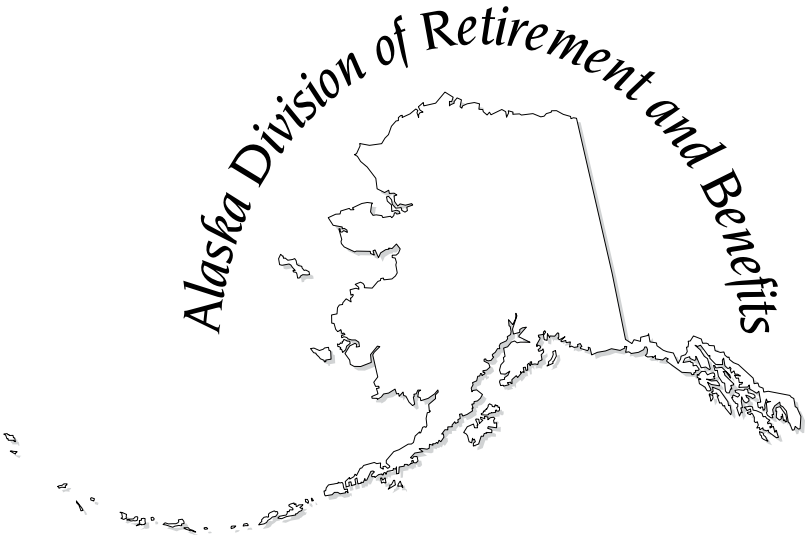


STATE OF ALASKA

DIVISION OF RETIREMENT AND BENEFITS

Same-Sex Partner Supplement

Public Employees' Retirement System (Tier II and III)
Teachers' Retirement System (Tier II)

If you are electing a Joint and Survivor option for your same-sex partner or enrolling a same-sex partner in retiree medical, complete this supplement in addition to the Retirement Application.

Return this packet in its entirety.

The Alaska Department of Administration complies with Title II of the 1990 Americans with Disabilities Act (ADA). This publication is available in alternative communication formats upon request. To make necessary arrangements, contact the ADA Coordinator for the Division of Retirement and Benefits, at (907) 465-4460 or contact the TDD for the hearing impaired at (907) 465-2805.

Declaration of Tax Status
Alaska Benefit Plans

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
alaska.gov/drb

Division of Retirement and Benefits
P.O. Box 110203
Juneau, Alaska 99811-0203

Juneau: (907) 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

The State of Alaska offers coverage for same-sex partners and their eligible dependent children. In order to ensure proper tax treatment of the benefits for these dependents, the State must know the federal tax status of each dependent enrolled. The tax status of the dependent does not affect their eligibility for coverage but does impact the tax treatment of that coverage. The flowchart on the back of this form is provided to assist you in determining and verifying the federal tax status of your same-sex partner and dependent children. The chart is provided as an overview of the tax rules but given their complexity, we recommend you consult a tax advisor regarding your specific circumstances. Additional information regarding the tax implications is provided in "Retiree Important Tax Implications for Enrolling Same-sex Partners."

List every dependent you are enrolling for health coverage on your health dependent enrollment form in this packet and indicate whether they are a federal tax dependent, or not, after following the flowchart on the back of this form.

