2024 ARBenefits Public School Retirement Packet

Employee Benefits Division · ARBenefits
PO Box 15610 · Little Rock, AR 72231 · 877-815-1017
Fax: 501-682-1200

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Eligibility

To be eligible for ARBenefits retiree coverage:

1. Employees hired before July 2022 must be an active member of the ARBenefits plan on the last day of their employment; OR
2. Employees hired after July 2022 must have five (5) cumulative years enrolled on the plan; and
3. Begin drawing an annuity through their participating retirement system.

Former employees are held to the retirement eligibility rules in place when they left employment.

You have thirty (30) days to enroll in retiree coverage after meeting all three above criteria.

If you gain other group coverage upon retirement, you must enroll within thirty (30) days of losing that coverage.

Non-Medicare Retirees

If you are not yet eligible for Medicare, you can still remain on ARBenefits health insurance.

You must notify EBD of your retirement from the state so EBD can terminate your active coverage. You can elect to continue working or become a dependent on your spouse's coverage

Pre-65 Non-Medicare Retiree Plan Options

Non-Medicare retirees can enroll in either the Premium, Classic, or Basic Plan. These are the same plans you had as an active member.

	Premium	Classic	Basic
Individual Deductible	$750	$1,750	$4,000
Family Deductible	$1,500	$3,200/$3,300	$8,000
Individual Out-of-Pocket	Medical: $3,250 Pharmacy: $3,100	$6,450	$6,450
Family Out-of-Pocket	Medical: $6,500 Pharmacy: $6,200	$9,675	$12,900
Doctor's Office Visit	$25 copay	20% after Deductible	20% after Deductible
Specialist Office Visit	$50 copay	20% after Deductible	20% after Deductible
Urgent Care Visit	$100 copay	20% after Deductible	20% after Deductible
In-Patient Services	20% after Deductible	20% after Deductible	20% after Deductible
Out-Patient Services	20% after Deductible	20% after Deductible	20% after Deductible
Wellness Exams/Preventative Care	$0	$0	$0

Medicare Retirees

Medicare eligible retirees can select from the two Medicare plans with ARBenefits starting the first month of Medicare eligibility.

Ninety (90) days prior to turning sixty-five (65), you will receive a Pre-65 Election Request Letter. You must submit your completed Retiree Election Form and all other required documentation to EBD forty-five (45) calendar days from the date of the Election Request letter.

To enroll in Medicare Part A & Part B and learn more, you can:

- Visit https://www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)

You will need to provide EBD with a copy of your Medicare card showing the start date(s) of your Medicare Part A & Part B.

Medicare Retiree Plan Options

Medicare-eligible retirees can enroll in either the UnitedHealthcare (UHC) Group Medicare Advantage with Prescription Drugs PPO Plan (MAPD) or the Health Advantage (HA) Medicare Primary Plan.

Option 1 Provided by UnitedHealthcare

The ARBenefits UHC MAPD plan differs from other Medicare plans you might see advertised and is designed specifically for state and public school Medicare-eligible retirees. The ARBenefits UHC MAPD plan includes the benefits of Medicare Part A, B, and D (you cannot enroll in a separate Part D plan under this option).

Additional benefits include:

- The ability to see any provider (in or out of network) as long as they accept Medicare
- Free gym memberships
- Enhanced hearing and vision benefits
- Dental coverage
- Drug coverage with drug list managed by UHC

For more information:

- Call UnitedHealthcare: 1-844-488-3953
- Visit: www.transform.ar.gov/employee-benefits/retirees/medicare-advantage

IMPORTANT: You can only be enrolled in ONE (1) Medicare Advantage Plan or ONE (1) Medicare Prescription Drug Plan (Medicare Part D) at a time. If you enroll in ANY other Medicare Advantage or Medicare Part D plan, you will AUTOMATICALLY be disenrolled from the ARBenefits UHC MAPD Group Plan and lose the benefits you have selected.

Option 2 Provided by Health Advantage

The Health Advantage Medicare Primary Plan coordinates with your Medicare Part A & B benefits.

Public School Employee Medicare retirees do not have prescription drug coverage under the Health Advantage Plan and have to enroll in a separate Part D plan for drug coverage.

EBD will pay your physician claims like you have Medicare Part B coverage, even if you choose not to participate in Part B.

