BENEFITS

School Retirement Packet

Employee Benefits Division – ARBenefits
PO Box 15610 · Little Rock, AR 72231 · 877-815-1017

Retirement Basics

For members getting ready to retire, the boxes below can give you an overview of the process to enroll in retiree health coverage through ARBenefits.

Have questions not answered below?
Contact EBD at 1-877-815-1017 x1, or by e-mail at AskEBD@dfa.arkansas.gov.

Eligibility

To be eligible for ARBenefits retiree coverage, employees must:

1. Be an active member on the ARBenefits plan the last day of their employment; and
2. Be eligible to begin drawing an annuity through their retirement system.

Former members who are retiring, are held to the retirement eligibility rules in place when they left employment.

Options

Eligible employees can enroll in retiree coverage when they leave employment, or:

✔ If a member gains other group coverage when they retire, the member can enroll in retiree coverage at a later date when they lose that group coverage.

- *Will need to provide proof they have had continuous other group coverage without any lapses.*

✔ If a member is not eligible to begin their annuity when they retire, they can elect COBRA for 18 months. The member has 30 days to enroll in retiree coverage when they become eligible for their annuity, or else they will have to wait until their COBRA coverage ends.

Enrollment

To enroll in ARBenefits retiree health coverage, members can submit the ARBenefits Retirement Election Packet to EBD starting:

30 days prior to retirement health effective date

The Retirement Election Packet is available in the Forms and Publications section of www.ARBenefits.org. Employees can also get the packet by contacting EBD, or their agency/school district Health Insurance Representative (HIR).

Retirees can submit the packet to the fax number or mailing address listed at the bottom of the election form.

Retirement Election Packet

The ARBenefits Retirement Election Packet includes:

✔ ARBenefits Retiree Election Form
✔ Authorization to Release Information
✔ ARBenefits Spousal Affidavit
✔ Colonial Life Retiree Deduction Authorization

To continue coverage for any spouse and/or dependent children on their plan, retirees need to submit a marriage license, spousal affidavit, and birth certificates for dependent children if not already on file at EBD.

Retiree Election Form

On the ARBenefits Retiree Election Form, make sure you complete the boxes in section 1 for: Event, Event Date and Date Annuity Begins.

Event: Retirement
Event Date: Last day of employment
Date Annuity Begins: The date you start drawing your annuity from your retirement agency.

Your enrollment cannot be processed if these felds are left blank.

Medicare

If you are Medicare eligible when you retire, you need to provide EBD a copy of your Medicare card that shows Parts A & B coverage.

Retirees who become Medicare eligible after they retire will also need to submit a copy of their Medicare card to EBD.

ARBenefits is secondary coverage to Medicare for Medicare eligible retirees, and will pay as secondary whether the retiree has Medicare in effect or not.

Medicare eligible retirees who do not have Medicare coverage in effect (Parts A & B), will have more financial responsibility for their medical claims.

Life Insurance

If you want to continue any Colonial Life coverage in retirement, make sure you complete and submit the Retiree Deduction Authorization included in the retirement election packet.

This is true even if you are not electing to enroll in retiree health coverage.

If you retire, and Colonial Life does not receive your election to continue your life coverage within 31 days, you cannot regain that coverage at a later date.

Retiree Dental + Vision

ARSEBA offers a retiree dental, and a retiree dental & vision plan to both state and public school retirees. Retirees must reside in the state of Arkansas.

The plans are post-tax, and payment is through bank draft.

For more information, or to enroll visit www.mysmilecoverage.com/SOAR

ARBenefits Retirement and Medicare Information

Completing the Retiree Election Form

Retirement: You have 30 days from your qualifying event to enroll in a retirement health insurance plan and must have had active health insurance on your last day of employment.

Event date: Your last day of employment

Date annuity begins: When you start drawing your retirement check.

Action requested: Enroll in the plan

Retirement system: Mark which retirement system you are with APERS or ATRS, etc.

Benefit option: Choose which plan you wish to enroll in.

- If you or covered spouse is Medicare eligible, you will choose Premium plan. One can be Medicare eligible due to age—65 or older—or due to disability. Please include a copy of the Medicare card as soon as possible.
- If you and covered spouse are not Medicare eligible, you choose your Benefit Option, Premium, Classic, or Basic

Coverage level: Retiree only, Retiree and spouse, Retiree and child(ren), or Retiree and Family

Dependents: Please enter eligible dependents' information only.

- Eligible dependents are those that were on your active health insurance on your last day of employment.

Sign and date your form/application and enter your email address. Effective date is the first day of the month following the date of your application for your retirement health insurance.

APERS Retirees:

If your form/application is not processed by the 14th of the month prior to your retirement date, your premium will not be deducted for that month. You will need to mail in your first month's premium along with your retirement election form. APERS deductions will begin the next month.

- For example: Retirement date 2/1/2020, your form is processed on 1/16/2020, your deduction begins 3/1/2020, you will need to mail in February's health insurance premium.

If your form is processed the month of retirement, you may need to send in 2 months' premiums.

- For example: Retirement date 2/1/2020, your form is processed on 2/15/2020, deduction begins 4/1/2020, you will need to mail in February and March health insurance premiums.

