Arkansas State Employee New Hire Benefits Information

2026

Arkansas State Employees
New Hire Benefit Guide

Contents

Books provided by ARSEBA

STATE OF ARKANSAS
SARAH HUCKABEE SANDERS
GOVERNOR

Dear New Arkansas State Employee:

Welcome to your new job with the State of Arkansas! I'm thrilled you are joining the amazing team of hard-working men and women that keep our state running. It's a big responsibility, but I know you're up to the task.

To compensate you properly for your work on behalf of your fellow Arkansans, my administration has put together a comprehensive benefits package for all state employees. The enclosed information will help introduce you to your new role and walk you through the benefits to which you are entitled. Many of these are time sensitive, so contact your Health Insurance Representative or Employee Benefits Division with any questions.

Arkansas' public servants are the bedrock on which our entire state government stands. Without a good foundation, the whole structure crumbles. Thank you for your commitment to standing in strong support of your neighbors, family, and fellow Arkansans. We're all glad you're here.

Sincerely,

Sarah Huckabee Sanders

State Capitol Building • Little Rock, AR 72201
Telephone: (501) 682-2345
www.governor.arkansas.gov

Benefits are a valuable part of any compensation package. State employees are offered a wide variety of benefits. These benefits are available through payroll deduction and are available on a pre-tax basis when appropriate.

This benefit book is to outline the benefits that are subsidized by the state as well as the voluntary benefits that are wholly employee paid.

Eligibility – You are eligible to participate in the benefits program if you receive a regular paycheck, meaning you are not a seasonal or contract employee and working 1,000 or more hours each year. An extra help employee whose agency has agreed to pay the State match for their coverage and is willing to be responsible for all costs for participating in the Plan.

Dependents Eligible for Coverage – In most cases, eligible dependents include:

- Your legal spouse. Spouses eligible for coverage through his or her employer are not eligible for employer group coverage.
- Your dependent child(ren) who are under age 26
- Dependent child(ren) are defined as your or your spouse's natural or legally adopted child(ren)
- To verify eligibility of newly added dependents, you may be requested to provide supporting documentation (i.e. birth certificates, marriage certificate).

When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they become ineligible. You may be responsible for any cost for services received while your dependent was incorrectly listed as eligible.

Coverage Effective Date – Coverage is effective the first day of the month following the receipt of all applicable documentation and following any qualifying event. Note: The date of a qualifying event is not the date of eligibility.

Qualifying Events – For qualifying events, active members have 60 days from the date of the qualifying event to enroll/drop a spouse and/or dependent to the plan. Please note, retirees have only 30 days. List of approved qualifying events:

- Marriage, divorce, legal separation
- Birth or permanent legal adoption of a child
- Death of a spouse or child
- You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status
- Loss of eligibility for group health coverage or health insurance coverage

Pre-tax Premiums – Most products available to the state employees are available on a pre-tax basis. Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. For products such as health, dental, and vision insurance, you will automatically be in a pre-tax status unless you stipulate otherwise.

AR BENEFITS

Below is a snapshot of benefits covered by the ARBenefits plan for each of our 2026 Arkansas State Employee plan levels. A full schedule of benefits for each plan level is available HERE. If you have any questions, please contact EBD at 877-815-1017 or email Ask.EBD@arkansas.gov.

	PREMIUM		CLASSIC		BASIC
	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK
INDIVIDUAL DEDUCTIBLE	$500	$2,000	$2,500	$4,000	$6,450
FAMILY DEDUCTIBLE	$1,000	$4,000	$3,400/$5,000	$8,000	$12,900
INDIVIDUAL OUT-OF-POCKET MAX (MEDICAL)	$3,000	N/A	$6,450	N/A	$6,450
FAMILY OUT-OF-POCKET MAX (MEDICAL)	$6,000	N/A	$12,900	N/A	$12,900
	YOU PAY		YOU PAY		YOU PAY
COVERED SERVICES	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK
PHYSICIAN'S OFFICE VISIT	$25 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
SPECIALIST'S OFFICE VISIT	$50 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
OTHER PHYSICIAN SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
ADVANCED IMAGING (RADIOLOGY)	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
ER VIST AND OBSERVATION	$250 COPAY	$250 COPAY	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
IN-PATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
OUTPATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
DIAGNOSTIC SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
URGENT CARE CENTER	$100 COPAY	$100 COPAY	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
PHYSICAL EXAMS/PREVENTATIVE CARE	0%	0%	0%	0%	0%
IMMUNIZATIONS	0%	0%	0%	0%	0%
WELL BABY/CHILD CARE VISITS	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%
VISION SCREENING	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY
HEARING SCREENING	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY
INSULIN PUMP	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
GLUCOMETERS	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE

- Members must meet their plan's deductible amount before coinsurance begins for covered services.
- The family deductible is the deductible amount for any tier above Employee Only coverage (Employee + Spouse, Employee + Children, Family).
- Copays do not count towards the deductible amount. The out-of-pocket maximum includes the deductible, copays, and coinsurance amounts you have paid toward covered in-network services.
- Employees on the ***Premium Plan*** can have the $250 ER copay waived if they are referred to the ER by the Nurse24 hotline (1-866-458-0408). The Nurse24 hotline is not intended for use during medical emergencies.
- The plan will pay 100% for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
- There is no out-of-network coverage for the Basic Plan.

PRESCRIPTION DRUGS	PREMIUM	CLASSIC	BASIC
TIER 1 - GENERIC	$15 COPAY	20% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
TIER 2 - PREFERRED	$40 COPAY	20% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
TIER 3 - NON-PREFERRED	$80 COPAY	20% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
TIER 4 - SPECIALTY	$100 COPAY	20% AFTER DEDUCTIBLE	0% AFTER DEDUCTIBLE
REFERENCED PRICE DRUGS	PLAN PAYS CERTAIN AMOUNTS PER UNIT; MEMBER RESPONSIBLE FOR REMAINING COST	NOT COVERED	NOT COVERED
INDIVIDUAL RX OUT-OF-POCKET MAX	$3,100	N/A	N/A
FAMILY RX OUT-OF-POCKET MAX	$6,200	N/A	N/A

Employees on the Classic or Basic plans must meet their plan medial deductible amounts prior to starting the 20% coinsurance for covered medications.

2026 Rates (per payroll)

Premium

Employee Only: $75.90
Employee & Spouse: $226.24
Employee & Child(ren): $155.28
Employee & Family: $297.16

Classic

Employee Only: $36.21
Employee & Spouse: $129.34
Employee & Child(ren): $82.31
Employee & Family: $166.99

Basic

Employee Only: $0.00
Employee & Spouse: $52.60
Employee & Child(ren): $24.64
Employee & Family: $63.82

2026 Open Enrollment

Open Enrollment for the 2026 plan year is October 1-31, 2025. You can enroll online through the ARBenefits Member Portal at my.ARBenefits.org. Changes elected during Open Enrollment are effective 1/1/2026. If you do not want to make any changes to your ARBenefits medical health plan, you do NOT need to re-enroll. Your current coverage will stay as is for 2026.

If you have an FSA, you MUST re-enroll each year.

Visit our website at www.sas.arkansas.gov for more information.

Things you can do during Open Enrollment

- Enroll in an ARBenefits Plan
- Change plans between Premium, Classic, Basic
- Drop/add dependents
- Cancel your coverage for the next year
- Enroll in the FSA program for 2026

State & Public-School Employee Election Form

This form is to be used for Open Enrollment and New Enrollees ONLY. Please use the Change Form for other Qualifying Events.

Employee Information

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

Agency or District	Group Number	Home/Cell Number ☐ preferred	Work Number ☐ preferred

Mailing Address	City	State	Zip Code

Physical Address

Coverage

Enrollment Period:
☐ Open Enrollment ☐ Loss of other coverage
☐ New Hire Period
☐ Newborn

Type of Action:
☐ Enroll in the Plan
☐ Decline Coverage

If enrolling, pick a benefit option:
☐ Premium ☐ Basic
☐ Classic

Post-Tax Election:
☐ **ONLY** check this box if you wish to have your premiums withheld on a **post-tax** basis

If Declining, Reason for Decline: ☐ Enrolling in Spouse's Plan (complete 1 and 1a below) ☐ Not Interested (skip to signature at bottom)

1. Is spouse an AR State or Public School Employee? ☐ Yes (proceed to signature) ☐ No (complete fields below)

Spouse First Name:	MI:	Spouse Last Name:	Suffix:	Spouse Date of Birth:

1a. Spouse SSN or ITIN:	Spouse's Employer:

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.

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 60 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	Preferred Email

FOR PSE HIR USE ONLY First Day at Work:

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL

Department of Shared Administrative Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-683-0983

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

Instructions

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

Social Security Numbers are required for enrollment. Exception: A newborn's Social Security Number will be accepted after enrollment but must be sent in once it is received.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received by any dependent(s) while your dependent(s) was incorrectly listed as eligible.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include marriage, birth, and loss of group coverage.

You should receive ID cards in a timely manner from the Employee Benefits Division (EBD). If you do not, call EBD at 1-877-815-1017 (when you hear the recording, press 1).

Your effective date of coverage will be the first of the month following date of EBD receiving application and **ALL** corresponding documentation. Note: The qualifying date is NOT the date of eligibility.

Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. You will automatically be in a pre-tax status unless you select the post-tax option on this form and/or notify your payroll clerk.

Active members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to EBD.

