ARHealth Self Funded SM

Retirement Packet

for Arkansas State Retirees

Provided By

Employee Bene ts Division
Department of Finance & Administration
State of Arkansas

Retirement Overview

Upon retirement from your agency, you and your dependents are eligible to continue health coverage through several options which are outlined in detail below. ***The necessary forms must be submitted to Employee Benefits Division within 31 days of your retirement date.***

OPTION A – Health and Life Insurance Continuation under Retirement System
If you are eligible for a retirement benefit from one of the participating retirement systems*, you may continue your current health coverage in the retirement group by having the insurance premium deducted from your retirement check. Complete the form titled "Arkansas State Retiree Payroll Deduction Authorization" (#6200-f-1a) enclosed in this packet. **This is the form that notifies us of your intention to continue your health insurance.** Mail completed form to the Employee Benefits Division at the mailing address listed on the top. If your retirement benefit amount is inadequate to cover the insurance premiums, you will also be asked to set up a bank draft by completing the enclosed form, "Authorization Agreement for Pre-Authorization Payments (#6200-f-7b)."

OPTION B – COBRA Continuation ONLY
The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) allows for continuation of health benefits after termination or retirement. If you are not eligible for retirement benefits from one of the participating retirement systems* and would like to retain your current health benefits, you may continue your health insurance for a period of 18 months as a COBRA Continuant. If you have not received a COBRA Election Form in the mail within 14 days of your last date of employment, please contact the Employee Benefits Division at (877) 815-1017 .

OPTION C – COBRA until retirement benefits begin
If you are eligible for retirement (i.e. have enough years of service) but will not immediately receive a retirement benefit, you may choose health insurance coverage under COBRA for a maximum of 18 months (or until you are eligible to receive a retirement check if within the 18 month period). To enroll under COBRA, please read and complete the COBRA Election form that will be mailed to your home. When your retirement benefit begins, you may change to the retirement group by contacting the Employee Benefits Division. *NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION D – COBRA when retirement benefits are available
If you are eligible for retirement benefits from one of the participating retirement systems* when you retire, you may continue your health insurance through COBRA if you so choose. COBRA payments are made by bank draft. A bank draft payment is established by completing the "Authorization Agreement for Pre-Authorization Payments (#6200-f-7a)" included in this booklet. At the end of your COBRA benefit eligibility period (18 months) you will need to change to the retiree insurance group in order to continue your health insurance. It is very important to remember that you must remain on COBRA and make timely payments for the **entire** eligibility period to be eligible to begin insurance through the retirement system when COBRA coverage ends. *NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION E – Waiver of Enrollment
If you do not wish to continue the Health Insurance coverage at all, please complete the "Waiver Form (8100-f-10)" box and then sign and date the "Arkansas State Retiree Payroll Authorization Form (#6200-f-1a)." Once completed, that form should be sent directly to Employee Benefits Division.

**Participating Retirement Systems are: Arkansas Public Employees Retirement System, Arkansas Teacher Retirement System, Judicial Retirement System, Arkansas Highway and Transportation Department Retirement System, and Alternative Retirement System.*

