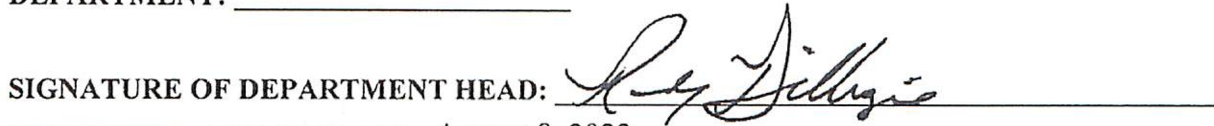
REQUEST FOR AGENDA PLACEMENT FORM

Submission Deadline - Tuesday, 12:00 PM before Court Dates

SUBMITTED BY: Randy Gillespie **TODAY'S DATE:** August 2, 2022

DEPARTMENT: Personnel



SIGNATURE OF DEPARTMENT HEAD:

REQUESTED AGENDA DATE: August 8, 2022

SPECIFIC AGENDA WORDING:

Consideration to approve agreement with Alerus for HRA services and authorizing the Judge's signature.

COMMISSIONERS COURT

AUG 08 2022

Approved

PERSON(S) TO PRESENT ITEM:

Randy Gillespie

SUPPORT MATERIAL: (Must enclose supporting documentation)

TIME: 10 mins
(Anticipated number of minutes needed to discuss item)

ACTION ITEM:
WORKSHOP: ✓
CONSENT:
EXECUTIVE:

STAFF NOTICE:

COUNTY ATTORNEY:
IT DEPARTMENT:
AUDITOR:
PURCHASING DEPARTMENT:
PERSONNEL:
PUBLIC WORKS:
BUDGET COORDINATOR:
OTHER:

This Section to be completed by County Judge's Office

ASSIGNED AGENDA DATE: ____________

REQUEST RECEIVED BY COUNTY JUDGE'S OFFICE:

COURT MEMBER APPROVAL: **DATE:**

ALERUS

CLIENT INFORMATION FORM

IMPLEMENTATION

EMPLOYER INFORMATION

Employer Name		Today's Date	Effective Date	
Johnson County		8/1/2022	10/01/2022	
Street Address		City	State	ZIP
2 N Main St., Room 215		Cleburne	Texas	76033
General Business Phone #	Federal Tax ID	6 Digit NAICS Code or Business Type	State of Incorporation	
817-556-6350	75-6001030	9111	Texas	

Type of Employer Entity (please check one)

☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Limited Liability Company
☐ Non-Profit Organization ☒ Government ☐ Church

Primary Signer Contact (Signer for service agreement and funding authorizations)		Primary Signer Contact Title
Roger Harmon		Johnson County Judge
Primary Signer Phone Direct Dial	Primary Signer Contact Email	Primary Signer Contact Online Access
817-556-6360	RogerH@johnsoncountytx.org	☐ Yes ☒ No
Primary Contact		Primary Contact Title
Darla Medford		HR Generalist/Benefits Coordinator
Primary Phone Direct Dial	Primary Contact Email	Primary Contact Online Access
817-556-6349	dmedford@johnsoncountytx.org	☒ Yes ☐ No
Billing Contact		Billing Contact Title
Laura Baxter		Personnel Assistant/Payroll Administrator
Billing Contact Phone Direct Dial	Billing Contact Email	Billing Contact Online Access
817-556-6162	laurab@johnsoncountytx.org	☒ Yes ☐ No
Payroll Contact		Payroll Contact Title
Jovelyn Hersick		Payroll Administrator
Payroll Phone Direct Dial	Payroll Contract Email	Payroll Contact Online Access
817-556-6350	jhersick@johnsoncountytx.org	☒ Yes ☐ No

Payroll Frequency (please check and provide initial payroll date for deductions)
☑ Weekly, Bi-Weekly ☐ 24 or ☒ 26, ☐ Semi-Monthly, ☐ Monthly, Date of 1st Payroll Deduction 10/07/2022

