

2023 ARBenefits Public School Retiree Packet



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

Eligibility

To be eligible for ARBenefits retiree coverage, you must:

1. Be an active member of the ARBenefits plan on the last day of your 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 leave employment.

You can enroll in retiree coverage within 30 days of leaving active employment. If you gain other group coverage when you retire, you can enroll within 30 days of losing that coverage. If you are not eligible to begin your annuity when you retire, you can elect COBRA and enroll within 30 days of becoming eligible for an annuity; otherwise, you will have to wait to enroll after your COBRA coverage ends.

Enrolling in Retiree Coverage

Plan Options

Non-Medicare retirees can enroll in either the Premium, Classic or Basic Plan. Medicare-eligible, retirees can enroll in either the ARBenefits Group MAPD PPO Plan or the ARBenefits Medicare Primary Plan.

The ARBenefits Group Medicare Advantage PPO Plan differs from other Medicare plans you might see advertised and is specifically designed for state and public school retirees. You will see significant savings in your monthly premiums and have additional benefits, including:

- the ability to see any provider (in or out of network) as long as they accept Medicare
- free gym membership
- enhanced hearing and vision benefits
- dental and drug coverage

Completing the Retiree Election Form

You have 30 days from your qualifying event to enroll in a retirement health insurance plan. You must submit this form by mail or fax to be enrolled in retiree coverage, and we will only accept forms sent 30 days before your retirement health effective date.

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.

- If you or your covered spouse is Medicare eligible, you/your spouse can choose from the ARBenefits Group MAPD Plan (administered by UnitedHealthcare) or the ARBenefits Medicare 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 your covered spouse are not Medicare eligible, you can choose the Premium, Classic, or Basic Plan.

Coverage level: Retiree only, Retiree and spouse, Retiree and child(ren), or Retiree and Family Dependents: Only dependents on your active health plan can be added as a dependent on your retiree plan.

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

Please note: You can only be enrolled in one Medicare Advantage Plan or one Medicare Prescription Drug Plan at a time. In addition, with limited exceptions, you cannot be enrolled in a Medicare Advantage Plan and a stand-alone Medicare Prescription Drug Plan simultaneously. If you enroll in any other Medicare Advantage Plan or Medicare Prescription Drug Plan, you may be disenrolled from the ARBenefits Group Medicare Advantage Plan.

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.

Additional Items Needed for Enrollment

In this packet are additional forms that may require your attention, including:

- **Retiree Election form:** This is the general form that all retirees must complete to have coverage.
- **Authorization to Release Information:** Allows authorization for another individual to access your medical information.
- **ARBenefits Spousal Affidavit:** This must be completed to add your spouse to the plan.
- **Colonial Life Retiree Deduction Authorization:** If you want to continue Colonial Life Coverage, you must complete this form.
- **Bank Draft Authorization Form:** If your annuity is not large enough to cover your premium, or you would like your premiums drafted from your bank account, you will need to submit this form.

Please note: The first premium must come from your annuity.

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.

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. If you become Medicare-eligible after retirement, you must submit a copy of your Medicare card to EBD.

Retiree Open Enrollment

Medicare retirees have an Open Enrollment period where they can switch plans. Once you change your plan, you cannot switch plans until the following Open Enrollment period.

Life, Dental and Vision

Dental and Vision

For retirees not on the ARBenefits Group MAPD Plan, dental and vision are provided through the Arkansas State Employee Benefit Advisors (ARSEBA). For more information or to enroll, visit www.mysmilecoverage.com/SOAR. For retirees on the ARBenefits Group MAPD, dental and vision coverage includes an annual eye exam, a \$150 annual allowance for glasses or contacts (not related to cataract surgery), and dental (review plan for allowances).

Life Insurance

If you want to continue any Colonial Life coverage in retirement, 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 later.

Medicare Retirees

Coverage due to ESRD

Entitlement to Medicare Part A is usually 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 the primary payer for a period of thirty (30) months for members on Medicare due to ESRD. During these 30 months of coverage, members will pay the non-Medicare premium rate.

You must notify EBD of your coverage due to ESRD in order for the correct premiums to be deducted. Failure to notify EBD could result in the member being responsible for the difference in back premiums if their Medicare information is incorrectly entered.