Qualifying Events to Enroll in Retirement Health Insurance

- You must be drawing a retirement annuity check for fully vested service with a State or Public-School agency.
- You must be in the Health Plan as an active employee your last day of employment.
- You must apply for enrollment within 30 days of your loss of coverage.
- You must fully complete a Retirement Health Insurance Election Form. This includes the boxes in Part 1, “Event, Date of Event, Date Annuity Begins”. Form will not be processed without these three boxes being completed.
- If you must have your premium drafted because your annuity is not large enough, you must complete a Bank Draft Authorization Form and submit with a VOIDED check attached.
- We require a copy of your Medicare Card, if you and/or your spouse are Medicare.
- If **continuing** coverage on a spouse, we require an updated Spousal Affidavit and a copy of your Marriage License. Coverage for continuing dependent children we require a copy of the Birth Certificate.
- We will **not** accept forms more than 30-days prior to the effective date.
- Arkansas Legislative Law allows a retiree a one-time option to enroll in the State and Public-School Retirement Health Plan. Enrollment is either at the time of eligibility or delayed enrollment due to current coverage on an employer sponsored group health plan with a qualifying event of involuntary loss of coverage. Once you enroll in the plan and then leave, you will no longer be eligible for participation in the plan. The decision is **FINAL.**

Medicare Retirees

It is the responsibility of the retired employee to notify Employee Benefits Division (EBD) when either they or their spouse become eligible for Medicare by sending in a copy of their Medicare card. Entitlement to Medicare Part A is normally issued at age 65, however, you may have Medicare Part A due to Disability or End Stage Renal Disease (ESRD).

EBD is required to be primary payer for a period of thirty (30) months for members on Medicare due to ESRD. During this 30-month period of coverage members will pay the non-Medicare premium rate. It is very important that you notify EBD of your coverage due to ESRD so the correct premiums will be deducted. Failure to notify EBD could result in the member being responsible for the difference in back premiums if their Medicare information is not entered correctly.

If claims are processed incorrectly, it will result in paid medical and/or pharmacy claims being overturned and the member being required to have the claims refiled under Medicare. Medicare claims must be filed no later than 12 months (or 1 full calendar year) after the date when the services were provided. If a claim is not filed within this time limit, Medicare cannot pay its share and you will become responsible for payment of the claims.

Medicare will often retro the effective date of Medicare coverage back to an earlier date. If Medicare does retro the coverage, then we are required to change our records back to the Medicare effective date. The change may result in a refund of premiums, or a charge for the difference in premiums, back to the begin date of · Medicare Part A.

The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the Plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for incurred claims.

Medicare Part A (hospital insurance) does not usually require recipients to pay a monthly premium. Medicare Part A includes coverage for:

- Inpatient hospital stays
- Hospice care
- Skilled nursing facility care
- Some home health care

Medicare Part B (physician insurance) is optional and usually requires a monthly premium. Medicare Part B includes coverage for

- Certain doctor services
- Outpatient care/Medical supplies
- Preventative services

Your Medicare Premium Plan for Retirees benefit coverage coordinates with your Medicare Part A & B benefits. To minimize your financial responsibility, we want to make sure that you understand that we will pay your physician claims like you have Medicare Part B coverage even if you choose to not participate with Part B.

Example of Patient Responsibility/Liability with and without Medicare Part B:

Our Payment with Medicare Part B	**Our Payment without Medicare Part B**
Office Visit $150.00	Office Visit $150.00
Medicare Approved $110.00	Medicare Approved $110.00
Medicare Payment $88.00	Medicare Payment $0.00
Medicare Write-off $40.00	Medicare Write-off $40.00
ARBenefits Payment $22.00	ARBenefits Payment $22.00
Member AmountDue $0.00	Member Amount Due $88.00

Medicare Part C (Medicare Advantage) is not administered by the federal government. Instead, it is sold by private insurance companies as a replacement for Original Medicare Part A and Part B benefits. Note: Since· Medicare Part C replaces traditional Medicare coverage, ARBenefits cannot coordinate as a secondary plan. Therefore, a member does not need to purchase coverage with both Medicare Part C and ARBenefits Medicare Premium Plan.

Medicare Part D (prescription drug plan) is sold through private insurance companies. We do not coordinate pharmacy benefits. If you elect Part D coverage and you have our pharmacy benefits, you will be responsible for any Part D repayment request. Medicare-Primary Public School Retires do not have prescription drug coverage under the ARBenefits Plan and should choose a Part D option to retain prescription drug coverage.

2022 Plan Year - Schedule of Benefits

What does ARBenefits cover for Medicare Primary Retirees?

Medicare Does Not Pay	ARBenefits Retiree Plan Covers
Part A Hospital Services	
Inpatient hospital deductible each benefit period	ARBenefits pays the deductible
Copayment per day for days 61-90 in a hospital	ARBenefits pays the copayment per day
Copayment per day for days 91-150 (Lifetime Reserve)	ARBenefits pays the copayment per day
100% of Medicare - Allowable expenses for additional 365 days after Medicare hospital benefits stop completely	ARBenefits pays
Calendar year blood deductible (First 3 Pints of Blood) If deductible is not met by the replacement of blood	ARBenefits pays
Copayment per day for days 21-100 in a Skilled Nursing Facility	ARBenefits pays the copayment per day
Part B Physician and Medical Services	
Part B deductible	ARBenefits pays the deductible
Normally 20% of Medicare-approved amount (Part B Coinsurance) and 20% of Medicare-approved charges for Durable Medical Equipment (After Part B Deductible Is Met)	ARBenefits pays 20% of the Medicare-approved amount
Medicare Part B excess charges 100% (*This benefit would apply when you receive services from a physician that does not accept Medicare assignment.*)	Coverage will be determined based on the level of coverage outlined in the SPD for active and non-Medicare members. Services paid at 100% will be no charge. Plan will pay 80% for Medicare Part B excess charges not paid by Medicare, but will be paid according to the deductible, copay and coinsurance when applicable.

Coordination of Benefits with Medicare

- The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Medicare Part B, the Plan will pay as though the member does have Part B and the member will have full financial responsibility for incurred claims.

