OZARK ACTION, INC. *VOLUNTARY* EMPLOYEE *DENTAL* PLAN SELECTION FORM
JULY 1, 2017 – June 30, 2018

EMPLOYEE NAME:____
PRINT CLEARLY

I elect the following **Dental** plan: **(Print name above, initial next to employee only or employee/family coverage and sign and date below.)**

Employee's may opt to purchase or continue this as a voluntary plan for either themselves and or them and their families, which may be payroll deducted. There are no changes to the plan benefits. New enrollees will have a six-month benefit wait period.

Base DENTAL Plan:

Deductible:	$25 in-network, $25 out of network.
Annual Maximum:	$750 in-network; $750 out of network.
Family Deductible:	3X Individual in-network; 3X Individual out of network.
Diagnostic & Preventive:	100% coinsurance in-network; 100% co out of network.
Basic Restorative:	80% coinsurance in-network; 80% co out of network.
Endodontics:	80% coinsurance in-network; 80% co out of network.
Periodontics	80% coinsurance in-network; 80% co out of network.
Oral Surgery:	Not covered.
Major Restorative:	Not covered.
Prosthetic Repairs:	Not covered.
Orthodontics:	Not covered.
Orthodontic Covers:	None.
Implants:	Not covered.
Brush Biopsy:	Not covered.
Pregnant/Diabetic Add'l Svcs:	Not covered
Sealants:	Covered under Basic Services.
Full Mouth X-Rays:	Coverage every 3 years.
Bitewing X-Rays:	1X per 12 mths <18 y/o, 1X per 24 mths >18 y/o.

Remember to check with your dentist to see if they are a provider. If they are not a provider, you may have to pay for services and then file a claim for reimbursement.

***Voluntary Employee* coverage** only: **Employee Base payroll deduction: $22.44 x 12 = $269.28**
17 pp = $15.84 (Head Start Center Staff) 26 pp = $10.37 (Year round staff)

______ **Voluntary Employee coverage only—will be payroll deducted.**

***Employee/Family* (employee payroll deduction**: **Family Base: $60.53 x 12 = $726.36**
17 pp = $42.73 (Head Start Center Staff) 26 pp = $27.94 (Year round staff)

______ **Voluntary Employee & Family Coverage—payroll deducted.**
If you want your family members covered, please list their name, date of birth, and relationship to employee.
If you do not list your family for family coverage you will only have employee coverage.

Spouse Name: ______________________; Date of Birth: _____________________; Relationship: ____________

Child Name: ______________________; Date of Birth: _____________________; Relationship: ____________

Child Name: ______________________; Date of Birth: _____________________; Relationship: ____________

Child Name: ______________________; Date of Birth: _____________________; Relationship: ____________

______**Employee is opting out of coverage for dental insurance. This means the employee will not have dental insurance coverage under the voluntary agency dental plan.**

This summary is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Certificate and by signing this summary, I agree to the benefits for the product selected as of the effective date indicated.

Signature: SIGN ANDPRINT NAME BELOW	Date