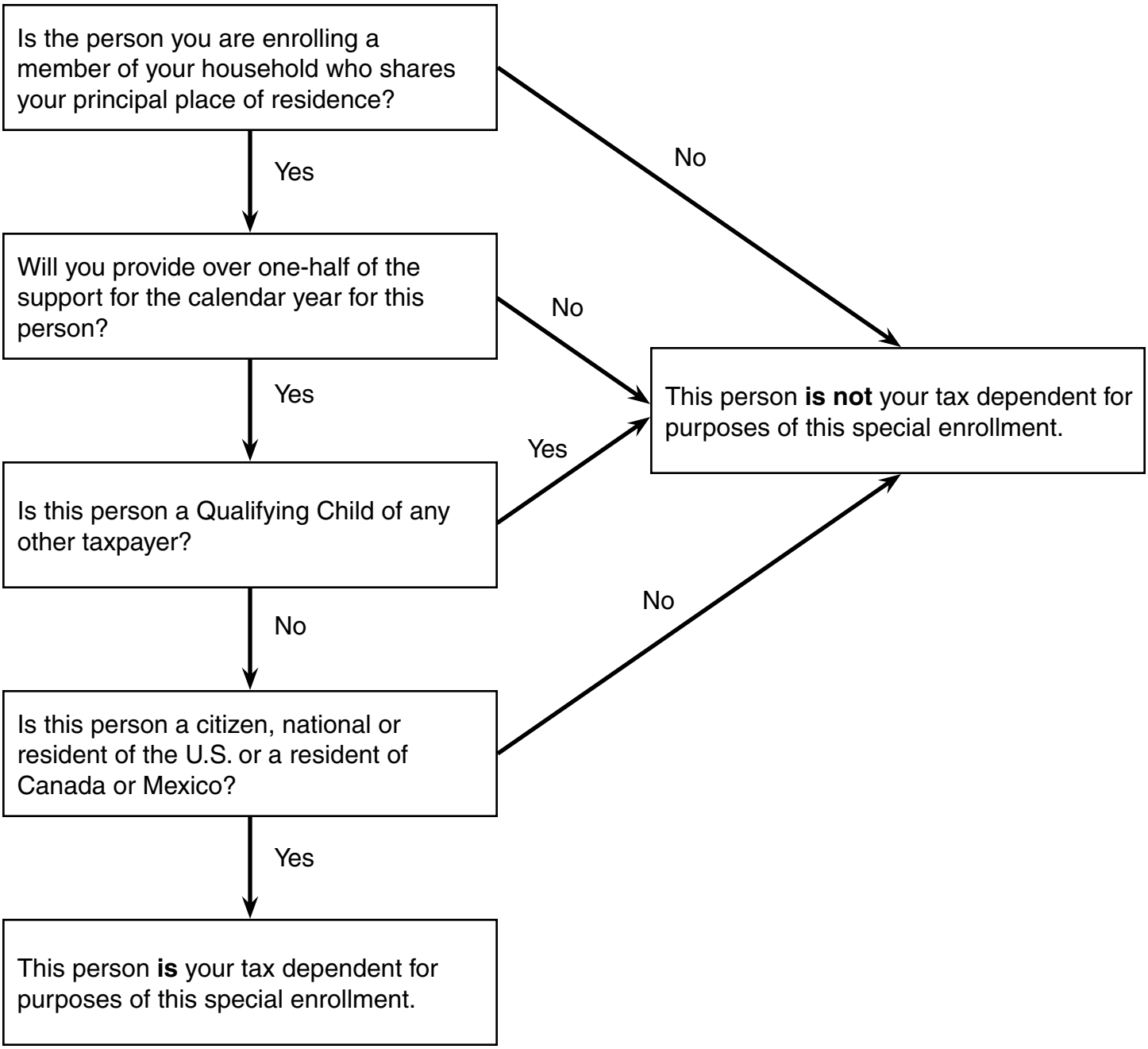
Member Name			Member RIN
Health Dependent Name		**Relationship to Member**	**Federal Tax Status**
		Same-Sex Partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-Sex Partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-Sex Partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-Sex Partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Date of Birth		
		Child of Same-Sex Partner	❑ This person **is** my tax dependent for purposes of this health plan. ❑ This person **is not** my tax dependent for purposes of this health plan.
	Date of Birth		

I understand that the division has a legitimate need to know the federal income tax status of my relationship with my same-sex partner and their child/children. I certify that the information I have listed above is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that if any information I have provided is false or misleading, it could result in termination of eligibility under the health plan. I agree to notify the Division if there is any change in these circumstances within 30 days of the change. I am aware that changes may impact the tax treatment of my coverage.

Member Signature _____ Date _____

Declaration of Tax Status
Alaska Benefit Plans

Answer the following questions for **each** person you listed on the other side of this form:



Retiree
Important Tax Implications For Enrolling Same-Sex Partners

The State pays the cost of covering a same-sex partner and eligible dependent children under the retiree medical plan. You pay the full premium for optional coverage under the Dental/Vision/Audio plan and the Long-term Care plan if you elected these benefits. Because of this, there are financial and tax implications to consider. The Internal Revenue Service (IRS) has determined that the cost of providing benefits for same-sex partners and their children who do not meet the IRC Section 152 (as modified by IRC Code Section 105(b)) definition of qualified "dependents" is considered ordinary or "imputed income" and is, therefore, subject to taxes.

If a same-sex partner or same-sex partner's child is not a "dependent" of the member under federal tax law, the State must report the fair market value (FMV) of a member's same-sex partner/child benefits as wages or "imputed income" to the Internal Revenue Service, resulting in increased taxable gross income for federal income taxes as well as Medicare taxes withheld from the retiree's check. In that case, the cost to the member of obtaining benefits for a same-sex partner and/or child of a same-sex partner is actually more than just the cost of the State paid premium.

Imputed income attributable to you for your same-sex partner's and/or your same-sex partner's eligible children's coverage will be reported on your retiree warrant for tax purposes. This amount represents the cost of providing benefits for your same-sex partner and/or their eligible children so that required taxes on the imputed income will be deducted from your retirement check.