- The Plan will cover services for our Medicare Primary members as for our active and non-Medicare members. If Medicare does not cover a particular vaccine/service/etc., the plan will cover the service at the Premium plan level if coverage is provided for our active and non-Medicare members.

- Coverage will be determined based on the level of coverage outlined in the SPD for active and non-Medicare members - services paid at 100% will be no-charge. For all other services deductible, copay and coinsurance will apply when applicable.

- All physician, hospital, and medical services offered to Medicare Primary Retirees on the ARBenefits Plan are subject to the provisions of the Schedule of Benefits listed in the Summary Plan Description. The ARBenefits Plan does not allow all services allowed by Medicare. Please review the SPD carefully to determine if a service is covered.

Prescription Drug Benefit for Medicare Primary Retirees	
School Retiree	• Members must sustain drug coverage through Medicare Part D.

PUBLIC SCHOOL NON-MEDICARE RETIREES
MONTHLY PREMIUMS

2022 Plan Year Rates - Effective January 1, 2022 - December 31, 2022

	Total Monthly Retiree Cost
Premium	
Retiree Only	$641.14
Retiree & Non-Medicare Spouse	$1,457.18
Retiree & Child(ren)	$1,192.60
Retiree & Non-Medicare Spouse & Child(ren)	$2,008.64
Retiree & Medicare Primary Spouse	$795.12
Retiree & Medicare Primary Spouse & Child(ren)	$1,346.58
Classic	
Retiree Only	$273.30
Retiree & Spouse	$565.78
Retiree & Child(ren)	$469.82
Retiree & Family	$746.20
Basic	
Retiree Only	$148.50
Retiree & Spouse	$269.72
Retiree & Child(ren)	$238.52
Retiree & Family	$335.72
The Basic plan meets the minimum essential coverage required under A.C.A.	

PUBLIC SCHOOL MEDICARE PRIMARY RETIREES
MONTHLY PREMIUMS

2022 Plan Year Rates - Effective January 1, 2022 - December 31, 2022

Medicare Eligible	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
Retiree Only	$231.98	$131.20	$100.78
Retiree & Non-Medicare Spouse	$896.01	$112.09	$783.92
Retiree & Child(ren)	$865.35	$108.25	$757.10
Retiree & Non-Medicare Spouse & Child(ren)	$1,739.02	$217.54	$1,521.48
Retiree & Medicare Primary Spouse	$423.65	$160.61	$263.04
Retiree & Medicare Primary Spouse & Child(ren)	$1,015.64	$127.06	$888.58

Subsidy authorized by Act 1075 of 2011

Plan Contribution is funded by PSE Trust Fund as Claims Reserve Allocation

STATE & PUBLIC SCHOOL RETIREE ELECTION FORM

ARBENEFITS

Part 1: Employee Information

First Name	MI	Last Name	Date of Birth	Gender ☐M ☐F	Social Security Number

Home Address	City	State	Zip Code

Event	Event Date	Date Annuity Begins	Home/Cell Phone Number	Work Phone Number

Part 2: Action Requested

Type of Action

- ☐ Enroll in the Plan
- ☐ Enroll as a Surviving Spouse
- ☐ Add/Drop a Dependent
- ☐ Open Enrollment
- ☐ Cancel Coverage
- ☐ Change Address

Drug Coverage Option

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- ☐ ARBenefits
- ☐ Medicare Part D

Retirement System

- ☐ APERS (State) 998
- ☐ APERS (School) 059002
- ☐ ATRS (School) 059001
- ☐ ATRS (State) 999
- ☐ HIGHWAY DEPT 091
- ☐ JUDICIAL 021
- ☐ VALIC/TIFF (Bank Draft) 999

Select a Benefit Option

☐ Premium ☐ Classic ☐ Basic

Select a Coverage Level

☐ Employee Only ☐ Employee & Child(ren)
☐ Employee & Spouse ☐ Employee & Family

Medicare

Our plan requires Medicare Retirees to have both Part A & Part B Medicare

Part 3: Add/Drop Dependents

To complete the RELATIONSHIP column, use the number that describes your dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardianship - 3, Collateral Dependent - 4

Add	Drop	Name (First, MI, Last)	Date of Birth	Social Security Number	Male	Female	Relationship
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Part 4: Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed if I have a qualifying status change event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 30 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to Î ÐÝÌ ÙÏ Ì health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or È ÊÔÈÐÔ. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address:

SUBMISSION TO EBD IS FINAL

ARBenefits • Department of 3ÙÈÕÚÍÖÙÔÈÙÐÖÕÈÕË 2ÏÈÙÌË 2ÌÙÝÐÊÌÚ • Employee Benefits Division
Post Office Box 15610 • Little Rock, AR 72231-5610 • Fax: 501.682.1200

Instruction Page

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

NOTE: Retirees or dependents that are Medicare Primary may only enroll in the Premium Plan option. Health Advantage is the carrier for the Medicare Primary Premium Plan. A copy of the Medicare card is required for any subscriber and/or spouse.

Note: The ARBenefits Medicare Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the plan will pay as though the member does have Part B, and the member will have full financial responsibility for incurred claims.

Public School Retirees with Medicare do not have pharmacy benefits through this plan. You will be required to obtain a Medicare Part D plan for your pharmacy needs.

Bank Draft Authorization Form, with VOIDED check attached, is needed if your retirement annuity is not large enough for your premium deduction. **WE CANNOT PROCESS WITHOUT A VOIDED CHECK.**

Your premiums are post-tax.

If you cancel your retirement insurance to leave the plan other than gaining employment with a state or public school agency, the decision is final and you cannot come back to the plan.