If claims are processed incorrectly, it will result in paid medical and/or pharmacy claims being overturned, and the member must have the claims refiled under Medicare.

Medicare claims must be filed no later than 12 months (or one full calendar year) after 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, we must change our records 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 beginning date of Medicare Part A.

Coordination of Benefits with Medicare

The ARBenefits Group MAPD PPO Plan includes the benefits of Medicare Part A, B, and D. The ARBenefits Medicare Premium Plan will coordinate as if Medicare Part A and Part B are both in force at the time of service. If you do not have Part B, the Plan will pay as though you have Medicare Part B, and you 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

The ARBenefits Medicare Premium Plan coordinates with your Medicare Part A & B benefits. To minimize your financial responsibility, EBD will pay your physician claims like you have Medicare Part B coverage even if you choose not to participate in Part B.

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

Our Payment with Medicare Part B

Office Visit \$150.00
Medicare Approved \$110.00
Medicare Payment \$88.00
Medicare Write-off \$40.00
ARBenefits Payment \$22.00
Member Amount Due \$0.00

Our Payment without Medicare Part B

Office Visit \$150.00
Medicare Approved \$110.00
Medicare Payment \$0.00
Medicare Write-off \$40.00
ARBenefits Payment \$22.00
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 Medicare Part C and ARBenefits Medicare Premium Plan.

Medicare Part D (prescription drug plan) is sold through private insurance companies, and we do not coordinate pharmacy benefits. Part D coverage is included if you are on the ARBenefits Group Medicare Advantage Plan (PPO). Public school retirees can sustain drug coverage through Part D if on the ARBenefits Medicare Primary Plan.

Contact with us any additional questions



P.O Box 15610
Little Rock, AR 72231



877-815-1017



Ask.EBD@arkansas.gov

Benefit Highlights

ARBenefits Group Medicare Advantage 13583

Effective January 1, 2023 to December 31, 2023

This is a short summary of your plan benefits and costs. See your Summary of Benefits for more information. Or review the Evidence of Coverage for a complete description of benefits, limitations, exclusions and restrictions. Benefit limits and restrictions are combined in- and out-of-network.

Plan costs

	In-network and out-of-network
Annual medical deductible	No deductible
Annual medical out-of-pocket maximum (the most you pay in a plan year for covered medical care)	You pay nothing for Medicare-covered services from any provider

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network and out-of-network
Doctor's office visit	
Primary care provider (PCP)	\$0 copay
Specialist	\$0 copay
Virtual visits	\$0 copay
Preventive services Medicare-covered	\$0 copay
Inpatient hospital care	\$0 copay per stay
Skilled nursing facility (SNF)	\$0 copay per day up to 100 days
Outpatient surgery	\$0 copay
Outpatient rehabilitation Physical, occupational, or speech/ language therapy	\$0 copay
Outpatient mental health	
Group therapy	\$0 copay
Individual therapy	\$0 copay
Virtual visits	\$0 copay
Diagnostic radiology services such as MRIs, CT scans	\$0 copay
Lab services	\$0 copay
Outpatient X-rays	\$0 copay

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network and out-of-network
Therapeutic radiology services such as radiation treatment for cancer	\$0 copay
Ambulance	\$0 copay
Emergency care	\$0 copay (worldwide)
Urgently needed services	\$0 copay (worldwide)

Additional benefits and programs not covered by Original Medicare

	In-network and out-of-network
Routine physical	\$0 copay; 1 per plan year*
Acupuncture – routine	\$0 copay, 12 visits per plan year*
Chiropractic - routine	\$0 copay, 15 visits per plan year*
Dental - routine	\$0 copay for preventive dental care including exams, cleanings, X-rays and fluoride. Additional fees may apply *
Foot care - routine	\$0 copay, 6 visits per plan year*
Over-the-counter care FirstLine Medical	\$0 copay; You receive \$40 each quarter to use on approved over-the-counter products as shown in the catalog or website.
UnitedHealthcare Healthy at Home	\$0 copay for 28 meals, 12 rides, and 6 hours of in-home personal care up to 30 days following all inpatient and SNF discharges. Referral required.
Hearing - routine exam	\$0 copay, 1 exam per plan year*
Hearing aids	Plan pays a \$2,800 allowance for hearing aids (combined for both ears) every 3 years* .
Vision - routine eye exam	\$0 copay, 1 exam every 12 months*
Vision - routine eyewear	Plan pays \$150 for eyeglasses every 12 months. Or, \$150 for contact lenses instead of eyeglasses every 12 months.*
Fitness program Renew Active® by UnitedHealthcare	\$0 copay for a standard gym membership at participating locations
Telephonic nurse services	Receive access to nurse consultations and additional clinical resources at no additional cost.
Personal Emergency Response System (PERS) Lifeline	\$0 copay for a personal emergency response system.