For more information you can contact EBD at: 1-877-815-1017.

Remember: If you cancel your ARBenefits retirement coverage to leave the plan for any reason OTHER than gaining employment with an Arkansas state agency or an Arkansas public school district, that cancellation is FINAL and you cannot return to the ARBenefits plan.

Coordination of Benefits with Medicare

The Health Advantage Medicare Primary 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 Medicare Part B, the Plan will pay as though you have Medicare Part B, and you will be responsible for any 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

Examples of patient responsibility/liability with and without Medicare Part B:

Your payment with Medicare Part B
Office visit: $150
Medicare approved: $110
Medicare payment: $88
Medicare write-off: $40
ARBenefits payment: $22
Member amount due: $0

Your payment without Medicare Part B
Office visit: $150
Medicare approved: $110
Medicare payment: $0
Medicare write-off: $40
ARBenefits payment: $22
Member amount due: $88

Medicare Part C (Medicare Advantage) is another Medicare health plan choice that provides all of your Part A and Part B coverage and many also provide Part D. Medicare pays a fixed amount to companies offering Medicare Advantage Plans and they must follow the rules set by Medicare.

Medicare Part D is a prescription drug plan that can be provided under a Part C plan or sold by private insurance companies.

Part D coverage is included in the UHC MAPD plan and if you sign up for a Part D plan while on the MAPD plan you will be kicked off and not permitted to return to any ARBenefits plan.

Public School Retirees do not have drug coverage included with the Health Advantage Primary Medicare Plan.

Retiree Open Enrollment

You are only allowed to change plans during the Retiree Open Enrollment Period. You are not permitted to add any other dependents as part of Open Enrollment.

If you do not wish to make any changes to your plan during Open Enrollment, then no update is needed from you.

Any changes made during Open Enrollment with take effect January 1 of the following year.

Life, Dental, and Vision Insurance

Life Insurance

If you want to continue any Colonial Life coverage in retirement you must submit the Colonial Life Election Form. If Colonial Life does not receive your election form within thirty-one (31) days after your retirement date, then you cannot regain that coverage later.

The Arkansas State Employee Benefit Advisors (ARSEBA) has more options for life insurance coverage for retirees. Contact them to discuss those options at 501-224-5234.

Dental and Vision

Dental and vision are also provided through ARSEBA. For more information or to enroll, visit www.mysmilecoverage.com/SOAR.

For retirees on the UHC MAPD Plan, dental and vision coverage includes an annual eye exam, a $150 annual allowance for glasses or contacts (not related to cataract surgery), and limited preventative dental care (review plan for allowances). UHC MAPD Plan members are allowed to enroll in additional dental and vision coverage.

Completing the Retiree Election Form

Eligible retirees can begin submitting the Retiree Election Form thirty (30) days prior to their eligibility date and have until thirty (30) days AFTER the eligibility date to enroll in coverage.

You must submit a Retiree Election Form to EBD in order to be enrolled in retiree coverage.

These are the individual boxes you will see on the form and what EBD needs for each of them:
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 the correct retirement system. Public School employees mark ATRS.
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 UnitedHealthcare MAPD or the Health Advantage Primary Plan. Medicare eligibility is determined by age - 65 or older - or by 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 Health Advantage 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 dependents on your retirement plan.

Sign and date your form and enter your email address.

Once eligibility requirements are met, the effective date of coverage is the first day of the month following the date EBD receives your completed application for your retirement health insurance.

Example: If EBD receives completed forms on 2/15, then coverage will begin on 3/1.

Arkansas 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 leave the ARBenefits retirement plan, you will no longer be eligible for participation in the plan. This decision is FINAL.

Once you become eligible for Medicare, please provide EBD with a copy of your Medicare card, indicating the start dates of both Medicare Part A and Part B coverage.

EBD may also request updated documents to maintain eligibility for our records.