RECIPROCITY SERVICE

- A retiree who is fully vested as a state employee AND fully vested as a public school employee (a participating member under both APERS and ATRS and drawing a retirement annuity from each) may choose to enroll in either the ASE or PSE retiree health plan.
- A retiree who is not fully vested under either system, but has enough time between the two systems to be eligible for reciprocity service will be enrolled in the retiree health plan of the system with the most service.

VESTING

- State and Public School retirees changed from a ten (10) year vesting to a five (5) years vesting effective 7/01/1997.
- Retirees with service prior to 7/01/1997 are still held to the ten (10) year vesting.
- Non-teaching school retirees that are paid under Arkansas Public Employees Retirement System (APERS) have school rates.
- Most College employed retirees and County retirees are not eligible under the State & Public School Retirement Health Insurance. Reciprocity services from these agencies do not make a retiree eligible for the health insurance.

Proof of dependent eligibility is required. Examples of required documentation are: birth certificates, marriage licenses, court documents and a Certificate of Credible Coverage for loss of coverage. The effective date is the first of the month following the date on the Election Form.

Please mail or fax your completed and signed Health Insurance Election Form to:

ARBenefits
P.O. Box 15610
Little Rock, AR 72231-5610
Fax: 501-682-1200

For assistance, contact ARBenefits at 1-877-815-1017 Monday through Friday, from 8:00 a.m. to 4:30 p.m. CST.

Learn more about plans, costs and providers at www.transform.ar.gov/employee-benefits

BANK DRAFT AUTHORIZATION

ARBENEFITS

I (we) hereby authorize the Department of Transformation and Shared Services – Employee Benefits Division to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debits in error to our bank account indicated at the financial institution named below (VOIDED CHECK), hereinafter called Depository, to debit and/or credit the same such account.

Retirement COBRA Effective Date: _____

Type of Account

☐ Checking
(Require Voided Check)

☐ **Savings****

Date of Draft

5th
7th
15th
20th
28th (Retirement Only)

COBRA – all COBRA NSF drafts must be paid by end of month to avoid termination of COBRA health insurance.

****Routing #:_____**

****Account #:_____**

Deduction Amount: $_____

Update to current account: $_____

This authorization shall remain in effect unless the Employee Benefits Division has received written notification from me (us) of its termination in such time and in such manner as to afford the Employee Benefits Division and Depository a reasonable opportunity to act on it.

Authorized Signer on Account: _____
(Please print name clearly)

Insured's Social Security No: _____
(Authorized Signer) (Date)

Per Arkansas Code S5-37-301, a $25.00 Return Item Charge fee plus a $2.00 service fee for bank drafts will be assessed per item returned not paid by the bank.

Enclose a Voided Check for Checking Accounts – must have original check – no copies
(Deposit Slip Cannot Be Used)

Return this authorization to:

Employee Benefits Division
PO Box 15610
Little Rock, AR 72231-5610

Entered: _____

Initialed: _____

Affidavit of Spousal Health Care Coverage

ARBENEFITS

This Affidavit must be completed for consideration to cover a spouse.

Employee Name:		**Employee SSN:**	
Spouse Name:		**Spouse SSN:**	

To be completed by employee electing to enroll a spouse in coverage.

Pursuant to Arkansas Code §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the Plan.

1. Is your spouse currently employed?

   ☐ **Yes** (If yes, please proceed to question #2)

   ☐ **No** (If no, sign and return this form along with your election form and a copy of your Marriage License.)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ **Yes** (If yes, sign and return this form along with your election form and a copy of your Marriage License.)

   ☐ **No** (If no, proceed to question #3)

3. Does your spouse's employer offer health insurance coverage?

   ☐ **Yes** ☐ **No**

4. Is your spouse covered by his/her employer sponsored health plan?
   ** If No, please submit information from your spouse's employer as to why your spouse is not covered.*

   ☐ **Yes** ☐ **No**

5. Does your spouse's employer sponsored coverage meet the Affordable Care Act (ACA) minimum guidelines?
   ** If No, please provide information from your spouse's employer stating that coverage does not meet ACA guidelines.*

   ☐ **Yes** ☐ **No**

For any questions or concerns, contact EBD Member Services at 1-877-815-1017x1

By signing this affidavit, I certify that the information provided above is accurate. I understand that any misrepresentation in the information I provided above will permit the Plan to terminate my coverage. If applicable, I authorize the release of the information noted above, and agree to its use in the application process for ARBenefits plan coverage.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Authorization to Release Information

AR BENEFITS

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows EBD (ARBenefits) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to EBD. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released)

Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____ Telephone #: _____

I authorize EBD (ARBenefits) to release my protected health information as described below

Recipient: (Person or organization that will receive your information)

Person's Name or Organization: _____

Address: _____ Telephone #: _____

Person's Name or Organization: _____

Address: _____ Telephone #: _____

Description of the Information to be Released: (What type of information will be released)

☐ Entire Health Record

☐ Other, please describe _____

This authorization will expire (Check ONLY ONE Box):

☐ When I revoke this authorization.

☐ Upon the following date, event, or condition: _____

If I fail to specify an expiration date, this authorization will expire in twelve (12) months from the date of this signing.

I understand that this authorization to release information is voluntary and is not a condition of enrollment in ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understand that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, and treatment for alcohol and drug abuse.

By signing below, I authorize the release of my protected health information as described above.