Current Benefits Administered by Alerus
☐ Retirement – Plan ID ☐ Payroll – Company #
☐ HRIS ☐ COBRA ☐ Banking ☐ Other

Broker (Agent) Name	Broker (Agent) Company Name	Broker's Phone	Broker's Email
Adam Kinyicky	Holmes Murphy & Associates	830-221-2257	akinyicky@holmesmurphy.com

Additional Contact(s) for Broker
Name: Julie Rickman | Phone: 707-761-2257 | Email: JRickman@holmesmurphy.com

Alerus Representative Contact Information (if applicable)
Name: | Phone: | Email:

EMPLOYER GROUP MEDICAL HEALTH PLAN INFORMATION

Insurance Carrier	Annual Renewal Date	Deductible Plan Year Begin	Deductible Plan Year End
Texas Association of Counties / BCBS	10/01/2022	10/01/2022	09/30/2023

Health Plan Deductible	Coinsurance After Deductible	Out of Pocket Maximum
Single: $ 2,000 Family: $ 4,000 Other: $	☒ Yes ☐ No	Single: $ 4,000 Family: $ 8,000 Other: $

4th Quarter Deductible Carryover	Embedded (Per Person) Deductible	RX Drug Co-Pay in Health Plan
☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No If yes, explain Tier 1: $10 copay; Tier 2: $50 copay; Tier 3: $75 copay

Is health plan HSA eligible?	Is there an HSA in place?
☐ Yes ☒ No	☐ Yes ☒ No

☐ HSA INVESTMENT LINEUP AND INFORMATION

Alerus Standard HSA Fund Lineup (Default) ☐ Yes ☐ No	Employer Retirement Fund Lineup (may take up to 12 weeks) ☐ Yes ☐ No If yes, please provide fund list with ticker symbols in an Excel spreadsheet. Funds should be listed in the other you would like them to appear with the default fund list.
Default Fund Options ☐ HCB interest bearing account ☐ Schwab government money fund ☐ Schwab treasury obligation MMG investor share	

HSA Monthly Admin Fee Paid By ☐ Employer ☐ Employee	# of Eligible Employees	# of HSA Participants	Transfer from Other Vendor ☐ Yes ☐ No
Is the employer contributing to employees' HSAs? ☐ Yes ☐ No	If yes, are the contributions: ☐ Flat Dollar? ☐ Matching? ☐ Other?		
ER Contribution Applied: ☐ Annually ☐ Quarterly ☐ Monthly ☐ With Each Payroll ☐ Other			
Is there a limited FSA in place? ☐ Yes ☐ No ☐ Adding Benefit to FSA Program			
Additional Comments:			

☐ FSA INFORMATION

Approximate Number of Eligible Employees		Approximate Number of Participants
Benefits Offered ☐ Health FSA ☐ Limited Purpose FSA ☐ Limited Purpose FSA with Post Deductible Expense ☐ Dependent Care FSA ☐ Parking/Transit ☐ HSA		
Plan Year Begin: End:	Mid-Year Takeover ☐ Yes ☐ No	FSA Contribution Annual Maximum ☐ IRS Max ☐ Other $
Claims Processed: ☐ Weekly (Friday) ☐ Daily		
Claims Run Out Period (after plan year and/or grace period end) ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other		
$550 Carryover Feature (medical and limited FSA only) ☐ Yes ☐ No		Did carryover apply to previous FSA plan year? ☐ Yes ☐ No If yes prior TPA name
Further Carryover Conditions ☐ Minimum carryover amount $ ☐ Carryover only if participant elects for new plan year		
2½ Month Grace Period? ☐ Yes ☐ No	If yes: ☐ 2½ months ☐ Other	For: ☐ Medical ☐ Dependent Care
Additional Comments:		