Supporting documentation is required for proof of dependent eligibility. For changes being made due to a qualifying event, documented proof a qualifying event has occurred is also required such as a Certificate of Credible Coverage (COCC). More information is available in the ARBenefits Summary Plan Description.

If adding a dependent as a Permanent Legal Guardian your account will be subject to an annual review.

If a Member is currently not enrolled on the plan and has a newborn, only **ONE** parent is permitted to enroll with the newborn.

Competed election forms can be submitted to EBD by fax, mail, or online through the ARBenefits Member Portal at www.myarbenefits.org.

For assistance, contact EBD at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:00PM CST or email Ask.EBD@arkansas.gov. To learn more about plans, costs, and network providers visit https://sas.arkansas.gov/employee-benefits.

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL.

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

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 (Letter from employer explaining why they are not eligible is required. Spouse will not be added if this is not provided.)
   - ☐ My Spouse is self-employed, provide company name: _____

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 Shared Administrative Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

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masa

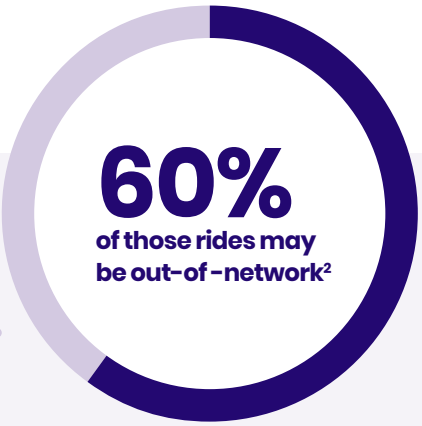
Why choose MASA?

MASA protects your finances and gives you compassionate support for medical transport.

No one should have to worry about transport bills during or after an emergency. Unfortunately — even for the insured — these costly bills have become a normal, expected part of emergency care and continue to rise every year.

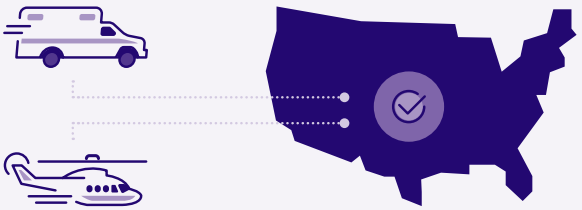
MASA is the simple solution to a complex problem for millions of Americans. As the leading provider of emergency and medical transport protections, MASA supports members with solutions for out-of-pocket costs due to medical transport while also offering services for use during recovery and beyond.

1 in 15 families
need an ambulance each year[1]



MASA has been trusted for over 50 years and supports 2 million members globally.

Emergency medical transports are covered nationwide — no network needed for MASA protection.



Specialized services for emergencies away from home are available — like return transports for the patient, their pets, vehicles, and children.

MASA claims team is focused on paying, not denying, with an easy process — just send us the bill.

Enroll today!

1: MASA, Emergency medical transportation: The true costs — and how they're rising, 2024
2: FAIR Health, 2023

Compare plans

masaAccess+

Gain peace of mind and shield your finances knowing there's a MASA plan best suited for your needs.

	Emergent Plus	Emergent Premier	Platinum
Emergency Ground Ambulance Coverage MASA provides coverage for out-of-pocket expenses for emergency ground transportation to a medical facility.	● 2	● 2	● 2
Emergency Air Ambulance Coverage MASA provides coverage for out-of-pocket expenses for emergency air transportation to a medical facility, up to plan limits.	● 2+	● 2+	● 2
Hospital to Hospital Ambulance Coverage If specialized care is required but not available at the initial emergency facility, MASA provides coverage for out-of-pocket expenses for a ground or air ambulance transfer to the nearest appropriate medical facility, up to plan limits.	● 2+	● 2+	● 2
Repatriation to Hospital Near Home Coverage If you're hospitalized while more than 100 miles away from home and your care provider has approved continued care at a hospital nearer to your home, MASA coordinates your transfer and provides coverage for medical transportation to the approved medical facility.	● 2	● 3	● 4
Minor Return Transportation Coverage If a minor or child is left unattended due to your emergency transport, MASA will guide you through the process of their return and reimburse transport expenses for their safe return home, up to plan limits.		● 3	● 3
Pet Return Transportation Coverage If your pet (or livestock) is left unattended due to your emergency transport, MASA will guide you through the process of returning your pet and will reimburse you for transportation expenses up to the plan limits for their safe return home.		● 3	● 3
Post Admission Continued Care Transportation Coverage If you need care in a rehabilitation facility, skilled nursing facility, long-term care facility, hospice, or at home after an emergency, MASA will reimburse out-of-pocket expenses for ride-hailing, taxi, or public transportation to these appointments or back home, up to $500 annually for each member.		● 1	
Sick While Away From Home Expense Protection If you become too ill to return home while more than 100 miles from home, MASA will reimburse you for out-of-pocket expenses you incur due to your extended stay, up to $5,000, up to twice per year.		● 4	
Patient Return Transportation Coverage MASA will help coordinate and provide payment for a commercial flight back home after discharge from the hospital following an emergency that occurred 100 miles or more away from home.			● 4
Companion Emergency Transportation Coverage Should a companion be allowed to travel with you during emergency transport, MASA provides coverage for the additional costs incurred.			● 3
Hospital Visitor Air Transportation Coverage If you are hospitalized more than 100 miles from home, MASA coordinates and provides coverage for a supportive companion to join you.			● 3
Mortal Remains Transportation Coverage If you pass away more than 100 miles from home, MASA will assist your family members with coordinating transport of your remains on a commercial airline to the airport nearest your home.			● 4
Vehicle & RV Return Coverage If an emergency occurs requiring you to leave your vehicle or RV by ambulance, MASA coordinates and provides coverage for the return of the vehicle or RV to your home.			● 3
Organ Retrieval Transportation Coverage If you need an organ transplant, MASA provides coverage for the cost of transporting the organ to be used in an organ transplant procedure.			● 1
Organ Recipient Transportation Coverage If you need an organ transplant, MASA coordinates and provides coverage for transporting you to a suitable airport nearest to the site of the transplant procedure.			● 1
Member cost per pay period (single or family)	**$5.00**	**$7.50**	**$17.50**

Coverage territories
1: United States only | 2: United States and Canada. | 3: United Sates, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas, and Bermuda.
4: Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or U.S. travel advisories.
+ MASA shall cover up to $20,000 in out-of-pocket expenses

Disclaimer
This material is for informational purposes only and does not provide any coverage. The benefits listed, and the descriptions thereof, do not guarantee coverage and do not represent the full terms and conditions applicable for usage and may only be offered in some memberships or policies. Premiums, benefits, and coverage vary depending on the plan selected. Family plans cover dependents defined as a spouse, domestic partner, or other legally recognized person who is under the age of 26 and is the member's biological child or a person over whom the member has legal custody. For a complete list of benefits, premiums, terms, conditions, and restrictions, please refer to the applicable member services agreement or policy for your state. For additional information and disclosures about MASA plans, visit: https://info.masaglobal.com/disclaimers

MyARFamily AT A GLANCE

- Maternity Leave
- FMLA
- Nursing Moms
- ARBenefits

- Health Prevention
- Adoption
- Foster Care
- Arkansas 529 Plan

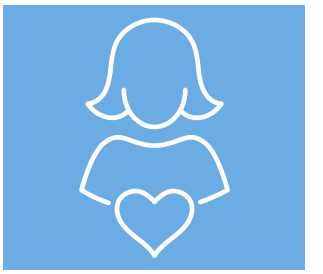
- CPR Training
- Maternal and Child Health
- Newborn Screening
- Birth Certificate Services

- Adoption Assistance
- Postpartum Support
- WIC Assistance
- Imagination Library

and many other resources in one convenient location.

State Maternity Leave

Act 770 of 2023 allows eligible state employees to take up to twelve weeks of paid maternity leave after birth, adoption or foster-care placement of an employee's child.

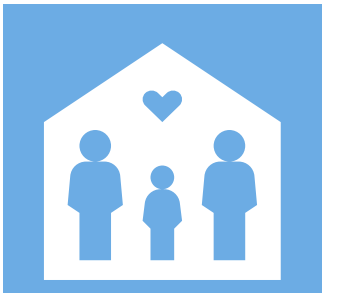


FMLA

Under the Family and Medical Leave Act (FMLA), eligible parents are entitled to receive up to twelve weeks of unpaid leave. Both mothers and fathers are entitled to family leave to care for a new baby, newly adopted child, or newly placed foster child.

Arkansas Adoption Assistance

Federal and state adoption assistance programs are designed to help parents who are thinking about or are in the process of adopting a child or children with special needs from foster care.



Arkansas 529 Plan

The Arkansas 529 Plan is an educational savings account that offers up to $10,000 in state tax deductions for contributions. Savings in Arkansas 529 can grow tax deferred through a variety of investment options. Money can be withdrawn tax free to pay for qualified higher education and vocational school.

Check out MyARFamily by visiting www.transform.ar.gov/personnel/myarfamily/ or by scanning the QR code.