_____

Signature of Member or Legal Representative

_____

Printed Name of Member or Legal Representative

_____

Date

For EBD Use Only

Member ID#: _____

Completed By _____

Employee Benefits Division - ARBenefits

P.O. Box 15610 * Little Rock, AR 72231 * 877.815.1017

TRANSFORM.AR.GOV

Rev. 10/14/19

2000-f-10

State of Arkansas Retirees

Colonial Life

Employees who retire after January 1, 2020 may continue their Colonial Life Group Term Life with AD&D coverage(s). Retirees may elect to take up to 50% of their current active employee coverage into retirement. Colonial Life Group Term Life with AD&D coverage(s) are subject to an additional 50% benefit reduction at age 75 for retiree and spousal coverage(s). Increases in coverage are not allowed at or after retirement. Please complete the Colonial Life Service and Payment Authorization Form and return it within 31 days of your retirement.

- Forms received after 31 days will not be processed.
- Completed forms may be returned by mail or fax:

  Colonial Life
  PO BOX 1365
  Columbia, SC 29202
  Fax #: 803-678-6861

Please remember that your active coverage must be canceled by your employer before your retirement elections can be processed.

- Please also note that you may receive a termination notice for your active employee coverage prior to your retirement coverage(s) being issued.

Supplemental Group Term Life with AD&D coverage is an age banded product which means that your rates will increase in January after you cross into a new age band.

Additional questions may be answered by reviewing the Colonial Life Group Term Life with AD&D Insurance for Retired Employees brochure.

Note: If you do not want to continue your Colonial Life Group Term Life with AD&D coverage(s) into retirement, you don't need to complete a Colonial Life Service and Payment Authorization Form. Your active employee coverage will automatically terminate after your retirement date.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
STATE OF ARKANSAS RETIREES - GROUP TERM LIFE WITH AD&D SERVICE FORM AND PAYMENT AUTHORIZATION FORM

Retired: ☐ AR State Employee ☐ AR Public School Employee	Retirement Date (mm/dd/yyyy):
Name of District/Agency retired from:	Code of District/Agency retired from:

Retiree Information

Retiree Name (First, MI, Last)	Gender ☐M ☐F	Birthdate (mm/dd/yyyy)	Social Security No.

Home Address – Street	City	State	Zip Code	Member No.

Email Address	Primary Phone No. Secondary Phone No.

List all policies/certificate numbers related to this request (Required to process):

Qualifying Life Event — Event Date

☐ Marriage ☐Legal Separation ☐ Birth or Adoption of Child ☐Death of Spouse
☐ Divorce ☐Annulment ☐ Placement of Child for Adoption ☐Death of Dependent Child

Service Requested

☐ Cancel Retiree Coverage ☐ Decrease Coverage ☐ Cancel Dependent Child(ren) Coverage ☐ Change Address
☐ Surviving Spouse Coverage Continuation ☐ Cancel Spouse Coverage ☐ Change Name ☐ Change Retiree Premium Payment Method

If adding a spouse or child coverage as a result of a qualifying life event, an Enrollment Form or Evidence of Insurability Form must be completed.
If canceling or decreasing coverage, complete Cancel/ Decrease Details below. For all other changes, complete the corresponding section below.

Surviving Spouse Coverage Continuation

Surviving Spouse Name:

Cancel/Decrease Details
All coverages are reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.

Coverage Type	Check only if you wish to cancel or decrease coverage	New Amount of Coverage Requested (required)
Basic Group Term Life and AD&D	☐ Cancel	$5,000
Expanded Basic Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
Spouse Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
[1]Dependent Child(ren) Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$

[1]Elected child(ren) coverage includes all eligible dependents. If cancelling, all dependent child(ren) coverage will be removed.

Name Change

Previous:	Current:	Reason: ☐ Marriage/Divorce ☐ [2]Correction ☐ [2]Other

[2]A copy of legal documentation is required unless your name is changing due to reason of marriage or divorce.

Address Change

Home Address – Street	City	State	Zip Code

Email Address	Primary Phone No. Secondary Phone No.

Select the retirement system in which you participate. Always complete. Check only one of the following:

☐ APERS State (998) ☐ ATRS School (059001)
☐ APERS School (059002) ☐ ATRS State (999)
☐ HIGHWAY DEPARTMENT (091) ☐ JUDICIAL (021)

If you wish to pay your premiums on a direct pay basis, check and complete Premium Payment Method Change Section below. ☐

Premium Payment Method Change – If your premiums will not be deducted from your retirement check, please select a payment method

1. ☐ **Please deduct monthly premiums from my bank account.**
☐1st - 5th ☐6th - 10th ☐11th - 15th ☐16th - 20th ☐21st - 26th

Your draft will occur on one of the dates within the range you have selected.
Please include a voided check or provide:
Routing # _____ Account #_____

_____
Signature of bank account owner (REQUIRED)

2. ☐ Please bill me directly. (Choose one of the following):

☐ Quarterly (3 times your monthly premium)
☐ Semi-Annual (6 times your monthly premium)
☐ Annual (12 times your monthly premium)

IPG for direct pay retiree policies (Internal use only): I2058329

Authorization Section

If this form is not received by Colonial Life & Accident Insurance Company before the monthly pension deduction deadline, a direct bill will be mailed to you. Failure to pay this bill may result in cancelled coverage. Once the initial bill is paid, monthly deductions from your pension check will automatically begin. In the event my retirement annuity does not have sufficient funds for premium deduction, a Bank Draft Authorization form, along with a voided check must be attached. Premiums paid will be post-tax. I understand that my elections can only be changed if I have a qualifying status change event and that I must request such changes within 60 days of the qualifying event.

I hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my life insurance plan. I further authorize you to pay such amounts to the insurance company providing such insurance or its authorized representative. This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.