Because the child of a same-sex partner must be financially dependent on you to be eligible for coverage under the retiree medical plan, in most situations a child of a same-sex partner who is eligible for coverage under the medical plan will also be a dependent of the retiree under federal tax law, and no income will be imputed to you for coverage of the child for federal tax purposes. If, however, the child is eligible for coverage but does not qualify as a dependent under federal tax law, imputed income would be attributable to you for that child's coverage.

Imputed income does not affect calculations for member-elected and paid benefits, such as dental/vision/audio or long-term care. Nor does imputed income affect dependent life coverage because benefits are paid entirely by the member and deductions are always taken on an after-tax basis.

The following table shows the amount of income that will be imputed each month based on benefit plan elections. In most cases Medicare taxes equal to 1.5% of the imputed amounts shown and federal income tax will be withheld. The actual amount of income tax withheld depends on your retirement pay and the amount of allowances you claim on Form W-4. Imputed income amounts are included for coverage of children of a same-sex partner, in the unusual event that the covered child is not a "dependent" for federal tax purposes.

Fair Market Value for Non-Tax Qualifying Dependents

(These numbers do NOT represent the tax you will pay)

Coverage Level	Calendar Year 2012 Monthly Imputed Income
Retiree and Same-Sex Partner	$808
Retiree and Child of Same-Sex Partner	$333
Retiree and Family (Including same-sex partner and child of same-sex partner)	$1,141

An Exception to the Rule: Dependents for Federal Income Tax Purposes

If your same-sex partner and same-sex partner's eligible dependent children qualify as your dependents under IRC Section 152 (as modified by IRC Section105(b)), the costs for their benefits are not considered taxable income to you. Generally, to qualify as an IRC Section 152 dependent (as modified by Code 105(b)) of a retiree during a given tax year, the same-sex partner (and, if eligible under the Plan's rules, the same-sex partner's children) must be a "qualifying relative" of the retiree. To be a "qualifying relative," the same-sex partner and/or child of the same-sex partner must meet the following requirements:

1) Have the same principal place of abode as the retiree for the full tax year (January 1 through December 31), except for temporary absences such as vacation, military service, or education. If the partnership dissolves other than on December 31, for reasons other than the death of the same-sex partner, the tax exclusion is lost for the entire year. If the relationship terminates due to the death of the partner, the partner would continue to be treated as a dependent for the entire tax year;

2) Receive more than half of his or her support from you, the retiree;

3) Be a U.S. citizen, U.S. national, or a resident of U.S., Canada, or Mexico; and,

4) Not be anyone else's "qualifying child" under IRC Section 152.

Whether or not you will be claiming your same-sex partner and partner's dependent children as tax dependents for insurance purposes under IRC Section 152 (as modified by IRC Section 105(b)) you must complete and sign the Declaration of Tax Status Form (PDF). It may be required that Section 152 dependent status be redeclared each tax year.

Retirees are strongly encouraged to consult with a tax advisor before declaring a same-sex partner satisfies each of the above requirements to be considered a qualifying relative as defined by the IRS. The State will assume your same-sex partner DOES NOT qualify as your tax dependent for tax-free health insurance if you do not file a declaration that the same-sex partner meets the requirements to be considered a qualifying relative.

Please note:
This information is not intended as tax advice but rather to alert retirees of potential tax ramifications and IRS rules.

The State recommends all retirees wishing to enroll their same-sex partner under a State-sponsored plan consult with a qualified tax advisor to fully understand the tax issues involved.

Retiree Same-Sex Partner Affidavit

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
alaska.gov/drb

Division of Retirement and Benefits
P.O. Box 110203
Juneau, Alaska 99811-0203

Juneau: (907) 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

SECTION I. RETIREE INFORMATION

COMPLETE BOTH SIDES

Retiree Name (Last, First, MI)	Sex ❑ Female ❑ Male	Member RIN	Contact Phone
Mailing Address (City, State, ZIP+4)			
Same-Sex Partner Name (Last, First, MI)		Sex ❑ Female ❑ Male	Date of Birth

Before signing the affidavit and enrolling a same-sex partner in insurance coverage under the state's plans, you and your same-sex partner should contact an attorney and tax advisor about possible legal and tax consequences.

To enroll your same-sex partner and any children of the same-sex partner, you must also complete the applicable dependent enrollment forms. The same-sex partner affidavit and dependent enrollment forms must be received or postmarked no later than the last day of the month prior to your retirement effective date.

