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

EMPLOYEE NAME:_____
PRINT CLEARLY

Sign\date below. Agency does not pay for vision coverage; employees can elect optional coverage and premiums will be payroll deducted for vision plan.

Payroll deductions: 17 pay periods/ 26 pay periods

_____**Employee only Plan: $8.31 x 12 months = $99.72**
Employee only: ***$ 5.87 (17 pp)/ $3.84 (26 pp)***

_____**Employee/Spouse Plan: $15.23 x 12 months = $182.76**
E/ Spouse: ***$10.75 (17 pp)/ $7.03 (26 pp)***

_____**Employee/Child(ren): $16.53 x 12 months = $198.36**
E/Child(ren): ***$11.67 (17 pp)/ $7.63 (26 pp)***

_____**Employee/Family: $23.23 x 12 months = $278.76**
E/ Family: ***$16.40 (17 pp)/ $10.72 (26 pp)***

_____**No Coverage—by initialing this line the employee is indicating that they do not want any coverage for vision under the vision plan.**

If you elect spouse, child(ren) or family coverage, please list below by name, date of birth and relationship to employee.

Spouse: _____; DOB: _____; Relationship: _____

Child: _____; DOB: _____; Relationship: _____

Child: _____; DOB; _____; Relationship: _____

Child: _____; DOB; _____; Relationship: _____

Exam Copayment:	*$20.00*
Prescription Lenses (Pair) Copayment:	*$20.00*

No cost shares (NCS) means no deductible, copayment or coinsurance up to the maximum allowable amount, however, a member may be responsible for any balance, due after the plan payment, including, but not limited to, benefits that reflect No Cost Share.

Frequency Limits (Exam, Lenses and Frame or Contact Lenses): Exam 12 mths/Lenses-12 mths/ Frames-24 Mths./ Contacts-12 months.

Frame Allowance:	*$130.00 Retail Value*
Contact Allowance:	*$130.00*

The following Non-Network Reimbursement Schedule applies:

Exam up to	*$ 42.00*
Single Vision Lenses up to	*$ 40.00*
Bifocal Lenses up to	*$ 60.00*
Trifocal Lenses up to	*$ 80.00*
Elective contacts up to	*$105.00*
Non-elective contact lenses up to	*$210.00*
Frame up to	*$ 45.00*

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 and Print Name Below	Date