_____ _____

Retiree Signature Date (mm/dd/yyyy)

Colonial Life

Group Term Life Insurance with Accidental Death & Dismemberment (AD&D) Insurance for Retired* Employees

How secure is your family's financial future without you?

If something happened to you, would your family be able to maintain their way of life? How would they cover ongoing living expenses? Colonial Life's group term life insurance can help provide financial security for your family.

Why is group term life insurance a good option?

- Death benefit protection
- Lower cost option
- Coverage for specified periods of time, which can be during high-need years
- Benefit is typically paid tax-free to your beneficiaries

AD&D insurance provides benefits to help cover the additional expenses associated with an accidental death, as well as the high costs of recovery and rehabilitation required by an accidental dismemberment.

The AD&D full benefit amount is equal to your group term life insurance death benefit amount.

The following benefits are paid under the AD&D benefit:

If the loss is:	% of the full amount paid
Loss of life	100%
Loss or loss of use of both hands or both feet or sight of both eyes	100%
Loss or loss of use of one hand and one foot	100%
Loss or loss of use of one hand and sight of one eye	100%
Loss or loss of use of one foot and sight of one eye	100%
Loss of speech and hearing	100%
Loss or loss of use of one hand or one foot	50%
Loss of sight of one eye	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%

Additional benefits and services:

Seatbelts and Airbags – Pays if the cause of death or dismemberment is a car accident and if the covered person was using a seatbelt or airbag.

Built-in accelerated death benefit provides an advance of up to 75% of the death benefit, to a maximum of $150,000, if the covered person is diagnosed with a terminal illness.[1]

Health Advocate employee assistance program provides 24-hour confidential personal support and referral service, including a medical bill saver service. Face-to-face sessions and video counseling with mental health professionals are available.[2]

ONLINE
ColonialLife.com/EAP

Telephone
1-888-645-1772

Life planning services offer financial and legal counseling services, as well as grief support and referral for up to 12 months after a claim.[2]

*Includes Arkansas state and public school employees retired after 1/1/2020.

Take action to retain your group term life with AD&D insurance coverage as a retiree.

Within 31 days of your retirement date, submit a group term life with AD&D service form and payment authorization form to Colonial Life via fax at 803-678-6861. The retiree service form and beneficiary designation form are available at ARBenefits.org.

[1] Terminal illness means an injury or sickness that results in the covered person having a life expectancy of 12 months or less and from which there is no reasonable prospect of recovery.

[2] The Employee Assistance Program and Life Planning Services, provided by Health Advocate, are available with Colonial Life & Accident Insurance Company's Group Term Life offering. Terms and availability of service are subject to change. The service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact the company for full details.

Your basic and optional coverages

Coverage options	Retiree coverage details. Retirees may not increase coverage amounts.
Basic group term life with AD&D insurance**	Upon retirement, coverage is reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.
Expanded basic group term life with AD&D insurance**	Upon retirement, coverage is reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.
Supplemental employee group term life with AD&D insurance **	Upon retirement, coverage is reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.
Supplemental spouse group term life with AD&D insurance	Upon retirement, spouse coverage is reduced by 50% of the active employee coverage. At age 75, spouse coverage is reduced by an additional 50%.
Supplemental dependent child(ren) group term life with AD&D insurance	No coverage reductions to dependent child(ren) coverage

** *At age 75, Basic, Expanded Basic and Supplemental Life Insurance may not exceed a combined face amount of $25,000, comprised of no more than $12,500 of Basic and Expanded Basic combined and no more than $12,500 of Supplemental Life coverage.*

2020 Retiree Rates* (per $1,000) Monthly cost of coverage

Retiree basic and expanded basic group term life with AD&D insurance	
$0.89 per $1,000	
Retiree supplemental group term life with AD&D insurance	
Age	**Employee**
Under 50	**$0.33**
50-54	**$0.52**
55-59	**$0.76**
60-64	**$1.13**
65-69	**$2.20**
70-74	**$ 3.58**
75+	**$ 7.14**
Retiree supplemental spouse group term life with AD&D insurance	
All eligible ages	**$1.01**
Retiree supplemental dependent child(ren) group term life with AD&D insurance	
All eligible ages	**$0.12**

*Includes Arkansas state and public school employees retired after 1/1/2020.

BENEFIT REDUCTION SCHEDULE

Retirees prior to 1/1/2020:

Refer to your certificate for benefit reduction details.

EXCLUSIONS AND LIMITATIONS

Losses Not Covered Under Your Life Insurance Benefit:

Your life insurance benefit does not cover any losses where death is caused by, contributed to by, or results from suicide occurring within 24 months after a covered person's initial effective date of insurance or after the date any increases or additional insurance becomes effective, whether sane or insane.

This applies to any amounts of insurance for which you pay all or part of the premium.

This applies to any amount subject to evidence of insurability requirements and we approve the evidence of insurability form and the amount you applied for at that time.

You will be given credit for any period of time applied toward the satisfaction of the suicide provision, if any, under your Employer's prior group life insurance plan.

Losses Not Covered Under the AD&D Insurance Benefit:

Your AD&D benefit does not cover any losses that are caused by, contributed to by, or resulting from:

- an attempt to commit or commission of suicide or intentional self-inflicted injury while sane or insane;
- active participation in a riot;
- an attempt to commit or commission of a felony or engaging in an illegal occupation;
- voluntary use of any drugs, poisonous substance, intoxicant or narcotic, except any drugs taken as prescribed by a physician and taken as prescribed. Accidental exposure to any poisonous substance will not be excluded;
- the presence of that percentage of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the accident occurred;
- disease of the body, mental infirmity or diagnostic, medical or surgical treatment;
- being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release; or
- investigational or experimental procedures, surgery, or drugs, including complications arising from having experimental or investigative procedures, surgeries, or drugs.