■ HRA INFORMATION

Type of HRA Program ■ Traditional HRA ☐ ICHRA ☐ EBHRA ☐ Tuition Reimbursement ☐ Lifestyle Spending Account			
Approximate Number of Eligible Employees 761		Approximate Number of Participants 693	
HRA Plan Year Begin: 10/1/2022 End: 9/30/2023	Start-Up (New) HRA ■ Yes ☐ No	Is first year a short plan year? ☐ Yes ■ No	Mid-Year Takeover ☐ Yes ■ No
Annual Benefit Amount Single: $ 1,000 Family: $ 2,000 Other: $ Tuition: $		Does the HRA pay after an HAS? ☐ Yes ■ No	
Deductible that Must Be Met Before HRA Pays ☐ NA ■ Single: $ 1,000 Family: $ 1,000 Other: $ ■ Applies Per Family Member (embedded)			
HRA Claims Paid ■ 100% to Annual HRA Amount ☐ % to Annual HRA Amount ☐ Other			

HRA Carry Forward ☐ Yes ■ No Maximum Carry Forward ($ or %): Maximum Accumulation: $	
Claims Processing ☐ Weekly (Friday) ■ Daily	Year-End Claim Run-Out Period ☐ 30 Days ☐ 60 Days ■ 90 Days ☐ Other
Additional Comments	

☐ COBRA/DIRECT BILL CONTINUATION INFORMATION

- **Submit all carrier rates with this form.** When submitting rates, please be sure to outline all tiers as follows: single, single + spouse, single + child(ren), family. Alerus is not responsible for any incorrect rates or improper notification of tier classification.
- Age banded rates are REQUIRED to be provided in Excel.
- $300 set up fee waived with two-year agreement.

# of Benefit Eligible Employees	Is this agency paying for this service for this group? ☐ Yes ☐ No	Pricing Option Choice ☐ Event ☐ PEPM	Two-Year Contracts ☐ Yes ☐ No
COBRA ☐ Yes ☐ No	Direct Bill Continuation ☐ Yes ☐ No	Do you want reports by division? ☐ Yes ☐ No	
List Division Names			

Do you want Alerus to process your new hire notices (general notice?	☐ Yes ☐ No
Do you want Alerus to process your letters of unavailability? You are required to let Alerus know when this notice is needed.	☐ Yes ☐ No
Do you want to allow your continuants to make late payments?	☐ Yes ☐ No
Are there any active or pending COBRA/direct bill continuants?	☐ Yes ☐ No

	Medical*	Medical*	Medical*	Dental	Vision
Renewal Date (mm/dd/yyyy)					
Self funded? Fully insured?	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured
Carrier Name					
Carrier Contact Name					
Carrier Contact Email					
Carrier Contact Phone					
Group Number					
Sub-Group Number					
Coverage Ends On	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month
*Medical Rates Renew On ☐ Anniversary Date ☐ First of Month Following Date of Birth			*Children 21+ Pay ☐ Child Rate ☐ Age Rate		

	FSA	HRA	EAP	Teledoc	Pediatri Dental
Renewal Date (mm/dd/yyyy)					
Self funded? Fully insured?	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured
Carrier Name					
Carrier Contact Name					
Carrier Contact Email					
Carrier Contact Phone					
Group Number					
Sub-Group Number					
Coverage Ends On	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month

Minnesota Groups Only

Monthly premiums need to be provided to Alerus, per 1,000 units of coverage. **Alerus will not complete rate calculations.**
For example, if the basic life and AD&D rate are bundled for MN Life Continuation purposes, that is the rate that should be provided.

	Basic Life	Voluntary Life	Family Basic Life
Renewal Date (mm/dd/yyyy)			
Self funded? Fully insured?	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured	☐ Self Funded ☐ Fully Insured
Carrier Name			
Carrier Contact Name			
Carrier Contact Email			
Carrier Contact Phone			
Group Number			
**Coverage Ends On	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month	☐ Event Date ☐ End of Month
Is the life benefit bundled with AD&D?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Rates Based On	NA	☐ Employee Age ☐ Spouse Age	NA
List Rates Renew On	☐ Anniversary Date ☐ First of Month Following DOB	☐ Anniversary Date ☐ First of Month Following DOB	☐ Anniversary Date ☐ First of Month Following DOB
Conversion Available?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

**Should "Event Date" be selected, Alerus will collect a pro-rated monthly premium from the continuant based on their date of event.