This packet contains additional forms that may require your attention, including:

Retiree Election Form: The general form that all retirees must complete to select coverage.
Authorization to Release Information: Allows authorization for another individual to access your medical information. If you have a Power of Attorney (POA) on file, you do not need this form.
ARBenefits Spousal Affidavit: This must be completed to add your spouse to the plan.
Colonial Life Retiree Deduction Authorization: If you want to continue with Colonial Life coverage with the state, you must complete this form.
Dental and Vision Form: These must be completed to add retirement dental and/or vision coverage.
Bank Draft Authorization Form: If your annuity is not enough to cover your premium or if you would like your premiums drafted from your bank account, you will need to submit this form. If you choose to have your premium drafted from your bank account, you must include a second, voided check along with the Bank Draft Authorization Form.

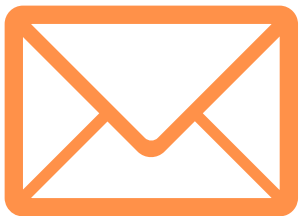
Payment

EBD requires a check payment as the initial payment for retirement insurance.

If you choose to have your premiums taken from your annuity, it will begin the second month of coverage.

You can choose to have premium payments come out of your bank account or your annuity at any time.

Contact EBD with any additional questions



P.O. Box 15610
Little Rock, AR 72231

877-815-1017

Ask.EBD@arkansas.gov

Other Contact Information

Phone: 501-682-1517
Toll Free: 800-666-2877
Website: www.artrs.gov

Phone: 501-224-5234
Fax: 501-663-1445
Toll Free: 800-682-7377
Email: service@arseba.com
Website: www.apers.org

Phone: 501-683-3151
Toll Free: 800-525-4368
Website: www.coloniallife.com

Phone: 501-301-9900
Website: www.voya.com

Phone: 800-633-4227
Website: www.Medicare.gov

Phone: 800-772-1213
Website: www.SSA.gov

Summary of Benefits

January 1, 2024 - December 31, 2024

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

ARBenefits Group Medicare Advantage (PPO)

Medical premium and limits	
	In-network and out-of-network
Monthly plan premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Maximum out-of-pocket amount (does not include prescription drugs)	$0 for Medicare-covered services from any provider If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the plan year. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.

Medical benefits		
		In-network and out-of-network
Inpatient hospital care[1]		$0 copay per stay Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital[1] Cost sharing for additional plan covered services will apply.	Ambulatory surgical center (ASC)	$0 copay
	Outpatient surgery	$0 copay
	Outpatient hospital services, including observation	$0 copay
Doctor visits	Primary care provider	$0 copay
	Virtual doctor visits	$0 copay
	Specialists[1]	$0 copay
Preventive services	Routine physical	$0 copay; 1 per plan year*
	Medicare-covered	$0 copay ▯ Abdominal aortic aneurysm screening ▯ Alcohol misuse counseling ▯ Annual wellness visit ▯ Bone mass measurement ▯ Breast cancer screening (mammogram) ▯ Cardiovascular disease (behavioral therapy) ▯ Cardiovascular screening ▯ Cervical and vaginal cancer screening ▯ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▯ Depression screening ▯ Diabetes screenings and monitoring ▯ Diabetes – Self-Management training ▯ Dialysis training ▯ Glaucoma screening ▯ Hepatitis C screening ▯ HIV screening ▯ Kidney disease education ▯ Lung cancer with low dose computed tomography (LDCT) screening ▯ Medical nutrition therapy services

Medical benefits		
		In-network and out-of-network
		▯ Medicare Diabetes Prevention Program (MDPP) ▯ Obesity screenings and counseling ▯ Prostate cancer screenings (PSA) ▯ Sexually transmitted infections screenings and counseling ▯ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▯ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19 ▯ "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100%.
Emergency care		$0 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently needed services		$0 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g. MRI, CT scan)[1]	$0 copay
	Lab services[1]	$0 copay
	Diagnostic tests and procedures[1]	$0 copay
	Therapeutic radiology[1]	$0 copay
	Outpatient X-rays[1]	$0 copay