Termination

Coverage terminates:

- if the group policy ends;
- the date you no longer meet eligibility requirements;
- the end of the grace period if we do not receive the required premium for your insurance; or
- the date the next premium is due after you ask us to end your coverage.

Premium will vary based on plan options and face amount.

Applicable to policy number GTL1.0-P-AR-SOA and certificate number GTL1.0-C-AR-SOA.
This is not an insurance contract and only the actual policy provisions will control.

DELTA DENTAL®

DENTAL AND VISION PLANS

State of Arkansas Retiree Program

Individual and familiy plans at a price that will make you smile.

WHAT'S COVERED?

PREVENTIVE AND DIAGNOSTIC

- Two routine exams per benefit period
- X-rays
- Two cleanings per benefit period
- Two fluoride applications for dependent children up to age 19
- Sealants for dependent children up to age 16

BASIC RESTORATIVE SERVICES

- Minor emergency treatment
- Fillings
- Simple extractions
- Space maintainers for dependent children up to age 14
- Stainless steel crowns for dependent children up to age 16

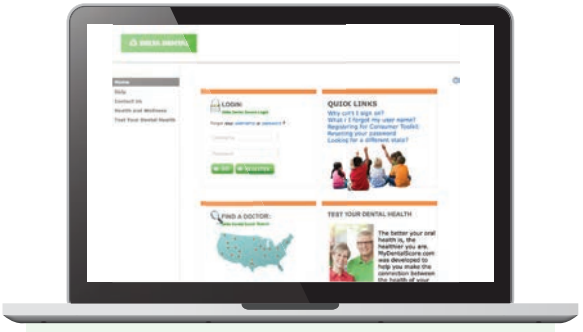
MAJOR RESTORATIVE SERVICES

- Crowns
- Endodontics (root canals) Oral surgery
- Dentures, bridges, partials

Why Delta Dental?

Dental insurance is not a sideline of our business — it is the heart.

We are the state's largest and most experienced dental insurance company, and our expertise is why nearly 2 million members across the country trust their smiles to Delta Dental of Arkansas.



Easy access

We make it easy for you to access the information you need at any time. Through our website, you can:

- Locate a dentist
- Check claims status and history
- Review plan coverage
- Print ID cards,
- and more!

FREQUENTLY ASKED QUESTIONS

Who is eligible for coverage under a Delta Dental Individual and Family plan?

You must be an Arkansas resident and a State of Arkansas Retiree Program member to be eligible for coverage. Acceptance is guaranteed regardless of age, dental history or pre-existing conditions.

What are the age limitations for dependent children?

Dependent children can continue coverage until the end of the month in which they turn 26.

What services are NOT covered under this plan?

For a complete list of services not covered, please visit our website to view the Schedule of Benefits. General services that are not covered include:

- Tooth implants
- Tooth whitening
- Athletic mouth guards
- Braces and retainers
- Treatment for TMJ (temporomandibular joint disturbances)
- Services to correct cosmetic dentistry
- Dental care started prior to the date the patient became covered under this plan

DELTA DENTAL®

DeltaDentalAR.com

WHY DENTAL INSURANCE?

People with dental insurance typically visit the dentist more often than those without, resulting in better dental and overall health.

Besides keeping your smile healthy, your dentist can also help identify more than 120 signs and symptoms of non-dental diseases —including heart disease and diabetes—before they become larger problems.[1]

Prevention costs less than treatment. Most dental plans, such as Delta Dental Individual and Family, encourage prevention by covering the cost of exams, cleanings, X-rays and more in order to help prevent dental disease rather than to perform expensive, and sometimes painful, restoration work later.

DENTAL PLANS	Delta Dental Dentist	Non-participating Dentist
Individual/family deductible	$50/$150	
Individual benefit-year maximum	$1,500	
What the plan pays for after you have satisfied the deductible		
Preventive & Diagnostic	100%	80%
Basic Restorative Services	80%	60%
Major Restorative Services	60%	50%
Waiting Periods*		
Preventive & Diagnostic	None	
Basic Restorative Services	None	
Major Restorative Services	6 Months	

Monthly Premiums	
Individual Only	$38.98
Individual & Spouse	$77.70
Individual & Child(ren)	$75.86
Individual & Family	$125.72

The dental plans offered in this brochure do not include pediatric dental services as required under the Affordable Care Act (ACA). To learn about Delta Dental's ACA compliant dental plans and assistance to determine if you need an ACA compliant pediatric dental plan, call our marketing representatives at (800) 971-4108 or visit www.mysmilecoverage.com/AR.

*Deductible does not apply.

OUT-OF-NETWORK BENEFITS (NON-PARTICIPATING)

Services conducted through an out-of-network dentist will be reduced as indicated above by Delta Dental of Arkansas after applying the applicable deductibles, copayments and maximums. This means your out-of-pocket expense will be more if you choose an out-of-network dentist.

*WAITING PERIODS WILL BE WAIVED IF:

1. Your application is received within 31 days of the termination of your prior carrier.
2. You have had at least six months of continuous coverage in Major Restorative Services.

To waive waiting periods, please submit a copy of your Certificate of Creditable Coverage verifying your previous dental coverage and a copy of your covered benefits.

Delta Dental has the largest network of dentists in Arkansas and across the nation,[2] which means you will find affordable care wherever you are.

1 J Am Dent Assoc, Vol 134, No suppl_1, 41S-48S. 2003 American Dental Association and Dental Management of The Medically Compromised Patient, 8th Edition, 2013, Mosby Elsevier, St. Louis, MO. 2 Delta Dental Plans Association, web.