SECTION II. AFFIDAVIT

Under the penalty of perjury, we each hereby certify that we each:

(1) are at least 18 years old and are each competent to enter into a contract;

(2) have been in an exclusive, committed, and intimate relationship with each other for the last consecutive 12 months and intend to continue that relationship indefinitely;

(3) have resided together at a common primary residence for the last 12 consecutive months and intend to reside together indefinitely;

(4) consider ourselves to be members of each other's immediate family;

(5) are not related to each other to a degree of closeness that would preclude us from marrying each other in Alaska if we were of the opposite sex from each other;

(6) are neither one of us legally married to anyone else;

(7) have not executed an affidavit affirming same-sex partner status with anyone else within the last 12 months;

(8) are each other's sole domestic partner and are each responsible for the common welfare of the other;

(9) share financial obligations, including joint responsibility for basic living expenses and health care costs;

(10) understand that, under applicable federal income tax law, payments for medical coverage of a same-sex partner or child of a same-sex partner may not be eligible for pre-tax treatment, and coverage of a same-sex partner may result in additional imputed taxable income to the covered employee, retirement system member, or survivor and related withholding for payroll, income, or pension and annuity taxes; and

(11) understand that, in addition to requirements of this section, there are terms and conditions of coverage set out in each group policy, state plan of self-insurance, or alternative insurance program to which we are bound.

SECTION III. SUPPORTING DOCUMENTATION

In order to enroll a same-sex partner in group insurance coverage, you must provide the Plan Administrator with documentation establishing that you and your same-sex partner meet at least five of the eight criteria set out below.

Please check five boxes that prove:

- ❑ joint interest in real property, as evidenced by title or mortgage, lease, or rental agreement, by the employee or retirement system member and the same-sex partner.
- ❑ joint ownership or purchase of a motor vehicle by the employee or retirement system member and the same-sex partner.
- ❑ joint ownership of a checking, savings, or investment account or joint liability for a loan or credit account by the employee or retirement system member and the same-sex partner.
- ❑ the same-sex partner is named as primary beneficiary for a life insurance policy of the employee or retirement system member.
- ❑ the same-sex partner is named as primary beneficiary for the employee's or retirement system member's pension or annuity plan benefits, deferred compensation plan, Individual Retirement Arrangement or Account, 401(k) plan, Keogh plan, or other tax-deferred or taxable plan.
- ❑ the same-sex partner is named as primary beneficiary in the employee's or retirement system member's will.
- ❑ the same-sex partner has authority to deal with property owned by the employee or retirement system member under a valid written power of attorney.
- ❑ the employee or retirement system member has given the same-sex partner written authority to make decisions concerning the employee's or retirement system member's health and well-being if the employee or retirement system member is unable to do so.

Supporting documentation does not need to be submitted with your retirement application, but it is required before your benefits can be finalized. All determinations of whether a particular item of proof is acceptable to prove financial interdependence shall be made by the Plan Administrator at his/her sole and absolute discretion.

❑ Check this box if you provide more than one-half of your same-sex partner's support in accordance with IRS Regulations.

In completing this form, the undersigned declare under penalty of perjury that the undersigned employee/member and same-sex partner meet the requirements of 2 AAC 38.010(b) that are set out in the affidavit. The undersigned employee/member of state retirement system agrees to notify the administrator in writing within 30 days after eligibility ends under the above requirements.

Signature of Employee/Retiree	Date	Signature of Same-Sex Partner	Date

Signature witnessed by:

Division of Retirement and Benefits Plan Representative, Notary Public, or Postmaster	Date

On this_____day of_____ 20____, personally appeared before me, _____ whose identity I proved on the basis of satisfactory evidence to be the signer of the participant's signature above, and he/she acknowledged that he/she executed it.

SEAL
OR
STAMP
REQUIRED

Notary Public_____

State of_____ and Borough/County of_____

Residing at_____ Commission Expires_____

Office Use Only:

❑ Accepted ❑ Rejected Date verified_____ Initials_____

Retiree Beneficiary Designation

(Last Check and Account Balance)

FOR OFFICE USE ONLY

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alaska.gov/drb

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P.O. Box 110203
Juneau, Alaska 99811-0203

Juneau: (907) 465-4460
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Fax: (907) 465-3086

READ CAREFULLY BEFORE COMPLETING: The person(s) that you designate as your beneficiary or beneficiaries on this form will receive the retirement system benefits (last check and account balance, if any) payable upon your death. To change your beneficiary or beneficiaries address, marital status, or other information, complete and send a new form to the above address. NOT FOR SBS OR OPTIONAL LIFE INSURANCE.