Medical benefits		
		In-network and out-of-network
Hearing services	Exam to diagnose and treat hearing and balance issues[1]	$0 copay
	Routine hearing exam	$0 copay, 1 exam per plan year*
	Hearing Aids	The plan pays up to a $2,800 allowance for hearing aids (combined for both ears) every 3 years.*
Routine dental services See Evidence of Coverage for more details.	Oral exams	$0 copay, 2 procedures per plan year.
	Routine cleaning	$0 copay, 2 procedures per plan year.
	Dental bitewing X-rays	$0 copay, 1 procedure per plan year.
	Minor Services (Includes Fillings and Nitrous Oxide)	$0 copay, unlimited per plan year.
	Benefit limit	$0 yearly deductible and $500 combined in and out-of-network plan year maximum. If you receive services from an out-of-network dentist, the plan pays according to a maximum allowable fee schedule. You pay all fees in excess of this amount.
Vision services	Exam to diagnose and treat diseases and conditions of the eye[1]	$0 copay
	Eyewear after cataract surgery	$0 copay
	Routine eye exam	$0 copay, 1 exam every 12 months*
	Routine eyewear	Plan pays up to $150 for eyeglasses, or $150 for contact lenses instead of eyeglasses, every 12 months.*

Medical benefits		
		In-network and out-of-network
Mental Health	Inpatient visit[1]	$0 copay per stay Our plan covers an unlimited number of days for an inpatient hospital stay.
	Outpatient group therapy visit[1]	$0 copay
	Outpatient individual therapy visit[1]	$0 copay
	Virtual behavioral visits	$0 copay
Skilled nursing facility (SNF)[1]		$0 copay per day: days 1-100 Our plan covers up to 100 days in a SNF per benefit period.
Outpatient Rehabilitation (physical, occupational, or speech/language therapy)[1]		$0 copay
Ambulance[2]		$0 copay
Medicare Part B Drugs Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Chemotherapy drugs[1]	$0 copay
	Other Part B drugs[1]	$0 copay

Prescription drugs

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D prescription drug benefit and your supplemental drug coverage. You can view the Certificate of Coverage at retiree.uhc.com/ARBenefits or call Customer Service to have a hard copy sent to you.

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

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 31-day supply at a retail pharmacy.

Stage 1: Annual Prescription (Part D) Deductible	Since you have no deductible, this payment stage doesn't apply.		
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing** **31-day supply**	**Retail Cost-Sharing** **93-day supply**	**Mail Order Cost-Sharing** **93-day supply**
Tier 1: Preferred Generic	$15 copay	$45 copay	$30 copay
Tier 2: Preferred Brand [1]	$40 copay	$120 copay	$80 copay
Tier 3: Non-Preferred Drug [1]	$80 copay	$240 copay	$160 copay
Tier 4: Specialty Tier [1]	$100 copay	$300 copay	$200 copay
Stage 3: Coverage Gap Stage	After your total drug costs reach $5,030, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.		
Stage 4: Catastrophic Coverage	During this payment stage, the plan pays the full cost for your covered drugs. You pay nothing.		

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.

[1] You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

Additional benefits		
		In-network and out-of-network
Acupuncture services	Medicare-covered acupuncture (for chronic low back pain)	$0 copay
	Routine acupuncture services	$0 copay, up to 12 visits per plan year*
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1]	$0 copay
	Routine chiropractic services	$0 copay, up to 15 visits per plan year*
Diabetes management	Diabetes monitoring supplies[1]	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch® Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay
	Diabetes self-management training	$0 copay

Additional benefits		
		In-network and out-of-network
	Therapeutic shoes or inserts[1]	$0 copay
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	$0 copay
	Prosthetics (e.g., braces, artificial limbs)[1]	$0 copay
Fitness program Renew Active® by UnitedHealthcare		$0 copay for Renew Active® by UnitedHealthcare, the gold standard in Medicare fitness programs for body and mind. It includes a free gym membership at a fitness location you select from our nationwide network, online classes, content about brain health and fun social activities. Visit UHCRenewActive.com to learn more today. Once you become a member you will need a confirmation code. Log in to your plan website, go to Health & Wellness and select Renew Active or call the number on your UnitedHealthcare member ID card to obtain your code.
Foot care (podiatry services)	Foot exams and treatment[1]	$0 copay
	Routine foot care	$0 copay, 6 visits per plan year*
Over-the-counter (OTC) card Healthy Benefits Plus		$0 copay $40 credit each quarter to purchase approved OTC items from network retail locations or through the OTC catalog. Credits expire at the end of each quarter. Shop in store, call or go online. 1-833-216-6709, TTY 711, visit HealthyBenefitsPlus.com/UHCRetiree, or download the Healthy Benefits Plus app.