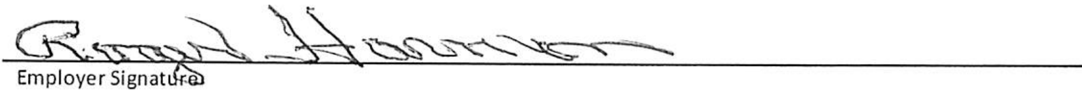
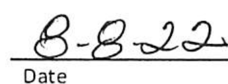
REVIEW INFORMATION

PLEASE CAREFULLY REVIEW YOUR PREMIUMS INFORMATION PRIOR TO SUBMITTING TO ALERUS. There will be a **$75.00 charge per hour** for correcting and responding to erroneous information, including:

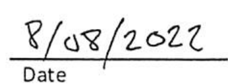
- Premium corrections
- Carrier changes requested after plan rate changes have been processed
- Plan setup corrections including, but not limited to
  - Late notification of rates or carrier changes
  - Urgent updates required for reinstatements

Employer/Broker Acknowledgement

By my signature, I acknowledge that I have read all information outlined by this document and submitted all required information necessary for Alerus to perform their job duties. All information herein and attached is correct to the best of my knowledge.

Employer Signature — Date



Broker Signature — Date

Important Restrictions

Complete the employer and plan information and return to the implementation team at **hwsetup@alerus.com** to begin the implementation process. Alerus cannot begin this process until these pages have been signed and submitted.

Pursuant to the terms or our contract, you are solely responsible for ensuring that the renewal and premium information provided to Alerus by you (the client) or your representative (your broker or consultant) is accurate. Alerus has no responsibility to confirm that the information provide to it is accurate and may rely on and use such information, (e.g., for purposes of communicating the premiums a continuation participant must pay) without question. Alerus has no liability whatsoever if the renewal and premium information provided to it is inaccurate. Additionally, for any renewal information that is received late (after the renewal date), the change in premiums for continuation member will be made effective the first of the month following the date of receipt — we cannot back bill participants for late renewals. Alerus does not take responsibility for any premium discrepancies caused by late renewal information. If you have any questions or concerns regarding this process, please reach out to **cobra@alerus.com** or 800.761.1934.

ADOPTION AGREEMENT
FOR
HEALTH REIMBURSEMENT ARRANGEMENT

The undersigned Employer adopts Health Reimbursement Arrangement and elects the following provisions:

EMPLOYER INFORMATION

1. EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER:

   Name: Johnson County

   Address: 2 N. Main St., Room 215
   Street

   Cleburne (City) Texas (State) 76033 (Zip)

   Telephone: 817-556-6350

2. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER: 75-6001030

3. TYPE OF ENTITY:
   - a. ☐ Corporation (including Tax-exempt or Non-profit Corporation)
   - b. ☐ Professional Service Corporation
   - c. ☐ S Corporation
   - d. ☐ Limited Liability Company that is taxed as:
     - 1. ☐ a partnership or sole proprietorship
     - 2. ☐ a Corporation
     - 3. ☐ an S Corporation
   - e. ☐ Sole Proprietorship or Non-profit Corporation
   - f. ☐ Partnership (including Limited Liability)
   - g. ☒ Governmental Entity
   - h. ☐ Other:__________

   NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Heath Reimbursement Arrangement.

PLAN INFORMATION

4. PLAN NAME: **Johnson County Texas Health Reimbursement Plan**

5. EFFECTIVE DATE:
   - a. ☒ This is a new Health Reimbursement Arrangement effective as of 10-1-2022 (hereinafter called the "Effective Date").
   - b. ☐ This is an amendment and restatement of a previously established Health Reimbursement Arrangement of the Employer which was originally effective ____ (hereinafter called the "Effective Date"). The effective date of this amendment and restatement is ____.

