Retail	\$40 plus 10% off the amount over \$70	28%
<b>Spectacle Lenses (Uncoated Plastic)</b>		
Single	\$35	30%
Bifocal	\$55	27%
Trifocal	\$65	28%
Lenticular	\$110	31%
<b>Lens Options (Add to Lens Prices Above)<sup>2</sup></b>		
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%
<b>Contact Lenses (in lieu of eyeglasses)</b>		
Conventional	20% off Provider's Usual & Customary	20%
Disposable/Planned Replacement	10% off Provider's Usual & Customary	10%
<b>Value-Added Features</b>		
Lens 1-2-3! <sup>®</sup> Membership	Free Membership	Up to 50%
Laser Vision Correction Discount	Up to 25% off Provider's U & C <sup>3</sup>	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](http://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.



# qcd | WELLNESS PROGRAM

## QCD of America Discount Prescription Card

[www.QCDofAmerica.com](http://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 medications.
- ✓ 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. QCD Discount RX Card is administered by RxCareCard.

*To print your card, visit [www.QCDofAmerica.com](http://www.QCDofAmerica.com) and click on Wellness Program!*