	In-network and out-of-network
Rally Coach™ Programs	\$0 copay for the Rally Coach™ Programs: Real Appeal® Weight Loss and Real Appeal Diabetes Prevention, Wellness Coaching and the Quit for Life® Tobacco Cessation Program * Refer to your Evidence of Coverage for eligibility requirements.

* Benefits are combined in and out-of-network

Prescription Drugs

	Your cost		
Initial Coverage Stage	Network Retail Pharmacy (31-day retail supply)	Network Retail Pharmacy (93-day retail supply)	Mail Service Pharmacy (93-day supply)
Tier 1: Preferred Generic	\$15 copay	\$45 copay	\$30 copay
Tier 2: Preferred Brand	\$40 copay	\$120 copay	\$80 copay
Tier 3: Non-Preferred Drug	\$80 copay	\$240 copay	\$160 copay
Tier 4: Specialty Tier	\$100 copay	\$300 copay	\$200 copay
Coverage gap stage	After your total drug costs reach \$4,660, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost		
Catastrophic coverage stage	After your out-of-pocket costs (what you pay including coverage gap discount program payments) reach the \$7,400 limit for the plan year, you move to the Catastrophic Coverage Stage. In this stage, you will continue to pay the same cost share that you paid in the Initial Coverage Stage		
Pharmacy Out-of-Pocket Maximum	When your total Out-of-Pocket costs (what you pay) reach \$3,100 you will not pay any copay or coinsurance		

Your plan sponsor offers additional prescription drug coverage. Please see your Additional Drug Coverage list for more information.

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change each plan year.

The Drug List (Formulary), pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Y0066_GRMABH_2023_M

UHEX23PP0071187_000

2023 Plan Year - Schedule of Benefits

ARBenefits Medicare Primary Plan

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% (<i>This benefit would apply when you receive services from a physician that does not accept Medicare assignment.</i>)	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 The ARBenefits Medicare Primary Plan	
School Retiree	<ul style="list-style-type: none">• Members must sustain drug coverage through Medicare Part D.



PUBLIC SCHOOL NON-MEDICARE RETIREES MONTHLY PREMIUMS

2023 Plan Year Rates - Effective January 1, 2023 - December 31, 2023

	Base Monthly Premium	State & Plan Contribution	Monthly Retiree Cost
Premium			
Retiree Only	\$880.85	\$279.67	\$601.18
Retiree & Non-Medicare Spouse	\$1,761.70	\$377.13	\$1,384.57
Retiree & Child(ren)	\$1,213.61	\$109.11	\$1,104.50
Retiree & Non-Medicare Spouse & Child(ren)	\$2,094.47	\$223.27	\$1,871.20
Retiree & Medicare Primary Spouse	\$1,118.70	\$356.59	\$762.11
Retiree & Medicare Primary Spouse & Child(ren)	\$1,451.46	\$185.99	\$1,265.47
Retiree & MAPD Primary Spouse	\$966.16	\$356.48	\$609.68
Retiree & MAPD Primary Spouse & Child(ren)	\$1,299.74	\$186.06	\$1,113.68
Classic			
Retiree Only	\$765.79	\$488.33	\$277.46
Retiree & Spouse	\$1,531.58	\$919.12	\$612.46
Retiree & Child(ren)	\$1,055.09	\$569.51	\$485.58
Retiree & Family	\$1,820.88	\$1,029.88	\$791.00
Basic			
Retiree Only	\$675.89	\$521.19	\$154.70
Retiree & Spouse	\$1,351.77	\$1,022.02	\$329.75
Retiree & Child(ren)	\$931.22	\$662.29	\$268.93
Retiree & Family	\$1,607.11	\$1,199.06	\$408.05
The Basic plan meets the minimum essential coverage required under A.C.A.			