Additional benefits		
		In-network and out-of-network
UnitedHealthcare Healthy at Home		$0 copay for the following benefits for up to 30 days after each inpatient and SNF discharge: □ 28 home-delivered meals* □ 12 one-way trips to medically related appointments and the pharmacy* □ 6 hours of non-medical personal care services - a professional caregiver can help with preparing meals, companionship, medication reminders, and more. No referral required. Call the customer service number on your UnitedHealthcare member ID card for more information and to use your benefits. *Call Customer Service to request a referral for each discharge. Some restrictions and limitations may apply.
Home health care[1]		$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Personal emergency response system (PERS) Lifeline		$0 copay for a personal emergency response system. Help is only a button press away. A PERS wearable device can quickly connect you to the help you need, 24 hours a day in any situation. Call or go online to order your device. 1-855-595-8485, TTY 711 or lifeline.com/uhcgroup
24/7 Nurse Support		Receive access to nurse consultations and additional clinical resources at no additional cost.
Opioid treatment program services[1]		$0 copay
Outpatient substance abuse	Outpatient group therapy visit[1]	$0 copay
	Outpatient individual therapy visit[1]	$0 copay

Additional benefits	
	In-network and out-of-network
Rally Coach™ Programs	$0 copay for Rally Coach™ programs: Real Appeal® Weight Management, Real Appeal Diabetes Prevention, Wellness Coaching and a tobacco cessation program. Call or go online to get started today. rallyhealth.com/retiree • Real Appeal 1-844-924-7325, TTY 711 • Rally Wellness Coaching 1-800-478-1057, TTY 711 • Tobacco Cessation 1-866-784-8454, TTY 711 *Refer to your Evidence of Coverage for eligibility requirements
Renal Dialysis[1]	$0 copay

[1] Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.
[2] Authorization is required for non-emergency Medicare-covered ambulance air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground transportation. Emergency ambulance (ground or air) does not require authorization.

*Benefits are combined in and out-of-network

About this plan

ARBenefits Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

About providers and network pharmacies

ARBenefits Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare Program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **retiree.uhc.com/ARBenefits** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

2024 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.

RATES


ARKANSAS DEPARTMENT OF
AR
TRANSFORMATION AND SHARED SERVICES

AR BENEFITS

PUBLIC SCHOOL NON-MEDICARE RETIREE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2024 – DECEMBER 31, 2024

PLAN	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTALLY MONTHLY RETIREE COST
PREMIUM			
RETIREE ONLY	$880.85	$351.89	$528.96
RETIREE & NON-MEDICARE SPOUSE	$1,761.70	$515.08	$1,246.62
RETIREE & CHILD(REN)	$1,213.61	$241.81	$971.80
RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$2,094.47	$443.55	$1,650.92
RETIREE & MEDICARE PRIMARY SPOUSE	$1,118.70	$421.92	$696.78
RETIREE & MEDICARE PRIMARY SPOUSE & CHILD(REN)	$1,451.46	$311.82	$1,139.64
RETIREE & MAPD PRIMARY SPOUSE	$966.16	$428.16	$538.00
RETIREE & MAPD PRIMARY SPOUSE & CHILD(REN)	$1,299.74	$318.38	$981.36
CLASSIC			
RETIREE ONLY	$765.79	$513.61	$252.18
RETIREE & SPOUSE	$1,531.58	$932.04	$599.54
RETIREE & CHILD(REN)	$1,055.09	$594.31	$460.78
RETIREE & FAMILY	$1,820.88	$1,060.94	$759.94
BASIC			
RETIREE ONLY	$675.89	$542.35	$133.54
RETIREE & SPOUSE	$1,351.77	$1,017.37	$334.40
RETIREE & CHILD(REN)	$931.22	$669.54	$261.68
RETIREE & FAMILY	$1,607.11	$1,197.55	$409.56
The Basic Plan meets the minimum essential coverage required under A.C.A.			

State Contribution is funded by legislation.