ARSEBA
ARKANSAS STATE EMPLOYEES
BENEFIT ADVISORS

For more information please contact: Arkansas State Employees Benefit Advisors
Phone:(501)224-5234 or (888)224-5233 E-mail: service@arseba.com
Website: www.arseba.com

For provider search please visit www.deltadentalar.com

DELTA DENTAL

State of Arkansas	Base Plan		Premium Plan		Plan Differences
	In Network	Out of Network	In Network	Out of Network	
	Delta Dental PPO (4 out of 10 dentist in Arkansas)		**Delta Dental PPO Plus Premier (9 out of 10 dentist in Arkansas)**		*Network Access*
Calendar Year Maximum (Preventative, Basic and Major Expenses)	**$1,000**		**$2,000**		*Annual Maximum*
Calendar Year Deductible					
Per Individual	$25		$25		
Per Family	$75		$75		
Preventative and Diagnostic Services	**100%**	**80%**	**100%**	**80%**	
	No Deductible	No Deductible	No Deductible	No Deductible	
Oral exams and Cleanings	**1 Per Year**	**1 Per Year**	**2 Per Year**	**2 Per Year**	*1 Exam &Cleaning versus 2*
X-Rays(Bitewing, Panoramic, Full Mouth)	**Bitewings**- as required, **Full mouth** - 1 in 60 consecutive months	**Bitewings**- as required, **Full mouth** - 1 in 60 consecutive months	**Bitewings**- as required, **Full mouth** - 1 in 60 consecutive months	**Bitewings**- as required, **Full mouth** - 1 in 60 consecutive months	
Fluoride Application	1 per year for dep children to age (19)	1 per year for dep children to age (19)	1 per year for dep children to age (19)	1 per year for dep children to age (19)	
Sealants	dep children to age (16)	dep children to age (16)	dep children to age (16)	dep children to age (16)	
Basic and Major Services- Deductible applies					
Space Maintainers	80%	60%	80%	60%	
Minor emergency treatment	80%	60%	80%	60%	
Simple Extractions	80%	60%	80%	60%	
Fillings	60%	50%	80%	60%	*Fillings at 60% versus 80%*
Crowns	60%	50%	60%	50%	
Prosthodontics(Dentures and Bridges)	60%	50%	60%	50%	
Surgical Periodontics	60%	50%	60%	50%	
Oral Surgery	Not covered	Not covered	60%	50%	*Oral Surgery coverage*
Non-Surgical Periodontics	Not covered	Not covered	60%	50%	*Non-Surgical Periodontal*
Periodontal Maintenance	Not covered	Not covered	60%	50%	*Periodontal Maintenance*
Endodontics(Root Canal)	Not covered	Not covered	60%	50%	*Endodontics coverage*
Riders					
Child Orthodontia (through age eighteen (18))	Not covered	Not covered	60%	50%	*Orthodontia coverage*
Lifetime Orthodontia Maximum	Not covered	Not covered	$1,000		
Carryover Benefit *Added 2018**	Carryover Benefit: $250 Claims Threshold: $499 Carryover Benefit Maximum: $1,000		Carryover Benefit: $500 Claims Threshold: $999 Carryover Benefit Maximum: $2,000		*Carryover Benefit*
Other Items Waiting Periods	6 Month on Major services		6 Month on Major & Orthodontic Services		
Monthly Rates Guaranteed from 1/1/2025-12/31/2026					*Monthly Rate Difference*
Employee	$ 20.60		$ 30.72		*$ 10.12*
Employee + Spouse	$ 41.06		$ 61.22		*$ 20.16*
Employee + Children	$ 40.12		$ 59.78		*$ 19.66*
Family	$ 66.48		$ 99.08		*$ 32.60*

DELTA DENTAL

DENTAL ENROLLMENT/CHANGE FORM

Fax Form to ARSEBA
(501) 663-1445
Arkansas State Employees Benefit Advisors
1301 West 7th Street, Little Rock, AR 72201
Questions? Call (501) 224-5234 or (888) 224-5233

ARSEBA
ARKANSAS STATE EMPLOYEES BENEFIT ADVISORS

AGENCY NAME:_____

For internal use only:

Delta Dental Group Number:_____

Effective Date:_____ (MM)_____(DD)_____(YY)

LAST NAME: _____ FIRST: _____ MI: _____

SSN: _____ PERSONNEL NUMBER: (employee ID) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ EMAIL: _____

DATE OF HIRE: _____(MM)_____(DD)_____(YY) GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____(MM)_____(DD)_____(YY) MARITAL STATUS: ☐ SINGLE ☐ MARRIED

1. COVERAGE CHANGES

*Please check the box(es) next to the reason for your change

Type of coverage selected & plan option (choose one)

Base Dental
- ☐ Employee $20.60
- ☐ Employee/Spouse $41.06
- ☐ Employee/Child(ren) $40.12
- ☐ Employee/Family $66.48

Premium Dental
- ☐ Employee $30.72
- ☐ Employee/Spouse $61.22
- ☐ Employee/Child(ren) $59.78
- ☐ Employee/Family $99.08

Monthly Rates effective January 1, 2025 – December 31, 2026

- ☐ Open enrollment
- ☐ New Hire
- ☐ Agency Change
- ☐ Term Coverage
- ☐ Status Change
- ☐ Address Change

Reason(s) for Status Change:
- ☐ Marriage*
- ☐ Divorce*
- ☐ Birth or adoption of child*
- ☐ Loss of spouse's coverage*
- ☐ No longer dependent child*
- ☐ Death of dependent*
- ☐ Name Change
- ☐ Other

*Date of event above: _____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	Last Name	First Name	MI	Spouse or Dependent	Gender M/F	Birthdate (MM/DD/YY)
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

3. 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 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. 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.

4 CERTIFICATION

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 fines and confinement in prison.

☐ I authorize payroll deductions.

Signature: _____ Date: _____ DAR-ENR-12

Note: For new hires, the effective date will be first of the month following the signature date provided on this form.

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Humana Vision 130

ARKANSAS

State of Arkansas

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$5	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$150 allowance 20% off balance over$150	$65 allowance
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$150 allowance, 15% off balance over $150	$104 allowance
• Disposable	$150 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

Humana®

Humana Vision 130

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33
Optional benefits		
• Polycarbonate Lenses for Children <19	Provides for standard polycarbonate lens with $0 copay. Not available in AK, CT, ID, & OH.	

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Please note that limitations and exclusions can be found in your policy or by contacting ARSEBA.

Provider Search Tool: Humana Vision Insight Network Provider Search

Humana®

Humana.com

Humana.

State of Arkansas

ARSEBA
ARKANSAS STATE EMPLOYEES
BENEFIT ADVISORS

VisionCare Enrollment/Change Form

Arkansas State Employees Benefit Advisors
1301 West 7th Street
Little Rock, Arkansas 72201
(501) 224-5234, Toll Free (888) 224-5233

Current Agency Name: _____	Employee Number:	Group Number:
If this is an agency change, previous Agency Name: _____		

Social Security No.	Last Name	First	MI	**Date of Birth** / /
Home Address				**Date of Hire** / /
City		State	Zip Code	Gender M ☐ F ☐
Home Phone ( )	Business Phone ( )			Marital Status Single ☐ Married ☐

List all members to be enrolled or affected by change

Add	Remove	Last Name	First Name	MI	Spouse or Dependent	Gender M/F	Date of Birth (MM/DD/YYYY)
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /

Coverage Changes

*Please check the box(es) next to the reason for your change

Type of Coverage (Select One)	☐ Open enrollment	Reason(s) for Status Change:
		☐ Marriage*
☐ Employee Only **$8.24** (Monthly)	☐ New Hire	☐ Divorce*
		☐ Birth or Adoption of Child*
☐ Employee Family **$21.42** (Monthly)	☐ Agency Change	☐ Loss of spouse's coverage*
		☐ Dependent no long eligible*
Plan Code: VISION	☐ Status Change	☐ Death of Dependent*
		☐ Name Change
Agent Number: 1738312	☐ Term Coverage	☐ Address Change
		☐ Other _____
EFFECTIVE DATE: _____		* Date of Event Above: _____

I wish to enroll/change in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

FAX COMPLETED FORM TO ARSEBA: (501) 663-1445

Signature: _____ Date: _____

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Colonial Life®

Group Term Life Insurance with Accidental Death & Dismemberment (AD&D) Insurance for Active 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.

There are two convenient options to enroll:

1. Enroll with a telephonic Colonial Life benefits counselor.

Ask benefits questions and complete your enrollment by calling:

833-703-1967, Employer Code: 8038317 | Monday-Friday | 7 a.m. to 7 p.m. CT

Benefit confirmation forms can be emailed to you at the conclusion of the enrollment.

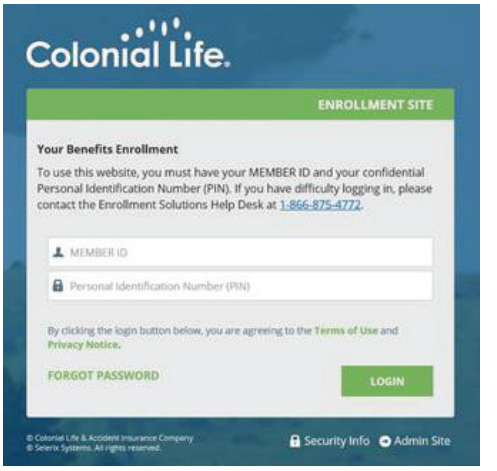
2. Self-enroll online.

Scan the QR Code or access the enrollment site URL directly at Harmony.benselect.com/SoA

Use the following login information:

- **Log In: MEMBER ID (This is also your Health ID number.)**
- **Personal Identification Number: The last four digits of your Social Security number and the last two digits of your birth year (six digits total)**

During your online enrollment, you will be prompted to accept or decline each coverage type, premiums will be displayed for your selections and the appropriate health questions will be displayed, when applicable. Benefit confirmation forms can be printed or saved at the conclusion of the enrollment.