6. NUMBER assigned by the Employer:
   - a. ☐ 501
   - b. ☐ 502
   - c. ☐ 503
   - d. ☒ Other: Public Entity

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7. PLAN ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will become the Administrator.)
a. ☒ Employer (Use Employer address and telephone number).
b. ☐ Use name, address and telephone number below:

Name: Randy Gillespie, Johnson County Personnel Director

Address: 2 N. Main St., Room 215
Street
Cleburne (City) Texas (State) 76033 (Zip)
Telephone: 817-556-6350

8. HRA CLAIMS ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will serve as the Claims Administrator.)
a. ☐ Employer (Use Employer address and telephone number).
b. ☒ Use name, address and telephone number below:

Name: Alerus Retirement and Benefits

Address: PO Box 64535
Street
St. Paul (City) Minnesota (State) 55164-0535 (Zip)
Telephone: (800) 898-9344

ELIGIBILITY REQUIREMENTS

9. ELIGIBLE EMPLOYEES :
a. ☐ N/A. No exclusions.
b. ☒ The following are excluded (select all that apply):
1. ☐ Union Employees.
2. ☐ Non-resident aliens.
3. ☒ Employees who are not participating in the Employer's group medical plan (must be selected for integrated HRA).
4. ☐ Salaried Employees.
5. ☐ Hourly Employees.
6. ☐ Leased Employees.
7. ☐ Part-Time Employees scheduled to work at least _____ hours per week.
8. ☐ Employees who are participants in an Employer sponsored Health Savings Account.
9. ☐ Other: ______________________________.

10. THE FOLLOWING AFFILIATED EMPLOYERS will adopt this Health Reimbursement Arrangement as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):
a. ☐ N/A.
b. ☒ Name of Affiliated Employer (s): Johnson County Central Appraisal District, 109 N Main St., Cleburne, Texas 76033.

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11. CONDITIONS OF ELIGIBILITY:
Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:
a. ☒ Date of Hire (No service required)
b. ☒ Same conditions as Employer's group medical plan
c. ☐ _____ years after date of hire
d. ☐ _____ months after date of hire
e. ☐ _____ days after date of hire
f. ☐ Other: ____________________

12. EFFECTIVE DATE OF PARTICIPATION:
An Eligible Employee who has satisfied the eligibility requirements will become a Participant on:
a. ☐ the date on which such requirements are satisfied.
b. ☐ the first day of the month coinciding with or next following the date on which such requirements are satisfied.
c. ☐ the first day of the calendar quarter coinciding with or next following the date on which such requirements are satisfied.
d. ☐ the first day of the pay period coinciding with or next following the date on which such requirements are met.
e. ☐ the first day of the Coverage Period coinciding with or next following the date on which such requirements are satisfied.
f. ☒ same date as Employer's group medical plan.
g. ☐ Other:____________________.

BENEFITS

13. MAXIMUM BENEFIT PER COVERAGE PERIOD:
a. ☒ Single Coverage: $1,000
b. ☒ Single + 1 Coverage: $2,000
c. ☒ Family Coverage: $2,000
d. ☐ Other: ____________________.

DEDUCTIBLE THAT MUST BE SATISFIED BEFORE HRA REIMBURSES EXPENSES:
a. ☐ None
b. ☒ Single Coverage: $1,000
c. ☒ Single + 1 Coverage: $1,000 per individual
d. ☒ Family Coverage: $1,000 per individual
e. ☒ Other: _____

IS THE HRA PLAN DEDUCTIBLE EMBEDDED (PER PERSON)?
a. ☒ YES, DETAILS:$2,000 per individual ; Family coverage $4,ooo
____
b. ☐ NO

14. COVERAGE PERIOD is:
a. ☐ monthly.
b. ☐ quarterly (to).
c. ☒ yearly (10/1/2022 to 9/30/2023).
d. ☐ Other:____________________.