SECTION I. PERSONAL DATA

Is this a new address? ☐ **Yes** ☐ **No**

Member's Name (Last, First, M.I.)	Social Security Number	**Check all boxes that apply** ☐ Public Employees' Retirement System (PERS) ☐ Judicial Retirement System (JRS) ☐ National Guard Retirement System (NGRS) ☐ Teachers' Retirement System (TRS) ☐ Elected Public Officers Retirement System (EPORS)
Mailing Address (City, State, ZIP+ 4)		
Marital Status ☐ Married–Date_____ ☐ Divorced–Date_____ ☐ Same-Sex Partner_____ ☐ Single ☐ Widowed	Date of Birth	
Work Phone Number	Home Phone Number	

SECTION II. BENEFICIARY DESIGNATION

If you are married or a single parent, see the instructions on the back BEFORE designating your beneficiary or beneficiaries.

Place an "X" in the appropriate box to specify whether the beneficiary is primary or contingent. The "primary" beneficiary or beneficiaries will receive benefits if you die. The "contingent" beneficiary or beneficiaries will receive benefits ONLY if the primary is deceased.

☐ PRIMARY	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
Mailing Address (City, State, ZIP+4)		Social Security Number		

Check whether beneficiary is the primary or contingent ☐ **Check if this is an address change for your beneficiary**

☐ PRIMARY ☐ CONTINGENT	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
Mailing Address (City, State, ZIP+4)		Social Security Number		
☐ PRIMARY ☐ CONTINGENT	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
Mailing Address (City, State, ZIP+4)		Social Security Number		
☐ PRIMARY ☐ CONTINGENT	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
Mailing Address (City, State, ZIP+4)		Social Security Number		
☐ PRIMARY ☐ CONTINGENT	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
Mailing Address (City, State, ZIP+4)		Social Security Number		

I hereby certify that the information provided on this form is true and correct to the best of my knowledge. I understand that any deliberate misrepresentation for the purpose of obtaining benefits is an offense punishable by law.

Signature of Retiree	Date	Signature of Witness *(must not be a beneficiary)*	Date

SECTION III. CONSENT TO BENEFICIARY DESIGNATION

INSTRUCTIONS

If you are MARRIED, your spouse is automatically your 100% primary beneficiary unless they consent to another beneficiary, or your spouse is not entitled to benefits under the terms of a Qualified Domestic Relations Order (QDRO). Your spouse's written consent may be waived if:

- You were not married to your spouse during any part of your PERS or TRS employment;
- You have been married for less than one year;
- You have been married for less than two years and you have established that you and your spouse are not living together; or
- Your spouse cannot be located.

Your spouse may waive entitlement to benefits by completing and signing the *"Spouse's Consent"* below before a notary public or an authorized plan representative. If another person is entitled to benefits under a QDRO, that person may waive entitlement to benefits by completing and signing the *"QDRO Consent"* below before a notary public or an authorized plan representative.

If you are a SINGLE PARENT, there are death benefits that may be payable to your dependent child if you die before retirement. **These benefits are only payable to your children if they are your designated beneficiaries.** Because benefits cannot be paid directly to minor children, they will be paid to the children's parent or legal guardian, unless you establish a trust and designate the trust as beneficiary for your children. Y***ou should NOT designate another person as beneficiary to receive your children's benefits.*** Benefits payable to TRS survivors under the 1% Supplemental Contributions provision will be paid in accordance with Alaska Statutes 14.25.162-164.

If you wish to designate a same-sex partner to receive survivor benefits that may become available upon your death under AS 14.25.155, 14.25.157, 14.25.160, 14.25.162, 14.25.164, 14.25.167, AS 22.25.030, AS 39.35.420, AS 39.35.430, 39.35.440, 39.35.450, or former AS 39.37.060, you must submit the Same-Sex Partner Affidavit, and you must provide the documentation, required by 2 AAC 38.010. Your same-sex partner must be the only "primary" beneficiary listed on this form in order to qualify for the survivor benefits provide by the statutes mentioned above.

SPOUSE'S CONSENT

I, _____, am the spouse of _____ _____. I understand that I may be entitled to the death benefits that will be paid if my spouse dies. I have reviewed the *occupational and nonoccupational death provisions* described in the PERS and TRS *Information Handbooks*. I understand that, depending upon the circumstances of my spouse's death, I may be eligible to receive either a lump sum benefit or monthly benefits for the rest of my life and that major medical insurance may be available to me and my eligible dependents while I am receiving monthly benefits.

By signing this consent, I agree to waive my right to any benefits that would be paid to me and consent to the naming of the above beneficiary.

