Revised 2-4-19

qcd DENTAL BENEFITS

NLLEO-Dallas

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

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

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

DAVIS VISION
EYECARE REFRAMED℠

qcd DENTAL BENEFITS

Your Davis Vision Plan Benefits

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

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

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

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

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

Value for our Members

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

Convenient Network Locations

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

How to locate a Network Provider...

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

Freedom of Choice

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

Value-Added Features:

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

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

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

Contact your Human Resources department today to enroll.

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

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

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

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

OE00488 5/15/17

Plan Coverage & Cost Comparison

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

How to locate a Network Provider...

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

Visionworks

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

The Red Program

Group Enrollment

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

SUBSCRIBER INFORMATION

☐ New QCD Member ☐ Existing QCD Member making changes

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

COVERAGE SELECTED

☐ Employee Only
☐ Employee and One
☐ Employee and Family

DEPENDENT INFORMATION

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

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

Date _____ Applicant Signature _____

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

DENTAL ENROLLMENT FORM

PLEASE PRINT IN SPACE PROVIDED

RED PLUS ☐ WHITE ☐ BLUE ☐

EMPLOYER INFORMATION

EMPLOYER NAME	LOCATION	GROUP NO.

[EMPLOYEE][APPLICANT]

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

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

COVERAGE – Check Those That Apply

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE:____________

DEPENDENT INFORMATION

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

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

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

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

ACKNOWLEDGMENT AND AUTHORIZATION

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

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

DATE	CITY AND STATE

SIGNATURE OF [EMPLOYEE][APPLICANT]

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

VISION ENROLLMENT FORM

PLEASE PRINT IN SPACE PROVIDED

☐ FASHION VISION ☐ DESIGNER VISION ☐ DESIGNER GOLD VISION

EMPLOYER INFORMATION				
EMPLOYER NAME		LOCATION	GROUP NO.	
[EMPLOYEE][APPLICANT]				
LAST NAME	FIRST NAME		M.I.	
STREET ADDRESS	CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )		BIRTH DATE / /	
SEX MALE ☐ FEMALE ☐	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE ☐ MARRIED ☐	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE ☐ INACTIVE ☐
COVERAGE – Check Those That Apply				
☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE:___________				
DEPENDENT INFORMATION				
SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /		
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No	

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

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

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

ACKNOWLEDGMENT AND AUTHORIZATION

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

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

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