Enrollment opportunities:

1. During annual enrollment
2. 60-day new hire eligibility period
3. Within 60 days of a qualifying event, such as marriage, birth or adoption

Employees who are eligible for ARBenefits health insurance are also eligible for Group Term Life with AD&D insurance. Employees should allow a minimum of 7 business days from their new hire date before accessing the enrollment site or the telephonic enrollment. This will allow time for employees' eligibility data to be uploaded into the enrollment platform.

Your basic and optional coverages

Coverage options	Who pays	Benefit amount(s)	
Basic group term life with AD&D insurance	Employer	**$10,000**	Your employer is providing this benefit, and you will be automatically enrolled.
Expanded basic group term life with AD&D insurance	Employee	**$1,000** increments up to **$40,000**	Health questions are not asked during the 2026 Plan Year Open Enrollment and new hire enrollment.
Supplemental employee group term life with AD&D insurance	Employee	**$1,000** increments up to **$250,000**	Health questions are not asked during the 2026 Plan Year Open Enrollment and new hire enrollment for benefit amounts up to $100,000. Any benefit amount over $100,000 is subject to evidence of insurability.
***Supplemental spouse group term life with AD&D insurance**	Employee	**$1,000** increments up to **$50,000**	Health questions are not asked during the 2026 Plan Year Open Enrollment and new hire enrollment for spouse benefit amounts up to $10,000. Any benefit amount over $10,000 is subject to evidence of insurability.
***Supplemental dependent child(ren) group term life with AD&D insurance**	Employee	**$1,000** increments up to **$50,000**	Health questions are not asked during the 2026 Plan Year Open Enrollment and new hire enrollment for spouse and coverage up to $10,000. Any benefit amount over $10,000 is subject to evidence of insurability.

** Employee must elect supplemental group term life with AD&D insurance on themselves in order to elect supplemental group term life with AD&D insurance for the spouse or dependent child(ren). Effective 1/1/2020, the spouse and/or child supplemental group term life with AD&D benefit amount must be either equal to or lower than the employee's supplemental group term life with AD&D benefit amount.*

2026 Rates (per $1,000) Monthly cost of coverage

Expanded basic group term life with AD&D insurance

$0.31 per $1,000

Supplemental group term life with AD&D insurance

Age	Employee
Under 25	$0.12
25-29	$0.12
30-34	$0.15
35-39	$0.16
40-44	$0.25
45-49	$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

Supplemental spouse group term life with AD&D insurance

All eligible ages	$0.86

Supplemental dependent child(ren) group term life with AD&D insurance

All eligible ages	$0.12

A person may only be insured once under this plan. Married employees eligible for ARBenefits life insurance may not be insured both as an employee and as a spouse, and a child may only be insured by one employee.

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.

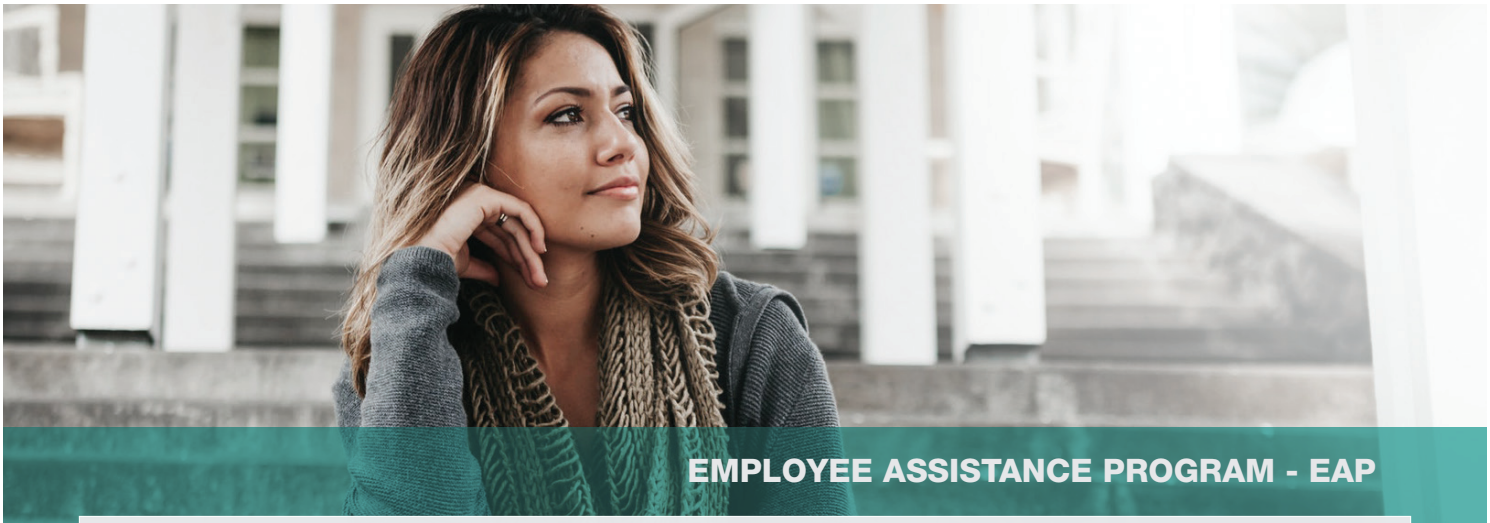
If you are no longer eligible for coverage as an active employee, you may be eligible to port your group term life and AD&D coverage, or you may convert your group term life and AD&D coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Evidence of Insurability means a statement of medical history which we will use to determine if an applicant is approved for coverage. Blood profiles and medical examinations, if applicable, will be provided at our expense. Evidence of Insurability is required for any amount of life insurance over the maximum guaranteed issue amount.

Premium will vary based on plan options and face amount selected.

The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date. The coverage will be effective on the date that you return to status as a member of an eligible class. If the certificate covers your spouse and/or dependent children, their coverage will be effective on the date that you return to status as a member of an eligible class.

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.



EMPLOYEE ASSISTANCE PROGRAM - EAP

When life's a little much,
reach out and get in touch.

Let's be real: life can be tough. When your responsibilities start to feel overwhelming and showing up each day with a smile on your face seems difficult, it's important to reach out for help. You can lean on your free and confidential Employee Assistance Program (EAP) for support.

We've got your back.

A free benefit from your workplace, the EAP can help you or anyone in your household:

- Be more present and productive at work
- Receive support when you don't feel ilke yourself
- Get help with responsibilities that are distracting or stressful
- Grow personal and career skills
- Be a caring, loving friend or family member
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life

We're here for you, always.

Life happens, regardless of the day or time. That's why we make ourselves available 24/7, even on holidays. So whenever you need to reach out, we're here for you.

Support Line
Call anytime
877-300-9103

Mobile app
Search for
Lucet EAP

Web
Visit lucethealth.com
for resources

SERVICES

- ☑ **Counseling**
  - In-person
  - Telephone
  - Text messaging
  - In-the-moment
  - Video
- ☑ **Consultation on**
  - Finances
  - Legal needs
  - Managing employees
  - Life
- ☑ **Crisis support**
- ☑ **Coaching**
- ☑ **Adult and child care resources**
- ☑ **Personal and professional training**
- ☑ **Digital behavioral health tools**

lucethealth.com
877-300-9103

Services are free and your employer will not know you reached out.

Use code 'arbenefits' when accessing via the website or by phone.

FSA/HSA

Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) are a benefit available to state of Arkansas employees as a way to set aside pre-tax money for medical expenses not covered by insurance.

Three types of FSAs are available: Health Care, Limited-Purpose and Dependent Care.

Healthcare FSAs provide tax savings on your out-of-pocket health expenses. A Limited Purpose FSA allows you to pay for dental and vision expenses until your deductible.

While employees cannot contribute to a Health Care FSA and an HSA at the same time, employees with an HSA can establish a Limited-Purpose FSA. Limited-Purpose FSAs can be used for dental and vision expenses only.

Employees can use their account funds on expenses such as: dental work, eye glasses and contact lenses, prescription drugs, and physical therapy just to name a few.

A Dependent Care FSA is a pre-tax benefit that allows you to pay for eligible dependent care services such as preschool, before/after school programs, child and elder day care. Once your account is funded, you can use the balance to be reimbursed for eligible expenses.

If you have questions regarding FSA/HSA, you can contact EBD Member Services at 1-877-815-1017 x1 and by e-mail at Ask.EBD@arkansas.gov.

	Health Savings Account (HSA)	**Flexible Spending Account (FSA)**
Eligibility	Must be enrolled in an ARBenefits High-Deductible Health Plan (Classic or Basic).	No eligibility requirements. You can have an FSA on any plan level, and even if you do not have ARBenefits coverage.
Annual contribution limits	2026 Limits: Individual: $4,400 Family: $8,750 *Persons aged 55 and older may contribute an additional $1,000 annually above those limits*	2026 Limits: Health & Limited: $3,400 Dependent Care: $7,500 Minimum Contribution: $200
Changing contribution amount	Employees can adjust their contribution amount anytime during the year.	Contributions can only be adjusted at open enrollment, or with a qualifying change in employment or family status.
Re-Enrollment	Employees do not have to re-enroll their HSA every year.	Employees must submit an election form every year during open enrollment to establish their FSA.
Rollover of funds	Unused funds roll over year-to-year.	Employees enrolled for 2026 can rollover up to $680 in 2027. Any amount unused over $680 will be forfeited after the annual run-out period.*
When can I use funds?	You must have the funds in your account in order to use them.	The amount you elect to contribute is available for you to use at the start of the year with the exception of Dependent Care FSA.
Connection to employer	You can take your HSA with you as you change employers. You own your account.	You will lose your FSA funds when you term employment with the State.
State contribution	The State of Arkansas contributes $25 each month for single employees and $50 for married employees with an HSA. **The state contribution counts towards your annual maximum contribution limit.**	No state contribution

*Must be enrolled in current year to rollover previous year funds. The 2025 rollover limit is $660.