Signature *(Your signature must be witnessed below)*	Date

Signature Witnessed by:

Plan Representative *(Must be a designated employee of the Division of Retirement and Benefits)*	**OR**	Notary Public or Postmaster	
ID Number		State of	Commission Expires

Alaska Division of Retirement and Benefits

Toll-Free: (800) 821-2251
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Health Benefits Enrollment/Waiver

For Retirees with Same-Sex Partners

Public Employees' Retirement System (PERS) Tier II & III
Teachers' Retirement System (TRS) Tier II

FOR OFFICE USE ONLY

Tiers II & III

PERSONAL DATA

Name	RIN or last 4 of SSN
Please indicate your retirement system: ❒ PERS ❒ TRS	

MEDICAL BENEFITS

I elect the following medical coverage:

❒ **No medical coverage**

❒ Individual only

❒ Individual and child(ren)

❒ Individual and same-sex partner

❒ Individual, same-sex partner, and child(ren)

DENTAL-VISION-AUDIO BENEFITS

I elect the following dental-vision-audio (DVA) coverage:

❒ **No dental-vision-audio coverage**

❒ Individual only

❒ Individual and child(ren)

❒ Individual and same-sex partner

❒ Individual, same-sex partner, and child(ren)

LONG-TERM CARE BENEFITS

I elect the following long-term care (LTC) option:

❒ **No long-term care coverage**

Individual (Member) coverage:

❒ Silver ❒ Gold ❒ Platinum

Same-sex partner coverage (may elect **only** if member is electing individual coverage):

❒ Silver ❒ Gold ❒ Platinum Same-sex partner's Date of Birth _____

❒ I am covered under my same-sex partner's LTC plan Same-sex partner's Date of Birth _____

CERTIFICATION

I acknowledge that I have been offered the two health plans available: dental-vision-audio and long-term care. I understand that this is my only opportunity to enroll in these plans and that by not electing coverage at this time under either plan, I waive my right to future participation in the DVA and LTC plan.

I authorize the deduction of premiums from my benefit check for any insurance elected above.

Signature _____ Date _____

Health Benefits Enrollment/Waiver Form

For Retirees with Same-Sex Partners

This form is for retirees and other benefit recipients who were first hired under the Public Employees' Retirement System (PERS) **after June 30, 1986**, or under the Teachers' Retirement System (TRS) **after June 30, 1990**, and are **not** eligible for system-paid medical coverage at retirement.

If you are already covered under your spouse or same-sex partner's LTC plan, you cannot be covered under a second plan. Please provide your spouse or same-sex partner's social security number so we may move your LTC coverage to your retirement benefit.

Your form must be postmarked or received in our office before your retirement date. This is your only opportunity to enroll in these plans. If you do not enroll at this time, you waive your right to participate in the future.

You may decrease or terminate your coverage at any time by notifying this office in writing. You may only increase DVA coverage within 120 days of the date you are married or 90 days of the date you become eligible to enroll a same-sex partner under 2 AAC 38.010-38.100, or have your first child.

LTC coverage may be added for your spouse within 120 days of marriage or 90 days of the date you become eligible to enroll a same-sex partner under 2 AAC 38.010-38.100.

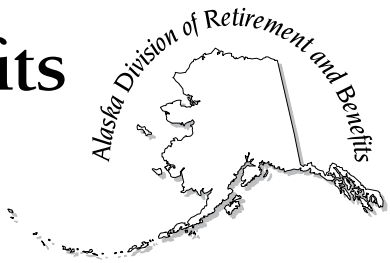
If you elect coverage, the premiums will be deducted from your benefit check each month. If your check is insufficient to deduct the premiums, we will contact you to make payment arrangements. The chart in the next column shows the monthly premiums for each option.

Coverage for:	Medical Premium	DVA Premium
Individual only	$ 807	$ 69
Individual and same-sex partner	$1,615	$136
Individual and child(ren)	$1,140	$123
Individual, same-sex partner, child(ren)	$1,948	$194