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15. THIS ARRANGEMENT SHALL REIMBURSE: (select all that apply)
    a. ☐ co-payments under the Employer's group medical plan
    b. ☒ deductibles under the Employer's group medical plan
    c. ☐ coinsurance under the Employer's group medical plan
    d. ☐ prescription drug expenses applied to group medical plan deductible.
    e. ☐ prescription drug co-payments under the Employer's group medical plan
    f. ☐ dental expenses, including orthodontia
    g. ☐ vision expenses
    h. ☐ all medical expenses within the meaning of Code Section 213
    i. ☐ dental, vision and preventative care only
    j. ☐ the following types of medical expenses ONLY:__________________.
    k. ☐ Other:__________________.

16 IF THE EMPLOYER MAINTAINS A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?
    a. ☒ N/A. The Employer does not maintain a Health Flexible Spending Account and/or Cafeteria Plan.
    b. ☐ This Plan (Heath Reimbursement Arrangement).
    c. ☐ The Health Flexible Spending Account under the Employer's Cafeteria Plan.

17. IS THE EMPLOYER SUBJECT TO THE FAMILY AND MEDICAL LEAVE ACT?
    If b. is selected, FMLA will not apply:
    a. ☒ Yes.
    b. ☐ No.

18. IS THE PLAN SUBJECT TO COBRA?
    If b. is selected, COBRA will not apply
    a. ☒ Yes.
    b. ☐ No.

19. CARRY FORWARD: Amounts not used during a Coverage Period shall:
    a. ☐ Be carried forward to the next Coverage Period, in an amount up to $_____. However, the maximum accumulation limit for a Coverage Period is $_____.
    b. ☒ Shall be forfeited.

20. RETIREES OR OTHER TERMINATED EMPLOYEES SHALL:
    a. ☐ continue to be eligible for reimbursement of any remaining balances.
    b. ☐ not participate beyond date of termination and unused amounts are forfeited.
    c. ☒ Other:Terminated employees will not be eligible for reimbursement on claims with a service date past their termination date. Retiring employees with the "Vested" status will not be eligible for reimbursement on claims with a service date past their termination date. Retiring employees with the "Tenured" status will continue to be eligible for reimbursement of any remaining balances. Refer to the attached section of the Johnson County handbook for more information on these statuses.
    __________________.

21. A CLAIM may be submitted up to 90 days after:
    a. ☒ the end of the Coverage Period.
    b. ☐ the end of each calendar year.
    c. ☐ Other:__________________..

22. For Participants who terminate employment, will a different filing deadline apply:

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a. ☒ No.

b. ☐ Yes, _____ days after termination.

23. Prorate HRA Benefit Amount for Mid-Year Enrollees:

a. ☐ Yes.
- ☐ Monthly
- ☐ Quarterly

b. ☒ No.

c. ☐ Other:____.

24. DEBIT/CREDIT CARDS shall be provided by the Employer for Medical Expenses: (debit card only available for HRA plans offering all 213(d) expenses)

a. ☐ Yes.

b. ☒ No.

25. HEALTH SAVINGS ACCOUNT provided by the Employer:

a. ☐ Yes.

b. ☒ No.

26. IS THE PLAN SUBJECT TO HIPAA?

If b. is selected, HIPAA will not apply.

a. ☒ Yes.

b. ☐ No.

27. COVERAGE OF DEPENDENTS: The Plan will cover the following (select all that apply):

a. ☒ Participant.

b. ☒ Spouse.

c. ☒ Dependents:

1. ☒ natural and adopted children.
2. ☒ stepchildren
3. ☒ foster children
4. ☐ Other: ______________________

28. OPT OUT: The Plan permits a participant to elect out of the arrangement at least annually. If less than annually, please describe below:

a. ☐ Participants may opt out: ______________________________.