Flexible Spending Account (FSA) Election Form

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____ Personnel # _____

Address **(Physical)** _____ City _____ State _____ Zip _____

Phone (____) _____ Email Address _____ Social Security Number _____

Payroll Effective Date ____ / ____ /____ mm/dd/yyyy Agency / School _____ ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event

Section 2: FSA Election and Annual Amount

I choose to participate in Flexible Spending Account.

☐ Health FSA – Medical Expenses ..... $ (Annual Amt.) _____ / 26 Pay Periods

☐ Limited Purpose FSA - Dental and Vision (Available only with HSA enrollment)..... $ (Annual Amt.) _____ / 26 Pay Periods

DCAP/Dependent Care FSA

☐ DCAP/Dependent Care FSA (Daycare/Elderly Care) Expenses..... $ (Annual Amt.) _____ / 26 Pay Periods

Section 3: Adoption Agreement / Employee Signature

I hereby authorize and direct my employer to reduce my earnings in the amount necessary to fund my Cafeteria Plan as indicated below. I understand such reductions, considered elective contributions under the Plan, will start with my first paycheck dated after the plan year begins. I understand that the purpose of this program is to allow employees to select qualified benefits within the guidelines of the Internal Revenue Code. I also understand that the flexible spending account plan(s) will allow me to be reimbursed for eligible out-of-pocket medical, dental, vision and/or dependent care expenses.

I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in my family status. I hereby certify the above information to be correct and true and I choose to participate.

Signature of Account Holder _____ Date ____ / ____ /____ mm/dd/yyyy

Visit ARBenefits Member Portal for online enrollment, or submit the paper form to EBD, by Fax: 501-683-0983, or mail ARBenefits, PO Box 15610, Little Rock, AR 72231, or provide to your HR Rep to submit.
For enrollment questions, please call toll-free at 877-815-1017, or email Ask.EBD@arkansas.gov.

Custodian
DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Plan Service Provider
Beneliance
www.beneliance.com
Serial No. 666576474227

State of Arkansas Employee Benefits Division
Toll Free: 877-815-1017 | Fax: 501-683-0983
Mailing: ARBenefits
PO Box 15610
Little Rock, AR 72231

Formulario de elección de cuenta de gastos flexibles (FSA)

Sección 1: Información del titular de la cuenta (en letra de imprenta)

Nombre (de pila, segunda inicial, apellido) _____ Personal # _____

Dirección residencial **(física)** _____ Ciudad _____ Estado _____ Código postal _____

Número de teléfono (____) _____ Dirección de correo electrónico _____ Numero de Suguro Social _____

Fecha de vigencia de la nómina ____ / ____ /____ mm/dd/aaaa Agencia / Escuela _____ ☐ Nueva contratación ☐ Inscripción abierta ☐ Evento clasificatorio

Sección 2: Elección de FSA monto anual

Elijo participar en las elecciones de la Cuentade Gastos Flexibles (Flexible Spending Account, FSA).

☐ FSA de salud – Gastos médicos ..... $ (monto anual) _____/ 26 Períodos de pago

☐ FSA de propósito limitado: dental y de la vista (disponible solo con inscripción en HSA) ..... $ (monto anual) _____/ 26 Períodos de pago

DCAP/FSA para el cuidado de dependientes

☐ DCAP/FSA para el cuidado de dependientes (Guardería/Cuidado de ancianos) gastos ..... $ (monto anual) _____/ 26 Períodos de pago

Sección 3: Acuerdo de adopción / Firma del empleado

Por el presente autorizo e instruyo a mi empleador a reducir mis ganancias en la cantidad necesaria para financiar mi Plan de Cafetería como se indica a continuación. Comprendo que dichas reducciones, consideradas contribuciones electivas en virtud del Plan, comenzarán con mi primer cheque de nómina fechado después de que comience el año del plan. Comprendo que el propósito de este programa es permitir que los empleados seleccionen beneficios calificados dentro de las pautas del Código de Impuestos Internos. También comprendo que el (los) plan(es) de cuenta de gastos flexibles me permitirá(n) ser reembolsado por gastos médicos, dentales, de la vista y/o de cuidado de dependientes elegibles.

Comprendo que este acuerdo de reducción salarial permanecerá en vigor y no podrá ser revocado o cambiado durante el año del plan, a menos que la revocación y la nueva elección sean a consecuencia de, y cónsonos con, un cambio en mi estado familiar. Por el presente certifico que la información que antecede es correcta y verdadera y yo elijo participar.

de la firma _____ fecha ____ / ____ /_____ mm/dd/aaaa

Visite el Portal para Miembros de ARBenefits para inscribirse en línea o envíe el formulario impreso a EBD por fax al 501-683-0983, envíelo por correo postal a ARBenefits, Apartado Postal 15610, Little Rock, AR 72231, o entrégueselo a su representante de Recursos Humanos para que lo envíe. Si tiene preguntas sobre la inscripción, llame gratis al 877-815-1017 o envíe un correo electrónico a Ask.EBD@arkansas.gov.

Custodio
DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Proveedor de servicios del plan
Beneliance
www.beneliance.com
Serial No. 666576474227

State of Arkansas Employee Benefits Division
Toll Free: 877-815-1017 | Fax: 501-683-0983
Mailing: ARBenefits
PO Box 15610
Little Rock, AR 72231

Health Savings Account (HSA) Election Form

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. Do not send contributions with this form. By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual," and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____

Address **(Physical)** _____ City _____ State _____ Zip _____

Phone (____) _____ Email Address _____

Social Security Number _____ Date of Birth ____ / ____ /____ mm/dd/yyyy Personnel # _____

Agency / School _____ HDHP Coverage: ☐ Single ☐ Married ☐ New Hire ☐ Open Enrollment ☐ Update

Section 2: HSA Contributions

I. Annual Employee Contribution $ _____/ 26 Pay Periods

II. Annual Employer Contribution $ _____ $25 Single per month for Annual amount of $300
$50 Married per month for Annual amount of $600

III. **Total Annual Contribution $** _____ *(Line I + Line II, not to exceed Contribution Maximums)*

Section 3: Adoption Agreement / Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that my benefits administrator is facilitating but not initiating the contribution. If the account is closed at any time, there will be a $25 closing fee.

This application is for the establishment of my individually owned Health Savings Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement, and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an Eligible Individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

Signature of Account Holder _____ Date ____ / ____ /____ mm/dd/yyyy

Visit ARBenefits Member Portal for online enrollment, or submit the paper form to EBD, by Fax: 501-683-0983, or mail ARBenefits, PO Box 15610, Little Rock, AR 72231, or provide to your HR Rep to submit.
For enrollment questions, please call toll-free at 877-815-1017, or email Ask.EBD@arkansas.gov.

Custodian

DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Plan Service Provider

Beneliance
www.beneliance.com
Serial No. 666576474227

State of Arkansas Employee Benefits Division

Toll Free: 877-815-1017 | Fax: 501-683-0983
Mailing: ARBenefits
PO Box 15610
Little Rock, AR 72231

Formulario de elección de cuenta de ahorros para gastos médicos (HSA)

El presente Acuerdo de Reducción Salarial (Salary Reduction Agreement, SRA) autoriza a su empleador a reducir su salario por el monto indicado consignado a continuación con el fin exclusivo de facilitar una contribución a su Cuenta de Ahorros de Salud. No envíe contribuciones junto a este formulario. Al completar este acuerdo, usted está indicando que a partir de la fecha de entrada en vigor de su elección de contribución, usted es un "Individuo elegible," y que autoriza a su empleador a facilitar sus contribuciones mensuales a su HSA en su nombre.

Sección 1: Información del titular de la cuenta (en letra de imprenta)

Nombre (de pila, segunda inicial, apellido) _____

Dirección residencial **(física)** _____ Ciudad _____ Estado _____ Código postal _____

Número de teléfono (_____) _____ Dirección de correo electrónico _____

Numero de Suguro Social _____ Fecha de nacimiento _____ / _____ /_____ mm/dd/aaaa Personal # _____

Agencia / Escuela _____ Cobertura HDHP: ☐ único ☐ casado/a ☐ nueva empleado ☐ inscripción abierta ☐ actualizar

Sección 2: Contribuciones a la HSA

I. Contribución anual de los empleados $ _____/ 26 períodos de pago

II. Contribución anual del empleador $ _____ $25 Individual al mes por un monto anual de $300
$50 Familiar al mes por un monto anual de $600

III. **Contribución anual total $** _____ *(Línea I + Línea II, sin exceder los máximos de contribución)*

Sección 3: Acuerdo de adopción/Firma del empleado

forme a la Sección 223 y la Sección 125 del Código de Impuestos Internos. Comprendo que esta solicitud no procesará hasta que mi empleador haya completado, aceptado y aprobado toda la documentación. Comprendo además que yo soy responsable de todas las contribuciones realizadas a mi HSA y que mi administrador de beneficios está facilitando, pero no está iniciando, la contribución. Si la cuenta se cierra en cualquier momento, se cobrará una tarifa de $25 por el cierre.