**PUBLIC SCHOOL MEDICARE PRIMARY RETIREES
MONTHLY PREMIUMS**

2023 Plan Year Rates - Effective January 1, 2023 - December 31, 2023

Medicare Eligible	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
Retiree Only	\$237.85	\$126.96	\$110.89
Retiree & Non-Medicare Spouse	\$1,118.70	\$334.78	\$783.92
Retiree & Child(ren)	\$571.43	\$27.21	\$544.22
Retiree & Non-Medicare Spouse & Child(ren)	\$1,454.46	\$70.58	\$1,383.88
Retiree & Medicare Primary Spouse	\$475.69	\$203.87	\$271.82
Retiree & Medicare Primary Spouse & Child(ren)	\$808.45	\$38.50	\$769.96

Subsidy authorized by Act 1075 of 2011

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



**PUBLIC SCHOOL MEDICARE PRIMARY RETIREES
MONTHLY PREMIUMS**

2023 Plan Year Rates - Effective January 1, 2023 - December 31, 2023

Medicare Eligible	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
MAPD Retiree Only	\$85.31	\$76.78	\$8.53
MAPD Retiree & Non-Medicare Spouse	\$966.16	\$250.84	\$715.32
MAPD Retiree & Child(ren)	\$418.89	\$19.95	\$398.94
MAPD Retiree & Non-Medicare Spouse & Child(ren)	\$1,301.92	\$62.00	\$1,239.92
MAPD Retiree & MAPD Primary Spouse	\$170.62	\$153.56	\$17.06
MAPD Retiree & MAPD Primary Spouse & Child(ren)	\$504.20	\$24.01	\$480.19

Subsidy authorized by Act 1075 of 2011

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

Arkansas State & Public School Retiree ELECTION FORM

Part 1: Employee Information							
Legal First Name	MI	Legal Last Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Enroll in the Plan <input type="checkbox"/> Enroll as a Surviving Spouse <input type="checkbox"/> Add/Drop a Dependent <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Change Address		Retirement System <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> APERS (State) 998 <input type="checkbox"/> APERS (School) 059002 <input type="checkbox"/> APERS Judicial 021 <input type="checkbox"/> Highway Dept. 091 </div> <div> <input type="checkbox"/> ATRS (School) 059001 <input type="checkbox"/> ATRS (State) 999 <input type="checkbox"/> VALIC/TIFF - Alternate Retirement- (Bank Draft) </div> </div>					
Select a Benefit Plan: <input type="checkbox"/> MAPD <input type="checkbox"/> Premium <input type="checkbox"/> Classic <input type="checkbox"/> Basic		Select a Coverage Level: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse </div> <div> <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Family </div> </div>					
Medicare							
Our plans 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
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
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, 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. 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 Transformation and Shared Services | Employee Benefits Division
Post Office Box 15610 | Little Rock, AR 72231-5610 | Fax: 501.682.1200

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE RETURNED FOR COMPLETION PRIOR TO PROCESSING TO ENSURE ACCURACY.

NOTE: As a Medicare eligible retiree of the State of Arkansas you will be enrolled in the ARBenefits Group Medicare Advantage Plan (MAPD) with the option to opt-out and enroll the Medicare Primary Premium Plan option. Currently, United Health Care is the carrier for the MAPD plan and Health Advantage is the carrier for the Medicare Primary Premium Plan. Each Member is required to maintain Medicare Part A and Part B coverage. A copy of the Medicare card is required for any subscriber and/or spouse/dependent.

ARBenefits Medicare Primary 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 Part B, and the member will have full financial responsibility for incurred claims.

Public School Retirees that opt-out of the ARBenefits Group MAPD plan and choose the Medicare Primary Premium Plan will 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

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.

Select One:

☐ Retirement Effective Date: _____ or ☐ COBRA Effective Date: _____

Type of Account <input type="checkbox"/> Checking (requires Voided Check) <input type="checkbox"/> Savings**	Date of Draft (select preferred for COBRA or Retirement – Note 28 th is available to Retirees ONLY) <input type="checkbox"/> 5 th <input type="checkbox"/> 20 th <input type="checkbox"/> 7 th <input type="checkbox"/> 28 th (Retirement Only) <input type="checkbox"/> 15 th	COBRA – All COBRA NSF drafts must be paid by end of month to avoid termination of COBRA health insurance. COBRA – 1st payment MUST be made by check.
---	--	--

****Routing #:** _____ **Deduction Amount: \$** _____

****Account #:** _____ **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)

Authorized Signer Signature: _____
(Authorized Signer) (Date)

Insured's Social Security No: _____

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

Employee Benefits Division - ARBenefits
P.O. Box 15610 * Little Rock, AR 72231 * 877-815-1017
<https://www.transform.ar.gov/employee-benefits/>



Affidavit of Spousal Health Care Coverage

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: _____

Employee Benefits Division - ARBenefits

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

TRANSFORM.AR.GOV



Authorization to Release Information

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

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.