Long-Term Care Benefits – Premium Rates By Age

Age at Retirement	Silver Option $400,000 max No inflation protection	Gold Option $300,000 max Simple inflation protection	Platinum Option $300,000 max Compound inflation protection
40 & under	$26	$76	$148
41	$27	$77	$150
42	$28	$78	$153
43	$30	$79	$155
44	$31	$81	$158
45	$33	$82	$161
46	$35	$84	$164
47	$37	$85	$167
48	$39	$89	$170
49	$41	$92	$172
50	$44	$96	$175
51	$46	$100	$177
52	$49	$103	$180
53	$52	$109	$184
54	$56	$114	$188
55	$60	$120	$192
56	$63	$126	$195
57	$67	$131	$199
58	$75	$143	$212
59	$84	$156	$225
60	$92	$168	$237
61	$100	$181	$250
62	$108	$193	$263
63	$123	$212	$281
64	$137	$231	$300
65	$151	$250	$319
66	$166	$269	$338
67	$180	$288	$357
68	$201	$313	$381
69	$222	$339	$404
70	$244	$364	$428
71	$265	$389	$451
72	$286	$414	$475
73	$314	$444	$502
74	$343	$474	$529
75	$371	$503	$556
76	$399	$533	$584
77	$427	$563	$611
78	$471	$609	$654
79	$515	$654	$698
80	$559	$700	$741
81	$603	$746	$784
82	$646	$791	$828
83	$731	$887	$923
84	$815	$982	$1,018
85 & over	$900	$1,078	$1,113

Same-Sex Partner Insurance Benefits



Public Employees' Retirement System (PERS) Tier II and III*

Teachers' Retirement System (TRS) Tier II**

Medical Plan

The following information applies to **Tier II and III PERS*** members (and their survivors) and **Tier II TRS**** members (and their survivors), who have met service eligibility requirements.

If you are a **Tier II/III PERS*** or **Tier II TRS**** member, you may receive retiree medical insurance coverage for yourself and your eligible same-sex partner and eligible dependents when you retire. If you enroll when you retire, coverage will begin on the first day of retirement. You pay the full monthly premium if you are under age 60. *Premiums will be deducted from your pension benefit.*

Regardless of your age at retirement, coverage under the retiree medical plan (AlaskaCare) requires you to pay the annual deductibles and any expenses that exceed the recognized charge. Details about this coverage are provided in the *Retiree Insurance Information Booklet*. This coverage ends when you die or become ineligible to receive monthly PERS or TRS benefits.

To receive this coverage, you must complete a *Health Benefits Enrollment/Waiver* form. If you sign up for coverage at retirement, you will **not** be subject to any pre-existing condition limitations. Your form must be received by the Division of Retirement and Benefits or postmarked **before your retirement date**.

If you do not select insurance at the time of retirement, you will have the opportunity to do so during an open enrollment period, offered annually. Coverage selected during open enrollment will be effective January 1 of the following year. The first premium will be deducted from your January pension benefit and noted as a deduction on your check stub.

If you select coverage during an open enrollment period, you and your eligible dependents may be subject to a **pre-existing condition limitation**. Under this limitation, only the first $1,000 of covered charges will be paid during the first 12 months of coverage for a condition that was diagnosed or treated in the three months prior to the effective date of coverage. If you do not have other group coverage, or if you had coverage that ended more than 90 days before the AlaskaCare coverage began, you are subject to this pre-existing condition limitation.

You have the option of selecting retiree medical insurance coverage for:

- yourself only;
- yourself and your same-sex partner;
- yourself and your eligible dependent children; or
- yourself, your same-sex partner, and eligible dependent children.

If you chose retiree medical insurance coverage for yourself only and then enter into a same-sex partner arrangement, or have your first child (by birth or adoption), you may increase your coverage to include your new dependent. You must apply for the additional coverage within 120 days of the change in your family structure or wait until the next open enrollment period. You may drop coverage for yourself or your dependents at any time.

At age 60, AlaskaCare coverage is system-paid for eligible PERS and TRS members and their survivors. PERS members hired on or after July 1, 1996, must have at least 10 years of **credited service**† to receive system-paid medical. Disabled members also have system-paid coverage while they are receiving PERS or TRS disability benefits. Once a disabled member is eligible for a normal retirement benefit, disability benefits cease.

When you enroll in AlaskaCare, a health insurance identification card will be mailed to you as soon as the claims administrator receives your eligibility from the Division of Retirement and Benefits—generally about two weeks after your first retirement check is issued.

Coverage under AlaskaCare will differ from coverage that you have with your current employer.

Dental-Vision-Audio (DVA) Plan

You may purchase DVA group insurance coverage for:

- yourself only,
- yourself and your same-sex partner,
- yourself and your eligible dependent children, or
- yourself, your same-sex partner, and eligible dependent children.

Details about this coverage are provided in the *Retiree Insurance Information Booklet*. The current premium rates are shown on the *Health Benefits Enrollment/Waiver* form.

If you want to receive DVA coverage, you must complete a *Health Benefits Enrollment/Waiver* form. Your form must be received by the Division of Retirement and Benefits or postmarked **before your retirement date**. If you enroll in the DVA Plan, your coverage will take effect on the first day of retirement.