Esta solicitud es para el establecimiento de mi Cuenta de Ahorros de Salud de propiedad individual con el custodio que se consigna a continuación. La información en esta solicitud es verdadera y exacta a mi leal saber y entender, y yo estoy enviando este formulario con la plena comprensión y aceptación de las disposiciones contenidas en el Acuerdo de Cuenta de Custodia, los Términos y Condiciones de la HSA, y la Declaración de Divulgación de la HSA. También reconozco que el Proveedor de Servicios del Plan (PSP) indicado al pie de este formulario está autorizado para realizar transacciones en mi cuenta, y que todas esas transacciones iniciadas por el PSP deben tratarse como si hubieran sido iniciadas directamente por mí, el Titular de la cuenta. Al presente soy, o lo seré en la fecha de mi primera contribución, un Individuo elegible tal cual se describe en el Acuerdo de Cuenta de Custodia. Comprendo que soy el responsable de mantener mi elegibilidad, y que el custodio asumirá que todas las contribuciones se hacen mientras yo soy elegible para hacerlas. Al presente estoy, o lo estaré en la fecha de mi contribución, cubierto por un Plan de Salud de Alto Deducible (High Deductible Health Plan, HDHP) que cumple con los requisitos detallados en el Acuerdo de Cuenta de Custodia.

Firma del Titular de la cuenta _____ Fecha _____ / _____ /_____ mm/dd/aaaa

Visite el Portal para Miembros de ARBenefits para inscribirse en línea o envíe el formulario impreso a EBD por fax al 501-683-0983, envíelo por correo postal a ARBenefits, Apartado Postal 15610, Little Rock, AR 72231, o entréguelo a su representante de Recursos Humanos para que lo envíe.
Si tiene preguntas sobre la inscripción, llame gratis al 877-815-1017 o envíe un correo electrónico a Ask.EBD@arkansas.gov.

Custodio
DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Proveedor de servicios del plan
Beneliance
www.beneliance.com
Serial No. 666576474227

State of Arkansas Employee Benefits Division
Toll Free: 877-815-1017 | Fax: 501-683-0983
Mailing: ARBenefits
PO Box 15610
Little Rock, AR 72231

Let's talk about the future

Have you thought about how to begin building the income you'll need for the future?

While your pension and Social Security offer you a good start, they may not be enough to fund the lifestyle you want in retirement. The AR Diamond Plan – your 457 Plan – is here to help you generate the income you may need by offering you an easy, tax-advantaged way to save. The AR Diamond Plan provides you with additional flexibility to save and invest for your future. To help you get started in the Plan, you'll be automatically enrolled into the AR Diamond Plan on your first day of employment, saving 3% each pay period on a pre-tax basis, and be invested in the Moderate Asset Allocation Lifestyle Model.

Once you're enrolled, you can choose to not participate (or opt out) in the Plan at any time. If you opt out within the first 90 days after your first payroll is processed, you can request a refund of any contributions made into the Plan. If you choose to opt out on day 91 and beyond, normal qualifying 457 distribution rules will apply.

What's in it for you – key benefits of the AR Diamond Plan

- **Pre-tax savings** – you pay less in taxes today
- **Roth savings** – you pay taxes today but not in retirement*
- **Tax-deferred investing** – your savings grows without being taxed
- **A choice of investments** – so you can create a portfolio that's right for you
- **Qualifying withdrawals** – should you need your savings before retirement
- **24/7 account access** – by smartphone or computer
- **Automatic enrollment** – easy enrollment starting at a 3% pre-tax contribution rate

To learn more about the Plan, go to **myplan.voya.com**.

Your contributions

You can save up to the annual IRS contribution limit on a pre-tax basis, after-tax with Roth contributions or a combination of both. If you are age 50 or older in any given year or within three years of your Normal Retirement Age, you can make additional catch-up contributions. You can change your contribution rate at any time. Please refer to www.voya.com/IRSlimits for current limitations.

About Voya Financial®

At Voya (NYSE: VOYA) we're dedicated to helping people feel more confident about the future. For more than 40 years, we've helped millions of people like you be ready for it through employer-sponsored retirement plans and other financial solutions.

As the provider for the AR Diamond Plan, we will manage the daily servicing of your Plan and provide you with plan information, transaction processing, account statements, saving and investing education and more.

* For Roth contributions and earnings to be eligible for tax-free withdrawals, your initial Roth deposit must have been in your account for at least five years and you must be at least age 59½ (or in the event of your disability or your death)

Ready to make a move for your future?

If you are a new employee of the State of Arkansas, you will receive a Personal Identification Number (PIN) by mail.

If you misplace your password or previously opted not to enroll, it's easy to request a new password.

- Go to the **Plan website** at myplan.voya.com and click on "Forgot Password?" or
- Call the **Plan Information Line** at 800-905-1833. Customer Service Associates are here to help Monday through Friday, 7:00 AM to 7:00 PM CT (excluding New York Stock Exchange holidays).

A new password will be mailed to your home address within seven business days.

Want to meet with a Plan representative to learn more about the Plan?

Your local AR Diamond Plan representatives[1] are available to meet with you one-on-one at your convenience. Call 501-301-9900 (or 866-271-3327) during standard business hours except on New York Stock Exchange holidays to schedule a time.

- Cheryl Daughenbaugh
- Brete Garland

See how your savings translate into estimated monthly retirement income with **myOrangeMoney®**. You'll find it on the Plan website and **Voya Retire** mobile app.

[1] Registered Representatives of Voya Financial Advisors, LLC

1969570_0223

Arkansas State Employee New Hires!

Schedule a Virtual Meeting by Scanning the QR Code Below. You wll be able to gather information, get quotes, and Enroll.

- Accident Insurance
- Cancer Insurance
- Critical Illness
- Dental Insurance
- Short Term Disability
- Hospital Indemnity
- Life Insurance
- Long Term Disability
- Vision Insurance
- Identity Theft
- Legal Services

DELTA DENTAL

LegalShield

Sun Life

IDShield + yourself.online

Humana

Colonial Life

Aflac

ManhattanLife

TRANSAMERICA

masa

Call ARSEBA at 501-224-5234 if you need help scheduling your Virtual Meeting

***New Hires Schedule a Virtual Meeting to visit with a Benefit Counselor during your first 60 days**

ARSEBA

ARKANSAS STATE EMPLOYEES
BENEFIT ADVISORS

New hire enrollment

ARKANSAS STATE EMPLOYEES BENEFIT ADVISORS

State of Arkansas is pleased to have Arkansas State Employees Benefit Advisors assist with your enrollment. During the enrollment, each of you are encouraged to attend a quick, private 1-to-1 session with a benefits counselor. In that session, you'll discuss all of your current benefits as well as new and updated benefit options. Your benefits counselor will answer any questions you may have and offer you simple, straightforward advice as you sort through your choices.

Contact your office HIR to find out when a benefit counselor will be at your office!

THE FOLLOWING VOLUNTARY BENEFITS WILL BE OFFERED DURING ENROLLMENT:

Accident insurance provides a benefit for a range of accidental injuries.

Group specified disease insurance provides a benefit to help you manage the financial impacts of a critical illness.

Term life insurance offers a predictable way to provide more life coverage at more affordable prices during high-need years.

Whole life insurance provides a benefit to help protect your family's way of life in the event of your death.

These benefits are being offered for a limited time with no medical underwriting to qualify for coverage. Eligibility requirements apply.

IF YOU ARE UNABLE TO ATTEND A 1-TO-1 BENEFITS COUNSELING SESSION, CONTACT THE ENROLLMENT CALL CENTER TO APPLY

Phone: 833-703-1967

Employer Code: 1395219

Time: 8 a.m. – 5 p.m. CT

Here's how it works:

1. Gather any information you may need to apply, such as dependents' names, birth dates, ages, Social Security numbers and addresses.
2. You can speak with a benefits counselor to answer any questions you may have or leave a message for a callback. A benefits counselor can complete your enrollment over the telephone.
3. You will receive an Election Form confirming your voluntary benefit elections via secure email.

For more details contact: Arkansas State Employees Benefit Advisors

888-224-5233 | 501-224-5234 | www.arseba.com

Colonial Life

ColonialLife.com

ManhattanLife™
Standing By You. Since 1850.

State of Arkansas

State of Arkansas is now making the following ManhattanLife Insurance and Annuity products available to its employees.