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.

2022 Retiree Rates* (per \$1,000)	
Monthly cost of coverage	
Retiree basic and expanded basic group term life with AD&D insurance	
\$0.98 per \$1,000	
Retiree supplemental group term life with AD&D insurance	
Age	Employee
Under 50	\$0.36
50-54	\$0.57
55-59	\$0.83
60-64	\$1.24
65-69	\$2.42
70-74	\$ 3.94
75+	\$ 7.85
Retiree supplemental spouse group term life with AD&D insurance	
All eligible ages	\$1.11
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.

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: <input type="checkbox"/> AR State Employee <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yyyy)
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 <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Separation <input type="checkbox"/> Birth or Adoption of Child <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Divorce <input type="checkbox"/> Annulment <input type="checkbox"/> Placement of Child for Adoption <input type="checkbox"/> Death of Dependent Child			Event Date
Service Requested			
<input type="checkbox"/> Cancel Retiree Coverage <input type="checkbox"/> Decrease Coverage <input type="checkbox"/> Cancel Dependent Child(ren) Coverage <input type="checkbox"/> Change Address <input type="checkbox"/> Surviving Spouse Coverage Continuation <input type="checkbox"/> Cancel Spouse Coverage <input type="checkbox"/> Change Name <input type="checkbox"/> 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		<input type="checkbox"/> Cancel	\$5,000
Expanded Basic Group Term Life and AD&D		<input type="checkbox"/> Cancel <input type="checkbox"/> Decrease	\$
Supplemental Group Term Life and AD&D		<input type="checkbox"/> Cancel <input type="checkbox"/> Decrease	\$
Spouse Supplemental Group Term Life and AD&D		<input type="checkbox"/> Cancel <input type="checkbox"/> Decrease	\$
1Dependent Child(ren) Supplemental Group Term Life and AD&D		<input type="checkbox"/> Cancel <input type="checkbox"/> Decrease	\$
1Elected child(ren) coverage includes all eligible dependents. If cancelling, all dependent child(ren) coverage will be removed.			
Name Change			
Previous:	Current:	Reason: <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> 2Correction <input type="checkbox"/> 2Other	
2A 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:			
<input type="checkbox"/> APERS State (998) <input type="checkbox"/> ATRS School (059001) <input type="checkbox"/> APERS School (059002) <input type="checkbox"/> ATRS State (999) <input type="checkbox"/> HIGHWAY DEPARTMENT (091) <input type="checkbox"/> JUDICIAL (021)			
If you wish to pay your premiums on a direct pay basis, check and complete Premium Payment Method Change Section below. <input type="checkbox"/>			
Premium Payment Method Change – If your premiums will not be deducted from your retirement check, please select a payment method			
1. <input type="checkbox"/> Please deduct monthly premiums from my bank account. <input type="checkbox"/> 1st - 5th <input type="checkbox"/> 6th - 10th <input type="checkbox"/> 11th - 15th <input type="checkbox"/> 16th - 20th <input type="checkbox"/> 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. <input type="checkbox"/> Please bill me directly. (Choose one of the following): <input type="checkbox"/> Quarterly (3 times your monthly premium) <input type="checkbox"/> Semi-Annual (6 times your monthly premium) <input type="checkbox"/> Annual (12 times your monthly premium)	
IPG for direct pay retiree policies (Internal use only): 12058329			

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)



DENTAL AND VISION PLANS

State of Arkansas Retiree Program

Individual and family
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



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.



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

REQUESTED EFFECTIVE DATE

MONTH

DAY
1st

YEAR

Individual & Family Application | Plan number SOARR01

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

APPLICANT INFORMATION

Name:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Routing Number: _____	Include a voided check with application.
Bank Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Number: _____	

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