PERS Tier II and III* and **TRS Tier II**** benefit recipients may enroll in the DVA plan during the annual open enrollment period if they are enrolling in the AlaskaCare medical plan for the first time during open enrollment. They may also enroll in the DVA plan at age 60 when system-paid medical begins. DVA coverage may be elected during open enrollment **only** if the same or greater level of medical coverage is being elected for the **first** time during that open enrollment.

**PERS Tier II and III members who first entered a PERS-covered position after June 30, 1986, but before July 1, 2006. **TRS Tier II members who first entered a TRS-covered position after June 30, 1990, but before July 1, 2006. †Credited service includes all service used in the calculation of a retirement benefit.*

Long-Term Care (LTC) Plan

You may purchase LTC group insurance coverage for yourself only, or coverage for both you and your same-sex partner. Details about the options available are provided in the *Long-Term Care Plan Booklet*. The current premium rates are shown on the *Health Benefits Enrollment/ Waiver* form.

If you want to receive LTC coverage, you must complete a *Health Benefits Enrollment/Waiver* form. Your form must be received by the Division of Retirement and Benefits or postmarked **before your retirement date**.

LTC coverage will be offered to you **only once**. If your *Health Benefits Enrollment/Waiver* form is not received or postmarked before your retirement date, your right to participate will automatically be waived and you will be unable to enroll later.

If you enroll in the LTC Plan, your coverage will take effect on the first day of retirement.

Optional Life Insurance Plan

If you are participating in a State-sponsored Optional Life Insurance Plan, you may elect to continue your coverage by completing an *Optional Life Insurance Continuation/Waiver* form. Your form must be received by the Division of Retirement and Benefits or postmarked **before your retirement date**.

The opportunity to continue this coverage will be offered to you only once. If your *Optional Life Insurance Continuation/Waiver* form is not received or postmarked by the deadline, your right to participate in the plan will automatically be waived and you will be unable to enroll later. Details about the coverage are provided in the *Retiree Insurance Information Booklet*.

Note: Be sure to review the tax information included in the *Retiree Important Tax Implications for Enrolling Same-Sex Partners* insert for the potential tax consequences of covering a same-sex partner.

AlaskaCare and Medicare

There are three parts to Medicare health coverage: Part A "hospital services," Part B "physician's services," and Part D "prescription drugs." A summary of these services and how they relate to the AlaskaCare plan follows. Detailed information about Medicare Parts A, B, and D is provided in the AlaskaCare *Retiree Health Plan Welcome Kit*, available online at: alaska.gov/drb/alaskaCare/retiree/pubs/welcome.html.

Coverage under AlaskaCare becomes supplemental to Medicare Parts A and B beginning the month that you or your dependents first become eligible to receive benefits. **If you do not enroll in Medicare Part B**, the estimated amount Medicare would have paid will be deducted from your claims before processing by AlaskaCare.

Part A—Hospital Services

- Almost everyone is eligible for premium-free Part A.
- Enrollment in Part A is automatic when you begin receiving Social Security benefits.
- The AlaskaCare plan becomes supplemental to Part A.
- If you are ineligible for Part A, AlaskaCare remains your primary carrier and your benefits are not reduced.

Part B—Physician's Services

Part B—Physician's Services

- Everyone is eligible for Part B, for which you pay a premium.
- You must purchase Part B as soon as you become eligible or you may pay more for the coverage later.
- The AlaskaCare plan becomes supplemental to Part B.
- If you don't purchase Part B, AlaskaCare will deduct the estimated amount Medicare would have paid from your claims before payment.

Part D—Prescription Drugs

- Part D was effective January 1, 2006.
- Everyone is eligible for Part D, for which you pay a premium.
- The AlaskaCare drug benefit is better the benefit offered under Part D.
- The AlaskaCare plan becomes supplemental if you purchase Part D.
- You can keep AlaskaCare coverage and not pay extra if you later decide to purchase Part D.

Need more information about Medicare enrollment?
Contact the Social Security Administration at their toll-free number: (800) 772-1213.

ENCLOSED *(if checked)*

- ☐ Retiree Insurance Information Booklet
- ☐ Long-Term Care Plan Booklet
- ☐ Health Benefits Enrollment/Waiver Form
- ☐ Optional Life Insurance Continuation/Waiver Form
- ☐ Insurance Claim Forms

Alaska Division of Retirement and Benefits

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Toll-Free: (800) 821-2251 | In Juneau: (907) 465-4460 | Fax: (907) 465-3086 | TDD: (907) 465-2805

The information in this brochure is not intended to replace the Alaska Statutes, the Alaska Administrative Code, or the plan documents. Language contained in Alaska Statutes, the Alaska Administrative Code, and the plan documents governs the plans.