

Consumer Driven Choices	RED*	RED PLUS	WHITE**	BLUE
Monthly Rates			With Ortho	With Ortho
Employee Only	No Charge	\$8.95	\$24.95	\$34.66
Employee + One	\$8.00	\$18.95	\$49.95	\$71.42
Employee + Family	\$12.00	\$28.95	\$74.95	\$120.08
	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	No Charge	No Charge	No Charge In-Network	
Routine Exams		100%*** of the Reimbursement Schedule	100%*** of the Reimbursement Schedule	
Cleaning	See Reduced Fee Schedule (Approximately 50% Savings)	QCD General Dentist Only	QCD General Dentist Only	100% of UCR
X-rays Complete Series				
Fluoride Treatment				
Sealants		See Reduced Fee Schedule (Approx. 50% Savings)	See Reimbursement Schedule for Out-of-Network Benefits	
Space Maintainers				
BASIC SERVICES - CLASS II				
Waiting Period	None	None	None	3 Months
Extractions			100%*** of the Reimbursement Schedule	
Fillings	See Reduced Fee Schedule (Approximately 50% Savings)	See Reduced Fee Schedule (Approximately 50% Savings)	QCD General Dentist Only	80% of UCR
			See Reimbursement Schedule for Out-of-Network Benefits	
MAJOR SERVICES - CLASS III				
Waiting Period	None	None	None	12 Months
Crowns			100%*** of the Reimbursement Schedule	
Bridges			QCD General Dentist Only	
Inlays/onlays	See Reduced Fee Schedule (Approximately 50% Savings)	See Reduced Fee Schedule (Approximately 50% Savings)	See Reimbursement Schedule for Out-of-Network Benefits	50% of UCR
Dentures				
Endo/Perio				
Oral Surgery				
ORTHODONTIA				
Waiting Period	None	None	None	12 Months
Lifetime Maximum Coverage	None	None	Life Max \$1,000	Life Max \$1,000
	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 No 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	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" 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.			

Fax, mail or email

Complete Itemized Bill to:

Direct Care Administrators
QCD Claims Department
P.O. Box 10
Bountiful, Utah 84011

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

Schedule of Programs Fees



Procedure Number	Member Fee	Procedure Number	Member Fee
DIAGNOSTIC DENTISTRY		ENDODONTICS	
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
PREVENTATIVE DENTISTRY		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	PERIODONTICS	
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
COSMETIC		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 DENTISTRY20% DISCOUNT		PROSTHODONTICS – REMOVABLE	
RESTORATIVE DENTISTRY		(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.	

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	Intraoral-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	Accession 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 st 30 Min	\$65
D9242	Intravenous Sedation- Each Addl 15 Min	\$27
D9930	Post-Surgical Complication Treatment	\$50

The Red Program

A managed cost dental and vision benefit program



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



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

No waiting periods for any new or existing employees

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 reimbursement 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

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.

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	
Frame¹	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.

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.

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	\$100	\$10	\$10	\$10
Lenses				
Bifocals	\$80	\$25	\$25	\$25
Scratch-Resistant Coating	\$45	\$0	\$0	\$0
Transitions®/1	\$123	\$70	\$65	\$65
Frame	\$150	\$40	\$16	\$0
TOTAL COST	\$498	\$145	\$116	\$100
TOTAL SAVINGS		\$353	\$382	\$398

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 2972 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:

- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

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 2972.

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.

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
	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



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.

AMERICAN HEARING BENEFITS

YOUR PARTNER IN HEARING



qcd DENTAL
BENEFITS

 **American**
HEARING BENEFITS

You and your family members have exclusive access to **free hearing consultations** and **discounts up to 48% off on all levels of hearing technology** through American Hearing Benefits

Exclusive Benefits include:



Discounts

- Discounts up to 48% on all AHB hearing aid technologies and styles
- FREE annual hearing consultations for you and your family
- Up to 3-year supply of FREE batteries (40 cells per hearing aid purchased per year)



Other Benefits

- Advanced technology, including Bluetooth® and rechargeable options
- Access to a nationwide network of 3,000+ hearing professional locations



Buy With Confidence

- 60-day risk-free trial period*
- FREE deluxe warranty plan (including loss and damage)
- A year of FREE follow-up office visits if needed (up to six visits)

Accessing your hearing program is easy!

Step 1

Contact us at **(888) 915-6932** with questions or to schedule your FREE consultation

Step 2

Our Hearing Care Advisor will answer questions and work with you to schedule an appointment with a hearing care professional in your area

Step 3

Once your hearing has been fully evaluated and it is determined that a hearing aid could benefit you, our professionals will make a recommendation based on your hearing loss, lifestyle and budget

Step 4

Now begin your life with better hearing. Once you make a hearing aid purchase decision, we give you a 60 day trial* period to be sure you are completely satisfied

Visit americanhearingbenefits.com/partners/QCD

or call us today at

(888) 915-6932

and mention code HEARQCD to take advantage of your exclusive member discounts

*Professional fees may apply.

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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 MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
COVERAGE – Check Those That Apply					
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN REQUESTED EFFECTIVE DATE: _____					
DEPENDENT INFORMATION					
SPOUSE NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> 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]					

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

<input type="checkbox"/> Employee Only
<input type="checkbox"/> Employee and One
<input type="checkbox"/> 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 <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
COVERAGE – Check Those That Apply					
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN REQUESTED EFFECTIVE DATE: _____					
DEPENDENT INFORMATION					
SPOUSE NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> 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]					