Arkansas State Health Plan Options & Rates

E ective January 1, 2009, Self-Insured Health Plan

ARHealth Retirees	Base Monthly Premium	State Contribution	Plan Contribution	Total Monthly Retiree Cost
Retiree Only (*Not Medicare Eligible*)	$655.98	$374.56	$19.02	$262.40
Retiree (*Not Medicare Eligible*) & **Spouse** (*Not Medicare Eligible*)	$1,311.85	$686.76	$34.76	$590.33
Retiree (*Not Medicare Eligible*) & **Child(ren)**	$1,049.55	$561.90	$28.47	$459.18
Retiree (*Not Medicare Eligible*) & **Spouse** (*Not Medicare Eligible*) & **Child(ren)**	$1,969.14	$999.63	$50.54	$918.97
Retiree (*Not Medicare Eligible* & **Spouse** (*Medicare Eligible*)	$988.33	$532.76	$27.00	$428.57
Retiree (*Not Medicare Eligible*) & **Spouse** (*Medicare Eligible*) & **Child(ren)**	$1,384.14	$721.17	$36.50	$626.47
Retiree Only (*Medicare Eligible*)	$337.96	$192.98	$9.80	$135.18
Retiree (*Medicare Eligible*) & **Spouse** (*Not Medicare Eligible*)	$970.86	$494.24	$24.99	$451.63
Retiree (*Medicare Eligible*) & **Child(ren)**	$717.70	$373.73	$18.91	$325.06
Retiree (*Medicare Eligible*) & **Spouse** (*Not Medicare Eligible*) & **Child(ren)**	$1,350.60	$674.99	$34.10	$641.51
Retiree (*Medicare Eligible*) & **Spouse** (*Medicare Eligible*)	$660.92	$346.71	$17.55	$296.66
Retiree (*Medicare Eligible*) & **Spouse** (*Medicare Eligible*) & **Child(ren)**	$1,040.66	$527.46	$26.67	$486.53

Arkansas State Health Plan Options & Rates for COBRA Participants

E ective January 1, 2009: Self-Insured Health Plan

	Total Monthly Premium	HRA DISCOUNT				
		One Healthy Discount Level I	One Healthy Discount Level II	Two Healthy Discounts Level I	One Healthy Discount Level I and One Level II	Two Healthy Discounts Level II
		$10 monthly savings	$20 monthly savings	$20 monthly savings	$30 monthly savings	$40 monthly savings
ARHealth Employee Only						
Health Advantage	$428.56	$418.56	$408.56	-	-	-
ARHealth - NovaSys	$459.65	$449.65	$439.65	-	-	-
HD PPO - NovaSys	$357.31	$347.31	$337.31	-	-	-
ARHealth Employee & Spouse						
Health Advantage	$1,014.84	$1,004.84	$994.84	$994.84	$984.84	$974.84
NovaSys	$1,089.48	$1,079.48	$1,069.48	$1,069.48	$1,059.48	$1,049.48
HD PPO - NovaSys	$843.87	$833.87	$823.87	$823.87	$813.87	$803.87
ARHealth Employee & Child(ren)						
Health Advantage	$631.44	$621.44	$611.44	-	-	-
NovaSys	$678.08	$668.08	$658.08	-	-	-
HD PPO - NovaSys	$524.57	$514.57	$504.57	-	-	-
ARHealth Employee & Family						
Health Advantage	$1,119.43	$1,109.43	$1,099.43	$1,099.43	$1,089.43	$1,079.43
NovaSys	$1,201.83	$1,191.83	$1,181.83	$1,181.83	$1,171.83	$1,161.83
HD PPO - NovaSys	$930.63	$920.63	$910.63	$910.63	$900.63	$890.63

When can I make plan changes?

- This year it will be October 1 – 31 to be ef ective January 1
- The only opportunity for a Retiree to add dependents (other than newly acquired) is if there is a loss of coverage (qualifying or family status change event).

Will I still be covered by life insurance when I retire?

- At your retirement, you can retain all of the life insurance amount you had as an active employee, provided you:.
  - apply within 31 days of retirement with Minnesota Life directly
  - are an annuitant under the Teacher Retirement System or Arkansas Public School Retirement System
- Life insurance premiums will be deducted monthly from your annuity check. If your annuity check is not suf cient to cover your life insurance premiums, you will be billed directly by Minnesota Life

Who do I contact to le a life insurance claim if a retiree or dependent dies?

- Minnesota Life needs to be contacted directly at 1-888-658-0193.
- If you need to change a benef ciary, please send that information directly to Minnesota Life.

How is the ARHealth plan di erent from the other plans?

- You have open access, which means that you may self-refer to a physician that is in-network and still receive in-network bene ts. Out-of-Network bene ts are only applied if you receive services from a non-participating provider.
- You will pay a $25 copayment (PCP) for services provided by one of the following in-network doctors in their o ce, with no deductible.
  - General Practitioners
  - Family Practitioners
  - Internal Medicine
  - Pediatricians
- You will pay a $35 copayment (Specialist) for services provided by an in-network specialist in their of ce, with no deductible.
- ARHealth members will be able to utilize the Health Advantage network of physicians and facilities.
- If you use an out of state participating Blue Cross provider, you will not be charged the di erence between the amount billed by the provider and the Blue Cross-allowed amount. You will be responsible for the deductible, coinsurance or copayment amounts.