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

AR BENEFITS

PUBLIC SCHOOL MEDICARE UNITEDHEALTHCARE (UHC) MAPD GROUP RETIREE MONTHLY PREMIUMS (MEDICAL & PHARMACY)

RATES EFFECTIVE JANUARY 1, 2024 – DECEMBER 31, 2024

MEDICARE ELIGIBLE	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
MAPD RETIREE ONLY	$90.31	$81.28	$9.03
MAPD RETIREE & NON-MEDICARE SPOUSE	$966.16	$296.88	$669.28
MAPD RETIREE & CHILD(REN)	$418.89	$51.67	$367.22
MAPD RETIREE & MAPD CHILD	$180.62	$162.56	$18.06
MAPD RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$1,056.47	$378.16	$678.31
MAPD RETIREE & NON-MEDICARE SPOUSE & MAPD CHILD	$1,561.92	$781.78	$780.14
MAPD RETIRE & MAPD SPOUSE	$180.62	$162.56	$18.06
MAPD RETIREE & MAPD SPOUSE & CHILD(REN)	$508.44	$77.60	$430.84
MAPD RETIREE & MAPD SPOUSE & MAPD CHILD	$270.93	$243.84	$27.09

Subsidy authorized by Act 1075 of 2011.

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

AR BENEFITS

PUBLIC SCHOOL MEDICARE HEALTH ADVANTAGE (HA) PREMIUM RETIREE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2024 – DECEMBER 2024

MEDICARE ELIGIBLE	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTALLY MONTHLY RETIREE COST
RETIREE ONLY	$240.37	$118.39	$121.98
RETIREE & NON-MEDICARE SPOUSE	$1,118.70	$353.52	$765.18
RETIREE & CHILD(REN)	$571.43	$50.81	$520.62
RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$1,454.46	$199.98	$1,254.48
RETIREE & MEDICARE PRIMARY SPOUSE	$480.74	$182.64	$298.10
RETIREE & MEDICARE PRIMARY SPOUSE & CHILD(REN)	$809.46	$72.40	$737.06

Subsidy authorized by Act 1075 of 2011.

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

FORMS

AR BENEFITS

State & Public-School Retirement Election Form

Employee Information

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

Mailing Address	City	State	Zip Code

Physical Address

Event	Event Date	Date Annuity Begins	Home/Cell Number

Coverage

Type of Action

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

Choose Retirement System

- ☐ APERS (State) 998
- ☐ APERS (School) 059002
- ☐ APERS Judicial 021
- ☐ Highway Dept. 091
- ☐ ATRS (State) 999
- ☐ ATRS (School) 059001
- ☐ VALIC/TIFF - Alternate Retirement (Bank Draft)

Payment Method

***Please complete Bank Draft Authorization Form**

- ☐ Annuity
- ☐ Checking*
- ☐ Savings*

Pre-65 Plan

- ☐ Premium ☐ Basic
- ☐ Classic

Post-65 Plan

- ☐ United HealthCare MAPD
- ☐ Health Advantage Premium

Choose Coverage Level

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

Medicare

Our plans require Medicare-eligible Retirees to be enrolled in BOTH Medicare Part A & B.

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents. To complete the RELATIONSHIP column, use the number that describes the dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardian - 3

ADD	DROP	NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying 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 give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the heath plan/insurer, for any administrative purpose, including evaluation of an application or claim. 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

Department of Transformation and Shared Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-682-1200

Rev. 8/1/2023

Instructions

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

Currently UnitedHealthCare is the provider for the Group Medicare Advantage Plan (MAPD) plan and Health Advantage is the provider for the Medicare Primary Premium Plan. Each Medicare eligible member is required to maintain Medicare Part A & 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 & 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 coverage. The member will have full financial responsibility for incurred claims.

Public School Retirees who choose the Medicare Primary Premium Plan will NOT have pharmacy benefits through this plan. You will be required to obtain Medicare Part D for your pharmacy needs.

If you choose the UnitedHealthCare MAPD Plan and enroll in a separate Medicare plan outside of ARBenefits, you will automatically be canceled from ARBenefits coverage. If you have questions about your coverage, call ARBenefits before making your decision.

The Bank Draft Authorization Form, with VOIDED check attached, is required if your retirement annuity is not able to cover the full cost of your premiums. WE CANNOT PROCESS WITHOUT A VOIDED CHECK.

Your premiums are taken out post-tax.

IF YOU CANCEL YOUR RETIREMENT INSURANCE OTHER THAN BY GAINING EMPLOYMENT WITH A STATE AGENCY OR PUBLIC SCHOOL, YOU WILL NOT BE ABLE TO COME BACK TO THE PLAN AND THE DECISION IS FINAL.