28. Additional provisions: ____

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Health Insurance Continuation for Retirement Eligible Employees Who Meet Certain Tenure Requirements

Eligible Employees

A. Full Time Regular Employees who, at the time they leave Johnson County employment, are:

1) eligible for retirement benefits under Texas County and District Retirement guidelines and
2) have a total of 20 years service with Johnson County of which at least 10 years are continuous service and
3) are covered under the Johnson County group health insurance program and/or Johnson County vision plan at the time of their separation (must be enrolled to continue coverage) and
4) are not Medicare eligible, OR

B. Elected Officials who, at the time they leave Johnson County employment, are:

1) eligible for retirement benefits under Texas County and District Retirement guidelines and
2) have a total of 16 years service with Johnson County of which at least 10 years are continuous service and
3) are covered under the Johnson County group health insurance program and/or Johnson County vision plan at the time of their separation (must be enrolled to continue coverage) and
4) are not Medicare eligible.

County Premium Contribution

The County may contribute all, part, or none of the premium payment. The County's contribution, if any, will be determined annually by Commissioners Court during the County budget process and will be effective on a fiscal year basis.

Dependents Coverage

Coverage for dependents who are not Medicare eligible and who are participants in the County's group health insurance plan and/or County's vision plan at the time of the employee's separation may also be continued. Premiums will be paid for by the retiree and are to be made to the County Treasurer no later than the 1st day of each month. In the event of the retiree's death, covered dependents may continue coverage until they become Medicare eligible provided they make required premium payments on a timely basis.

Premiums

If, in the future, Commissioners Court should require retirees on this program to pay all or part of the premium, then such premium payments are to be made to the County Treasurer no later than the 1st day of each month. Failure to submit required payments in a timely manner will result in cancellation and discontinued coverage.

Enrollment

Eligible employees must inform the Personnel Office not later than the day on which they leave County employment that they elect to continue coverage under this program. Failure to enroll in this program prior to the last day worked will forfeit the employee's option to continue coverage.

Discontinuation of Coverage

Coverage under this program will be discontinued if any of the following conditions occur:

a) the retiree or participating dependent becomes Medicare eligible.
b) the retiree has reached the maximum 3 year coverage time frame limit which will include any insurance coverage paid by Johnson County prior to October 1, 2011.
c) the retiree drops their coverage or coverage is dropped on a participating dependent. If coverage is dropped, re-enrollment at a later date will not be allowed.
d) the retiree fails to make any required premium payment in a timely manner.
e) the County discontinues employee group insurance.
f) Commissioners Court elects to discontinue this program.

Policy amended by Commissioners Court on May 27, 2014.

RETIREMENT-VESTED EMPLOYEE HEALTH INSURANCE CONTINUATION PROGRAM

ELECTION FORM

TERMS AND CONDITIONS:

1. An employee who is vested in the Johnson County retirement plan and leaves County employment is entitled to purchase continued health benefits coverage for himself and covered dependents unless the employee is eligible for group health benefits coverage through another employer. If an employee is not eligible for group health coverage under another employer's plan at the time he leaves the County but subsequently becomes eligible under another employer's plan, then at that time he will no longer be eligible for coverage under this program. **If a vested employee withdrawals or transfers his accumulated fund balance from the retirement plan at the time he leaves the County or at a subsequent date, then he will no longer be eligible for coverage under this program.**
2. The employee must inform the Personnel Office not later than the day on which the employee leaves County employment that the employee elects to continue coverage under this program. Failure to enroll in this program prior to the last day worked will forfeit the employee's option to continue coverage under this program.
3. If the employee elects to continue coverage on himself or an eligible dependent and at a subsequent date elects to discontinue coverage on himself or the dependent, then that person will no longer be eligible for coverage.
4. Coverage under this program is available only to those vested employees and eligible dependents that are covered by the County's health plan at the time the vested employee leaves County employment.
5. Coverage provided under this program will be the same level of coverage as that provided to current employees of the County. Premium cost to persons participating in this program will be the same as the cost charged to the County by the existing insurance provider.
6. When a participant of this program becomes eligible for federal Medicare benefits, the County will substitute a Medicare Supplement plan that will replace the existing employee plan.
7. Premium payments are to be made to the Treasurer's Office no later than the 1st of each month. Failure to submit payments on a timely basis will result in cancellation of coverage.