STATE OF ARKANSAS
Department of Finance
and Administration

EBD

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

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-1168 http://www.ARBenefits.org

State Retirees
Enrollment Form

1. Retiree Information: (please print) ❒ I decline coverage for myself

Last Name	First Name	MI	Gender	❒ Married ❒ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Work #:	
Primary Care Physician:	PCP #	Current patient?		

2. Dependent Coverage Information: ❒ I decline coverage for my dependents

SPOUSE	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:		
	Primary Care Physician:	PCP #	Current patient?	
DEP 1*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	Primary Care Physician:	PCP #	Current patient?	
DEP 2*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	Primary Care Physician:	PCP #	Current patient?	
DEP 3*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	Primary Care Physician:	PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.
**To be completed for dependents 19 and over only. Please submit proof of student status.

3. I Wish To Enroll In e Following Plan:

A. Select your level of coverage:
- ❒ Retiree Only
- ❒ Retiree & Spouse
- ❒ Retiree & Children

B. Plan Option:
- ❒ ARHealth Retiree

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒ Yes ❒ No
2) If Yes, what type of coverage? ❒ Medical ❒ Medicare, HIC # ______________________
If Medicare: Part A Effective Date / / or Part B Eff Date / /
If Medicare: Reason for Coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become ef ective only on the date specif ed by the Insurer after the application has been approved by the Insurer and after the rst full premium has been paid. (4) My signature authorizes Coordination of Bene ts under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my retirement earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/ insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of the health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

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 fines and confinement in prison.

I understand that if I decline to apply for coverage at retirement, that I may not be eligible for coverage at a later date.

Retiree's Signature: ______________________________ **Date:** ____________________

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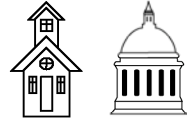
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 683-0983 http://www.ARBenefts.org

Change Form
Status, Name and Address



1. Employee Information: (please print)

Last Name	First Name		MI	❒ Married ❒ Single
Home Address	City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:	
If you would like benefit information sent to you by email, please print your email address:				
Primary Care Physician:	PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status): ***

LAST NAME	FIRST NAME		MI	GENDER
Social Security #	Date of Birth		❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**		
LAST NAME	FIRST NAME		MI	GENDER
Social Security #	Date of Birth		❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**		
LAST NAME	FIRST NAME		MI	GENDER
Social Security #	Date of Birth		❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**		

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.
**For dependents 19 and over only. Please submit proof of student status.
*** Social Security # is not required to add coverage for a newborn.

3. Change In Coverage (complete this portion if making any of the following changes):

Change in Status:		Reason for Change:
❒ Employee Only	❒ Add Dependent	❒ Birth - Date: ______________
❒ Employee & Spouse	❒ Delete Dependent	❒ Death - Date: ______________
❒ Employee & Children	❒ Name	❒ Divorce - Date: ______________
❒ Family	❒ Address	❒ Marriage* - Date: ______________
❒ Cancel Coverage		❒ Other: ______________________________

* Please attach Marriage License; Maiden Name if applicable

4. To Be Completed By Agency/School District:

Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: ______________________________ **Date:** ______________

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Phone: (501) 682-9656 **Toll Free: (877) 815-1017** **Fax: (501) 682-1168** **www.ARBenefits.org**

Bank Draft Authorization

I (we) hereby authorize the Department of Finance and Administration – 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 below at the financial institution named below, hereinafter called Depository, to debit and/or credit the same such account. Date of draft: 7th of the month.

Depository Name: ____

Address: ____

____

Routing Number: ________________________ Type of Account: ❒ Checking ❒ Savings

Total amount to be deducted monthly: __________________________

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.