TAKE CARE OF YOUR SMILE AND YOUR VISION!

Delta Dental also offers vision insurance when you select an individual or family dental plan.

Vision and eye health problems are the second most prevalent and chronic health care problems in the United States—affecting more than 120 million people. Like dental insurance, vision plans promote routine care, which keeps your eyes healthy and can help detect diseases such as diabetes.

Choose the dental plan that best fits your needs, and add vision to receive coverage for eye exams and glasses or contacts. With Delta Dental, you can keep your smile and vision healthy at a price you can afford.

VISION PLANS

In-network Vision Covered Benefits		
Vision Exam	Every 12 months	Covered in full after $10 copay
Frame	Every 24 months	Covered in full after $15 copay for any frame with a wholesale value up to $50 (retail prices vary but will be approximately up to $150). Frames from participating Walmart locations are covered up to a $68 retail value.
Lenses	Every 12 months	Standard single vision, bifocal, trifocal and lenticular covered in full after $15 copay
Contact Lenses (in lieu of lenses and frames)		
Contact Lens (elective)	Every 12 months	$150 which can be used toward the evaluation, fitting and follow-up care
Contact Lens (medically necessary)	Every 12 months	Covered in full with prior authorization
Laser Vision Correction	Once per lifetime	$150 per covered member

Dental & Vision Benefits Monthly Premiums	
Individual Only	$48.23
Individual & Spouse	$96.21
Individual & Child(ren)	$92.95
Individual & Family	$153.39

For more information about out-of-network benefits, please call (844) 304-7627.

More than 60,000 eye care providers nationwide.

To find an eye care provider in the Superior National Network, visit deltadentalar.com.

DELTA DENTAL®

MAIL TO: H&H Benefits Specialists
1301 West 7th Street
Little Rock, AR 72201

REQUESTED EFFECTIVE DATE		
MONTH	DAY	YEAR
	1st	

Individual & Family Application | Plan number SOARR01

Rates effective: October 1, 2019 — December 31, 2022

APPLICANT INFORMATION			
Name:	Date of Birth:	☐ Male ☐ Female	
Mailing Address:	City:	State:	ZIP:
Social Security #:	Home Number:		
Email:	Mobile Number:		

PLAN SELECTION (CHOOSE ONE)

☐ Dental ☐ Dental and Vision

TYPE OF COVERAGE (CHOOSE ONE)

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual and Family

DEPENDENTS

	First Name	Last Name	Social Security #	Date of Birth	Sex
Spouse					
Child					
Child					
Child					

PREVIOUS COVERAGE

Will this replace existing dental coverage? ☐ YES ☐ NO	If you are purchasing this coverage to replace an existing Delta Dental of Arkansas plan, please provide the anticipated termination date of your current plan:_____ If the coverage will replace a plan with another carrier, please submit a copy of the Certificate of Creditable Coverage and a list of covered benefits. A Certificate of Creditable Coverage benefits can be obtained from your previous insurance carrier on your employer group health administrator.

HOUSEHOLD RESIDENTIAL INFORMATION

Do all proposed insured reside in Arkansas? ☐ YES ☐ NO | If no, provide reason:

PAYMENT METHOD - BANK DRAFT OR CREDIT CARD ONLY (DO NOT SEND A LIVE CHECK)

Bank Draft: ☐ Monthly ☐ Annually
Bank Account: ☐ Checking ☐ Savings

Routing Number:_____
Account Number:_____

Include a voided check with application.

I authorize Delta Dental of Arkansas (DDAR) and the BANK* indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such a time and such a manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) day written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorization Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorization Bank Draft Program date.

_____ _____
Signature of Bank Account Holder Date

Monthly bank drafts are processed on the 5th of each month. *BANK also applies to Savings and Loan.

CREDIT CARD INFORMATION

Credit Card: ☐ Monthly ☐ Annually **Credit Card Type:** ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number:_____ Expiration Date (MM/YYYY):_____

CVC Number (3 digit security code on back of card):_____

Credit Card Holder's Name: _____

_____ _____

Signature of Credit Card Holder Date

Monthly credit card drafts are processed on the 5th of each month. (Example: February premium will be drafted on February 5th.)

CORRESPONDENCE

NOTICE: All correspondence regarding this plan will be sent electronically to the email address listed on the front of this application unless applicant requests to be contacted via mail.

☐ opt OUT of electronic correspondence

POLICY EFFECTIVE DATE

The Delta Dental policy effective date is always the 1st of the month. Applications can be submitted through mail or online at www.mysmilecoverage.com/SOAR. This application must be received by Delta Dental of Arkansas by the 25th of the month prior to the effective date (example: received by January 25th to be effective February 1st). Applications received after the 25th of the month will be made effective on the 1st of the following month (example: received on January 26th, will be effective March 1st).

AUTHORIZATION

I authorize dentists, dental office personnel and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

Applicant's Signature: _____ Date:_____

Signature of Parent/Legal Guardian: _____ Date:_____

(if policy is for a minor only)

City in which application was signed:_____, Arkansas

CERTIFICATION

I understand that if I applied for the dental plan outlined in this brochure I will not have benefits for major restorative services during the first six months after the issue date for a disease or physical condition which I now have or have had in the past, unless I supply Delta Dental of Arkansas with certification of creditable coverage.

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fine and confinement in prison. Statements made in this application are representations not warranties.

_____ _____

Applicant Signature Date

To be completed by sales representative ONLY if applicable

Agent's Name: _____ Agency's Name: H&H Employee Benefit Specialists

Agency NPN#: 01652069 Telephone Number: (888) 224-5233