CANCER CARE PLUS

"Limited Cancer and Dread Disease Policy"

Portable And Renewable For Life! *

BENEFIT PACKAGE OPTIONS	LOW PLAN	HIGH PLAN
CANCER SCREENING TEST - Payable for one annual cancer screening test. Not payable if received through any free-testing program or for any other cancer screening test for which a charge is not made. Payment based on benefit amount selected.	Pays $50 per calendar year	Pays $100 per calendar year.
FIRST OCCURRENCE BENEFIT (RIDER) - Payable when a covered person is diagnosed with cancer for the first time. Payable only once for each covered person and not payable for skin cancer Not available for ages 65 and above.	Pays $2,500.	Pays $10,000.
DAILY HOSPITAL CONFINEMENT BENEFIT - Payable when a covered person is confined to the hospital for the treatment of cancer or a dread disease. Payment is based on the daily benefit amount selected. Payable for the first 70 days of each period of confinement.	Pays $150 per day.	Pays $150 per day.
SURGICAL BENEFIT - Payable for surgeries performed in or out of the hospital to treat cancer or a specified dread disease. Benefits for surgical procedures are calculated as a percentage of the per-surgery maximum benefit amount selected.	Pays max per surgery $3,000.	Pays max per surgery $4,000.
RADIATION, CHEMOTHERAPY AND IMMUNOTHERAPY* We will pay the actual charges for Teleradiotherapy, Radio-Active Isotopes Therapy, Chemotherapy, Chemotherapy Enhancer Drugs, and Anti-Nausea and Immunotherapy drugs, as indicated in the policy, for the treatment of cancer or a specified dread disease. Benefits are based on the maximum monthly benefit amount selected. Actual Charges means the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided. This benefit is not payable if treatment is received in a government or charity hospital. **Note - Immunotherapy must be FDA approved*	Pays actual charges, max $5,000 per month.	Pays actual charges, max $5,000 per month.

This plan covers an additional 27 dread diseases.

** Subject to company's right to change premium.*

CENTRAL CARE DISABILITY INCOME

SHORT-TERM DISABILITY

The ManhattanLife Central Care Group Disability Income Insurance Policy provides a monthly disability benefit payable to an insured employee in the event of a total disability resulting from an off-the-job, covered accident or sickness.

Benefit coverage for up to 65% of salary, excluding bonuses and overtime.

MONTHLY BENEFIT AMOUNT

- $500 - $6,000

ELIMINATION PERIOD

(refers to the number of consecutive days you must be Totally Disabled before the policy begins to pay the Monthly Benefit for Total Disability)

- 0/7 or 0/14 (Accident/Sickness)

BENEFIT DURATION

- Total Disability - 6 months

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the Workers' Compensation System by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits that would otherwise accrue under the Workers' Compensation Laws. The employer must comply with the Workers' Compensation Law as it pertains to the non-subscribers and the required notifications that must be filed and posted.

For more information about enrolling, policy benefits, limitations and exclusions, please visit:

Arkansas State Employees Benefits Advisors

(888) 224-5233 or email service@arseba.com

POLICY FORM NUMBERS: CP4000 AR 4/04, DIMSTR and DICERT

OPEN ENROLLMENT DISCLAIMER: Not all products offered are guaranteed to issue and may include a pre-existing condition waiting period; please consult your agent representative for policy underwriting parameters.

Coverage is subject to policy exclusions and limitations that may affect benefits payable. This is not a complete disclosure of plan qualifications and limitations. See your ManhattanLife benefits counselor for complete details.

Underwritten by ManhattanLife Insurance and Annuity Company, 107777 Northwest Freeway, Houston, Texas 77092

Open enrollment planning isn't complete until you have Aflac

Aflac for State of Arkansas

Health insurance wasn't designed to cover everything. That's why there's Aflac. Aflac can help take care of what health insurance doesn't cover, so you and your employees can focus on caring for everything else.

Aflac supplemental benefits

Our product portfolio is as broad as your needs, with individual and group plans that help cover the expected – and unexpected – that's sure to come life's way.

Hospital Confinement Indemnity: Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

To learn more, contact your Aflac agent, Arkansas State Employees Benefit Advisors, 100172283 at service@arseba.com or (501) 224-5234.

Aflac®

Z2301267R1

Exp 11/25

AVAILABLE TO THE EMPLOYEES OF STATE OF ARKANSAS.
SCAN THE QR CODE FOR MORE INFORMATION

TRANSAMERICA®

UNIVERSAL LIFE INSURANCE WITH LIVING BENEFITS RIDERS

Underwritten by Transamerica Life Insurance Company

Help safeguard your family's future with life insurance that can assist with more than final expenses. With universal life insurance from Transamerica, you can build cash value that you can borrow[1] against to help pay for childcare, college tuition, or unexpected expenses.

MEET ALEXIS

Alexis enrolled in a $50,000 universal life insurance policy through her employer. This policy includes the Chronic Condition Rider — a feature that helps provide money for care if she were to fall ill. It lets her access her death benefit early if she's diagnosed with a qualifying condition that leaves her unable to perform at least two of the six Activities of Daily Living, which include bathing, dressing, toileting, transferring (e.g., ability to get into or out of a chair or bed), continence, and eating. And with additional riders, her benefits can go further. Alexis feels better knowing there would be financial support for her family if she passes.

INCLUDED RIDERS:

Extension of Benefits Rider: Increases the death benefit each month to allow the rider to continue providing a monthly benefit.

Benefit Restoration Rider: This rider will restore 100% of the death benefit that is accelerated under the Chronic Condition Rider, leaving a full death benefit for the beneficiary.

Family caregivers spend more than

$7,200

a year on out-of-pocket costs.[2]

AN EXAMPLE OF HOW THE INSURANCE AND RIDERS WORK

The below hypothetical example assumes this employee elected a $50,000 death benefit amount and the policy has living benefits.

$50,000 If Alexis is diagnosed with a qualifying condition, she can use the Chronic Condition Rider included in her policy *(4%/month for 25 months)*

\+ $50,000 Extension of Benefits Rider *(4%/month for an additional 25 months)*

= $100,000 **TOTAL *(PAID OVER 50 MONTHS)***

and

$50,000

100% PAID-UP DEATH BENEFIT *(SHOULD ALEXIS PASS AWAY)*

Would your family be financially secure without you?

Make today the day you plan for tomorrow.

YOUR BENEFITS AT A GLANCE

Death benefit amounts available:	$15,000 - $500,000 not to exceed 5x base salary
Guaranteed issue amount:	Employee: Up to $200,000, Spouse: Up to $50,000, Child: Up to $20,000
Can I continue my insurance after employment?	Yes, with our portability option
Riders (benefits):	Accelerated Death Benefit for Chronic Condition Rider Extension of Benefits Rider Benefits Restoration Rider Waiver of Monthly Deductions for Layoff or Strike Rider Accelerated Death Benefit for Terminal Condition Rider

HIGHLIGHTS

- Flexibility to adjust premiums up (to build more cash value) or down (if money is tight)
- Complements term life insurance and helps for all the stages of your life
- Family options available
- Benefits can be used with no restrictions — including costs associated with care from a family member or a facility

THREE WAYS YOU MIGHT BENEFIT FROM UNIVERSAL LIFE INSURANCE

1. Help your loved ones if you pass away
2. Borrow money to help pay for college tuition[1]
3. Use the living benefit to help pay for the cost of caregiving needs

Questions?

Visit: transamerica.com

Contact: (888) 763-7474

[1] Loans, withdrawals, and death benefit accelerations will reduce the policy value and the death benefit and may increase lapse risk. Policy loans are tax-free provided the policy remains in force. If the policy is surrendered or lapses, the amount of the policy loan will be considered a distribution from the policy and will be taxable to the extent that such loan, plus other distributions at that time, exceed the policy basis.

[2]"Family Caregivers Spend More Than $7,200 a Year on Out-of-Pocket Costs" AARP, June 2021

LIMITATIONS AND EXCLUSIONS

If an insure employee withdraws the cash value, tax consequences and/or surrender charges may apply. Fluctuations in interest rates or policy charges may require the payment of additional premiums. Individuals currently on disability or on premium waiver are not eligible for insurance. During the first two years, the death benefit for suicide is limited to the return of premiums paid, less any loans, partial surrender amounts, and accelerated benefits paid, if an; **ACCELERATED DEATH BENEFIT FOR CHRONIC CONDITION RIDER:** Transamerica will not pay rider benefits for care that is received or loss incurred as a result of: an intentionally self-inflicted injury or attempted suicide war or any act of war, declared or undeclared, or service in the armed forces of any country; the insured's alcohol, drug or other chemical dependence, except if the drug dependency is for a drug prescribed by a physician in the course of treatment for an injury or sickness; the insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the insured's involvement in an illegal activity; **EXTENSION OF BENEFITS RIDER:** The rider will terminate on the earliest of: the date the contract terminates; the date the contract lapses, subject to the grace period; the date the policy owner requests termination; the date the policy owner dies; the date the entire death benefit has been paid under the Accelerated Death Benefit for Chronic Condition Rider, or when the policy no longer satisfies the Eligibility for Benefits provision; the date the cumulative death benefit increases under this rider total 100% of the death benefit in force on the date the first monthly accelerated death benefit was paid under the Accelerated Death Benefit for Chronic Condition Rider; the date the nonforfeiture option, if any, becomes effective; or the date a one-time lump-sum payment under the Accelerated Death Benefit for Chronic Condition Rider is paid. **RESTORATION RIDER:** This Rider will terminate on the earliest of the following dates or events: 1. The date the contract terminates; 2. The date the contract Lapses, subject to the Grace Period; 3. The date the Owner requests termination; 4. The date the Insured dies; 5. The date the Accelerated Death Benefit for Chronic Condition Rider terminates; or 6. The date a Nonforfeiture Option under the contract, if any, becomes effective.

This is a brief summary of Transamerica Universal Life Insurance℠ UL10 Universal Life Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, Iowa. TLIC is not an authorized insurer in New York. Policy Form Series TMUL1000-0421 and TCUL1000-0421. Forms and form numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Up-to-date information regarding our compensation practices can be found in the disclosures section of our website at tebcs.com.