Completion of this form does not guarantee coverage on the retirement plan as certain conditions must be met in order to be enrolled on to either ARBenefits Retirement Plans.

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 with the ASE or PSE retirement 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) year vesting period effective 7/1/1997.
- Retirees with service prior to 7/1/1997 are still held to the ten (10) year vesting period.
- Non-teaching school retirees that are paid under Arkansas Public Employees Retirement System (APERS) have school rates.
- Most college and county employed 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: birth certificates, marriage licenses, court documents, and a Certificate of Credible Coverage (COCC) for loss of coverage.

If adding dependent as a permanent legal guardian you must include court documents and they will be subject to annual review.

You can also submit documents online through the ARBenefits Member Portal at www.myarbenefits.org.

For assistance, contact ARBenefits at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:30PM CST or email us at Ask.EBD@arkansas.gov.

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

Coverage is effective the 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-682-1200

SUBMISSION TO EBD IS FINAL

AR BENEFITS Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse or when dropping a spouse due to gaining employer group coverage.

Pursuant to Arkansas Code Ann. §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 ARBenefits 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. Is your spouse eligible for his/her employer-sponsored group health plan?

   ☐ Yes

   ☐ No (If no, please submit information from your spouse's employer as to why your spouse is not covered)

For any questions or concerns, contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits 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: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

AR BENEFITS

BANK DRAFT AUTHORIZATION

I 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. First month Retirement and COBRA payments MUST BE MADE BY CHECK.

All COBRA NSF drafts must be paid by the end of the month to avoid termination of coverage.

Select One:

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

☐ Annuity Routing #: _____

☐ Bank Draft Account #: _____

Type of Account	**Date of Draft**
☐ **Checking** (requires voided check) ☐ **Savings**	☐ **5th** ☐ **7th** ☐ **15th** ☐ **20th** ☐ **28th** ***Not available for COBRA**

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)

Member ID #: _____ Last 4 SSN: _____

Per Arkansas Code Ann. §5-37-301, 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.

*** Please enclose the first month's payment AND a voided check for bank drafts. MUST have original check - no copies (Deposit Slip can NOT be used) ***

MAIL FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610

Authorization to Release Information

This form is used to release your protected health infomation as required by federal and state privacy laws. Your authorization allows the Employee Benefits Division (EBD) 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 or filling out the Authorization to Revoke Release of Health Information form. Revoking this authorization will not effect any action taken prior to receipt of your written request.

Member Information (individual whose information will be released)

Name: _____ Member ID #: _____

Home Number: _____ Cell Number: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Recipient (Person or Organization that will receive your information)

Person's Name or Organization: _____

Address: _____ Home Number: _____

Person's Name or Organization: _____

Address: _____ Home Number: _____

Description of the Information to 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 select an option above, 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 the ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understnad 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 fo 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 Date

_____

Printed Name of Member or Legal Representative

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division

ATTN: Eligibility Department - PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

AR BENEFITS RETIREE CHANGE OF ADDRESS FORM

☐ **Changing Physical Address** ☐ **Changing Mailing Address** ☐ **Changing Both**

First Name	MI	Last Name
Member ID or Social Security Number		

PREVIOUS ADDRESS

Address		
City	State	Zip Code

NEW ADDRESS

Address		
City	State	Zip Code

Signature	Date	Phone Number

MAIL COMPLETED FORM TO:

TSS - EMPLOYEE BENEFITS DIVISION
PO BOX 15610
LITTLE ROCK, AR 72231

OR

FAX COMPLETED FORM TO:

501-682-1200

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

The dedicated Arkansas Customer Service number is 1-855-868-6009
Monday – Friday – 8:00 a.m. – 8:00 p.m.

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.