Authorization Signer on Account: ____
(Please print name clearly)

Insured's Social Security No.: ____

Signature: ____________________________ __________
(Authorized Signer) (Date)

Per Arkansas Code §5-37-301, a $25.00 Return Item Charge fee plus a $3.50 service fee for bank drafts will be assessed per item returned not paid from the bank.

Attach A Voided Check Here
(Deposit Slip Cannot Be Used)

Return this authorization to:
Employee Benefits Division
P.O. Box 15610
Little Rock, AR 72231-5610

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Retirement Deduction Authorization

(Insurance Rep use only:)

Date Sent: ______________

District/Agency Name: __________________________ District/Agency #: __________

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

The retirement system that I participate in is: **(Check *only* one of the following)**

- ❒ Public Employees Retirement System (APERS)
- ❒ Teacher Retirement System (ATRS)
- ❒ Judicial Retirement System
- ❒ Arkansas Highway and Transportation Retirement System
- ❒ Alternative Retirement System (Valic, etc) ______________ (Indicate which system)

Please refer to rate sheet to determine amount(s) to record:

Monthly Amount	Self	Self/Spouse	Self/Children	Family
Health Premium				

If a member is eligible for Medicare and does not have Part B, the plan will pay as though the member does have Part B and the member will have financial responsibility for claims incurred.

If you or your spouse have Medicare Parts A and B, please provide the following information:

Retiree

Medicare HIC # ______________________
Medicare Part A Eff. Date ______________________
Medicare Part B Eff. Date ______________________

Spouse

Medicare HIC # ______________________
Medicare Part A Eff. Date ______________________
Medicare Part B Eff. Date ______________________

Please sign, date and return within 30 days to the address above, attn: Retirement Section

Signature ______________________________ Date ____________ SSN ________________

(For Office Use Only)

Effective Date: ______________ EBD Initials: _________

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Waiver of Enrollment
for State & Public School Retirees

Credible Coverage Information

If you waive enrollment for yourself and/or your dependent(s) (including your spouse) because of other employer group health insurance coverage within 31 days of becoming an active retiree and eligible to draw a retirement annuity check, you may be able to enroll yourself or your dependent(s) (including your spouse) in the future provided that you request enrollment into the State or Public School Retirees health insurance program within 30 days of loss of your other employer group health insurance coverage.

Please check the appropriate box(es):

❒ I am enrolled on the last day of employment.

❒ I am eligible at this time to begin drawing a retirement annuity check.

❒ I decline coverage for myself. I am currently enrolled under another employer group health insurance plan. (Requires a letter of Creditable Coverage to enroll at a later date) **I have a one-time option to return to the retiree insurance program after the initial waiver of coverage.**

❒ I decline coverage for my dependents (including my spouse). They are currently covered under another employer group health insurance plan. (Requires a letter of Creditable Coverage to enroll at a later date) **I have a one-time option to return to the retiree insurance program after the initial waiver of coverage.**

❒ I decline coverage for myself. I am *not* currently covered under another employer group health insurance plan. **This decision is final and I may not enroll at a later date.**

❒ I decline coverage for my dependents (including my spouse). They are *not* currently covered under another employer group health insurance plan. **This decision is final and I may not enroll them at a later date.**

❒ I decline coverage as I am covered by Medicare and/or a Medicare supplement other than the State supplement plan. **This decision is final and I may not enroll at a later date.**

I hereby certify that:

(1) I have been given the opportunity to apply for health insurance coverage as a new state or public school active retiree. The coverage and the policy have been explained to me, and I decline to apply for coverage for myself and/or my dependent(s) (including my spouse) as listed above; and

(2) I understand that if I decline coverage now due to being covered under another employer group health plan, once I lose that coverage I must apply for this coverage within 30 days of the loss of coverage; and

(3) I understand that if I am eligible at this time to draw a retirement annuity and decline coverage for myself and dependent(s) (including my spouse) and that we are not currently covered under another employer group health plan at this time, I cannot enroll at a later date. **This decision is final.**

______________________________ ____________________

Retiree Signature Date

______________________________ ____________________

Social Security Number Group ID # / Agency

If you have any questions regarding this form or policy, please call our Customer Service Department at (501) 682-9656 or 1-877-815-1017.