EB3 2241361R1 V 06/23

TRANSAMERICA®

Sun Life®

Employee benefits

Protect what you love about your life

Effective December 1, 2025, State of Arkansas's Long-term Disability benefits will be administered by Sun Life.

For questions contact Arkansas State Employees Benefit Advisors at 501-224-5234

Voluntary Long-Term Disability insurance

Provides you with a monthly cash benefit to help pay for everyday expenses (such as mortgage/rent, utilities, childcare, or groceries) after your claim is approved if a covered disability takes you away from work for an extended time. This plan provides a benefit for covered disabilities resulting from injury or sickness 24 hours a day, seven days a week.

There are three coverage options to choose from:

- **Choice 1: 60%** of Total Monthly Earnings up to **$5,000** per month. Benefits begin after **180 days** and may be paid for up to **Social Security Normal Retirement Age** (**SSNRA**).
- **Choice 2: 60%** of Total Monthly Earnings up to **$5,000** per week. Benefits begin after **180 days** and may be paid for **at least 5 years, but not beyond age 70**.
- **Choice 3: 50%** of Total Monthly Earnings up to **$5,000** per week. Benefits begin **after 180** days and may be paid for **at least 5 years, but not beyond age 70**.

There are no health questions necessary to enroll in Long-Term Disability insurance.

A pre-existing limitation may apply.

If you become disabled within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Plan features

- Retro-disability Benefits
- Waiver of Premium
- 3-month survivor benefits

After your effective date of coverage, you will be able to register and create an account on the Sun Life website at www.sunlife.com/account. It's the simplest way to stay up-to-date on your plan and claims.

Read the important plan provisions section for more information including limitations and exclusions

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage") and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

ARSEBA
ARKANSAS STATE EMPLOYEES
BENEFIT ADVISORS

Limitations and exclusions

The below exclusions and limitations list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; operation of a motorized vehicle while intoxicated. We will not pay a benefit if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.); or for any Period of disability during which you are incarcerated.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Your age	Choice 1 rate*	Choice 2 rate*	Choice 3 rate*
< 25	0.220	0.150	0.130
25-29	0.350	0.210	0.170
30-34	0.680	0.370	0.280
35-39	1.130	0.540	0.420
40-44	1.620	0.770	0.550
45-49	2.120	1.100	0.770
50-54	2.490	1.360	1.010
55-59	2.740	2.080	1.580
60-64	2.940	3.510	2.440
65-69	2.210	3.260	2.340
70+	1.700	1.750	1.280

Example monthly earnings	Divide by 100	Multiply by rate	Example monthly cost
$2500	/ 100 = 25	x $0.220	= $5.500
Your monthly earnings	Divide by 100	Multiply by rate	Example monthly cost
$ _____	/ 100 = _____	x $_____	= $_____

Your monthly cost	Multiply by 12 months	Annual cost	Divide by your number of pay periods per year (ex: 12,24,26,52,etc.)	Your estimated cost per pay period
$ _____	/ 12	= $_____	/ _____	= $_____

MPFL-11337-c #1765317325 10/25 (exp. 10/27)

LegalShield | IDShield

Have You Ever

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ Been denied a warranty or insurance claim?
- ☐ Been overcharged or had a billing dispute?
- ☐ Purchased or leased a home?
- ☐ Worried about being a victim of identity theft?
- ☐ Been concerned about your child's identity?
- ☐ Lost your wallet?
- ☐ Been involved in a data breach?
- ☐ Had someone commit tax or employment fraud in your name?
- ☐ Had your driver's license or medical information stolen/used?

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** on unlimited personal or business issues
- **Letters/Calls** made on your behalf (initial letter or call on an unlimited basis)
- **Contracts/Documents** Reviewed Up to 10 pages per document
- **Will Preparation** - Last Will and Testament (for the named member)
- **Moving Traffic Violations** - (must be on the road legally) 15 day waiting period
- **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (if named defendant/respondent in a covered civil action suit)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, and other matters outside of normal coverage)
- **24/7 Emergency Access** for covered situations

The IDShield Membership Includes:

- **Continuous Credit Monitoring** IDShield continuously monitors your credit report. If changes occur, you'll receive an instant alert.
- **High Risk Application and Transaction Monitoring** We monitor the largest proprietary database of new account application data to detect potentially fraudulent new accounts when an application is submitted.
- **Dark Web Monitoring** Monitors your Personally Identifiable Information (PII) across the dark web, where criminals purchase personal data.
- **Username/Password (Credential) Monitoring** This powerful feature helps protect against takeovers of your social, financial and other online accounts.
- **Identity Threat & Credit Threat Alerts** You'll receive a threat alert if your PII is found.
- **Unlimited Consultation** On any cyber security issue.
- **Full-Service Restoration** Our Licensed Private Investigators will work tirelessly to restore your identity to its pre-theft status.
- **24/7 Emergency Access** We're here in the event of an identity theft emergency.

Put your law firm and identity theft protection in the palm of your hand with the LegalShield & IDShield mobile apps

Plan	Family Price (Bi-weekly)	Individual Price (Bi-weekly)
LegalShield	$7.36	$7.36
IDShield	$7.36	$3.90
Combined	$13.34	$11.26

Prepared for: State of Arkansas Employees

For more information, contact your Independent Associate:

ARSEBA
www.arseba.com
service@arseba.com
(501) 224-5234

LegalShield legal plans cover the member; member's spouse; never married dependent children under 21 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 23 if a full-time college student; or physically or mentally disabled dependent children. IDShield is a product of Pre-Paid Legal Services, Inc. d/b/a LegalShield ("LegalShield"). LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see www.idshield.com. All Licensed Private Investigators are licensed in the state of Oklahoma. LegalShield/IDShield is not an insurance carrier. Certain limitations apply. IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 10 dependents up to the ages 18. It also provides consultation and restoration for dependent children age 18 to 26. This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See plan details for your state of residence for complete terms, coverage, amounts, conditions and limitations.

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JOIN THE ORGANIZATION THAT SUPPORTS *You*

FOR JUST $2 PER PAY PERIOD

ADVOCACY

We monitor legislative and administrative activity related to state employees and consistently advocate for -

- better compensation
- retirement benefits
- health insurance

INFORMATION

- Email Alerts
- Text Alerts
- Legislative Analysis
- ASEA Newsletter
- www.aseaar.org

BENEFITS

Members-only discounts on

- Retail Services
- Entertainment
- Travel
- Fitness Centers

SERVICES

Funeral Assistance up to $1,000

Scholarships for you and your family members -

- 2-year schools
- 4-year schools
- vocational schools
- specialized skills training

For more information or to access members only content, visit www.aseaar.org

Join Today!

MEMBERSHIP APPLICATION by PAYROLL DEDUCTION

Please print legibly

First Name _____ Last Name _____ MI ___

Agency _____ Personnel # _____

Home Address _____ Email _____ Personal email preferred

City _____ ZIP _____ Mobile # _____

Fax or email to: 501-378-0113 or sbuckholts@aseear.org

Signature _____ Referred By _____

IRS regulations require ASEA to notify its members regarding a reasonable estimate of the portion of annual dues that are allocable to lobbying and political expenses and will be nondeductible for individual tax reporting. Currently, up to 5% of membership dues received may be used for lobbying and political expenses.

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Contact information for Benefits

Benefit	Contact	Phone	Address
Health Insurance	Employee Benefits Division (EBD) https://sas.arkansas.gov/employee-benefits/ e-mail: ask.EBD@arkansas.gov	(877) 815-1017 Press 1, then 2	501 Woodlane St., Ste 500 Little Rock, AR 72201
Dental and Vision Insurance	ARSEBA – Arkansas State Employees Benefit Advisors www.arseba.com e-mail: service@arseba.com	(501) 224-5234 (888) 224-5233 (501) 663-1445 Fax	1301 West 7th Street Little Rock, AR 72201
Health Savings Account/Flexible Spending Account	Beneliance https://www.beneliance.com/ (beginning January 1, 2026)	(501) 687-6954	PO Box 55068 Little Rock, AR 72215
Group Term Life Insurance	Colonial Life https://sas.arkansas.gov/employee-benefits/	(855) 868-6009	PO Box 1365 Columbia, SC 29202
Deferred Compensation	Arkansas Diamond Plan – Voya https://myplan.voya.com	(501) 301-9900 (866) 271-3327	
MASA – Emergency Transport	ARSEBA – Arkansas State Employees Benefit Advisors www.arseba.com e-mail: service@arseba.com	(501) 224-5234 (888) 224-5233 (501) 663-1445 Fax	1301 West 7th Street Little Rock, AR 72201
Other Voluntary Insurance: Accident Cancer Critical Illness Hospital Indemnity Life Insurance (Individual Term, Universal and Whole) Short Term Disability Long Term Disability LegalShield	ARSEBA – Arkansas State Employees Benefit Advisors www.arseba.com e-mail: service@arseba.com	(501) 224-5234 (888) 224-5233 (501) 663-1445 Fax	1301 West 7th Street Little Rock, AR 72201
AR State Employees Association	ASEA - www.aseaar.org	(501) 378-0187 (800) 950-8139	PO Box 1588 Little Rock, AR 72203
Employee Assistance Program - EAP	Lucet Health https://lucethealth.com/	(877) 300-9103	

Additional information and forms including Notice of Privacy Practices and HIPAA information can be found at: https://sas.arkansas.gov/employee-benefits/

Arkansas State Employee New Hire Benefits Information 2026