3-21 | NS-586158

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
Employee and spouse coverages are reduced by 50% of the active employee coverage. At age 75, employee and spouse coverages are 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:

☐ ARDOT RETIREES SOA 091 (E5373097)
☐ APERS STATE RETIREES 998 (E5381462)
☐ ARTRS RETIREES SOA 999,059001 (E5381587)
☐ ARJS STATE RETIREES SOA 021 (E5381488)
☐ APERS SCH RETIREES SOA 059002 (E5381470)
☐ ADJRS STATE RETIREES SOA (E5381496)
☐ STATE OF AR RETIREES to DIRECT BILL (E5381421), 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.*

2024 Retiree Rates* (per $1,000) Monthly cost of coverage

Retiree basic and expanded basic group term life with AD&D insurance	
$1.13 per $1,000	
Retiree supplemental group term life with AD&D insurance	
Age	**Employee**
Under 50	**$0.41**
50-54	**$0.66**
55-59	**$0.95**
60-64	**$1.43**
65-69	**$2.78**
70-74	**$ 4.53**
75+	**$ 9.03**
Retiree supplemental spouse group term life with AD&D insurance	
All eligible ages	**$1.28**
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 State of Arkansas Change of Beneficiary Form

FAX this direction	**Fax this form: 803-678-6861** Or mail: P.O. Box 1365, Columbia, SC 29202	From:	
		Number of pages:	

I am changing the following: ☐ Primary Beneficiary ☐ Contingent Beneficiary ☐ Both (If no box is checked, the form will be reviewed only for the beneficiary designations listed.)

Insured's name:	First:	Middle Initial:	Last:
SSN:	DOB: ____ / ____ / ________	Telephone:	Email:
Address:	City:	State:	ZIP:
Policy number(s):			

General Information

Naming a Minor as a Beneficiary: In some instances, Colonial Life may not be able to pay life insurance proceeds to a minor beneficiary unless a court appointed adult guardian, conservator or custodian has been properly designated for the minor's property in advance planning documents. When Colonial Life is unable to disperse benefits in such situations, Colonial Life will hold the proceeds (with interest earned on the funds) until the minor reaches the age of majority. If you have questions about the consequences of naming a minor as a beneficiary, feel free to discuss with a legal or estate planning professional.

Naming a Trust: Provide the name of the trust, the date the trust was established, and the address of where the trust is held.

Naming a Funeral Home: Provide the name, full address, and the owner or authorized personnel of the funeral home. Write "As Interest May Appear" and designate another primary beneficiary to receive any remaining benefits available after the funeral home's expenses have been paid.

Primary beneficiary(ies)

All fields must be completed for each beneficiary. Unless otherwise specified, proceeds will be paid in equal shares to surviving beneficiaries. If selecting more than one Primary Beneficiary, the percentages must equal 100%. Attach additional pieces of paper if more space is needed.

First:	Middle initial:	Last:		**Percentage**
DOB: _____ / _____ / __________	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

First:	Middle initial:	Last:		**Percentage**
DOB: _____ / _____ / __________	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

First:	Middle initial:	Last:		**Percentage**
DOB: _____ / _____ / __________	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

First:	Middle initial:	Last:		**Percentage**
DOB: _____ / _____ / __________	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

Contingent beneficiary(ies)	If at the time of the insured's death and all primary beneficiaries are disqualified or die before the insured, proceeds will be paid to the contingent beneficiaries listed in equal shares. If selecting more than one contingent beneficiary, the percentage must equal 100%. Attach additional pieces of paper if more space is needed.			
First:	Middle initial:	Last:		**Percentage**
DOB: _____/ _____/ _____	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

First:	Middle initial:	Last:		**Percentage**
DOB: _____/ _____/ _____	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

First:	Middle initial:	Last:		**Percentage**
DOB: _____/ _____/ _____	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

First:	Middle initial:	Last:		**Percentage**
DOB: _____/ _____/ _____	SSN:	Telephone:		
Address:	City:	State:	ZIP:	

Required signature (complete this section in its entirety)

_____ Signature of policy owner

_____ Date (MM/DD/YYYY)

Print policy owner name:		SSN:
DOB: ____/____ / _____	Telephone:	Email:
Address:	City:	State:	ZIP:

Special Notice for Residents of a Community Property State: *A spouse or former spouse may have an interest in life insurance proceeds or any accumulated cash value if the policy premiums were paid with community funds. It is your responsibility to consult your legal advisor to 1) ensure that any required consent from a spouse or former spouse has been received and 2) ensure that your spouse or former spouse will not be able to make a claim against any policy values and/or proceeds in the event any policy benefits become payable.*

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, 2024

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