



**COMMISSIONERS COURT  
COMMUNICATION**

COURT ORDER NUMBER 144839

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DATE: 3/11/2025

**SUBJECT: CONSIDERATION OF AN ADMINISTRATION AGREEMENT BETWEEN RELIASTAR LIFE INSURANCE COMPANY, A VOYA COMPANY, AND TARRANT COUNTY FOR AN EXCESS RISK COVERAGE POLICY (STOP-LOSS) FOR PLAN YEAR 2025**

**\*\*\* CONSENT AGENDA \*\*\***

**COMMISSIONERS COURT ACTION REQUESTED**

It is requested that the Commissioners Court approve the Administration Agreement between Reliastar Life Insurance Company and Tarrant County for Plan Year (PY) 2025.

**BACKGROUND**

On December 27, 2024, the Public Employee Benefits Cooperative (PEBC) Board of Governance approved Voya as the stop-loss insurance carrier for the PY 2025.

The specific deductible per covered person is \$500,000.00, and the premium for Excess Loss Insurance is \$55.14 per subscriber, per month. This represents a 4.25% decrease from the 2024 monthly rate of \$57.59 per subscriber. The monthly rate applies to all primary members enrolled in the PEBC medical plans (HDP/PPO), including employees, retirees, and COBRA participants.

The policy provides reimbursement for individual medical and prescription drug claims that exceed the \$500,000.00 specific deductible per covered person. The benefit period covers medical expenses incurred from January 1, 2025, through December 31, 2025. The contract is based on a 36/12 model, meaning claims incurred within a 36-month period are eligible for coverage, but must be paid within the following 12-month policy period.

The agreements have been reviewed by the Criminal District Attorney's Office.

**FISCAL IMPACT**

The financial impact for Plan Year 2025 is approximately \$2,806,846.56.

SUBMITTED BY	Human Resources	PREPARED BY:	Glorimar Lugo Ortiz
		APPROVED BY:	Roxie Held

# ADMINISTRATION AGREEMENT

ReliaStar Life Insurance Company, Minneapolis, MN  
ReliaStar Life Insurance Company of New York, Woodbury, NY  
Members of the Voya® family of companies  
(the "Company")



Policyholder Name (the "Policyholder") Tarrant County

Policy Effective Date 01/01/2025

**Insurance Contracts.** The Company issues insurance policies and certificates based on Policyholder's application and our state approved products (the "Policies"). Company's obligations are determined solely by the terms of the policies Company issues.

## EXCESS RISK COVERAGE

**Claim Administration.** Upon determination of a potential claim under the Policy, Policyholder will confirm employees' eligibility for coverage and provide required eligibility and claim documentation to the Company, either directly or through Policyholder's health claim administrator. The Company shall be responsible for all claim reviews, determinations and payments under the Policy.

**Confidentiality.** Company will keep confidential all information provided to Company by Policyholder or Policyholder's health claims administrator in connection with the Policy, in compliance with applicable law. Policyholder authorizes Policyholder's health claims administrator, if any, to release to the Company information and data regarding claims paid to be used in connection with the Policy.

## GROUP ANNUAL TERM LIFE, PERSONAL ACCIDENT INSURANCE, DISABILITY, CRITICAL ILLNESS, ACCIDENT AND/OR HOSPITAL CONFINEMENT INDEMNITY COVERAGE

**Policy Administration.** Policyholder's group policy will be "Self-Administered". This means that Policyholder or a third party that Policyholder engages will be responsible to maintain all enrollment, beneficiary, and billing records for the Policies (as applicable). The records Policyholder keep must provide the ability for Policyholder and/or Policyholder's employees to:

- appropriately apply Policy limits and rules
- know how much coverage the employee has at all times
- provide the employee with the appropriate "Conversion" and/or "Portability" documentation (as applicable)
- set up any payroll deductions correctly
- pay premium to the insurance company with supporting documentation
- file a claim

The parties agree that the Policies will be self-administered by Policyholder and that the insurance charges reflect that arrangement.

**Communications.** All forms and other materials Company provides to Policyholder must be presented to employees without alteration. Any benefit and eligibility descriptions Policyholder or Policyholder's third party service provider communicates to employees must be consistent with the materials and guidelines Company provides to Policyholder. Company will work carefully with Policyholder to make corrections in the case of any inadvertent error in communications. However, Policyholder is responsible for any costs incurred in correcting errors caused by incorrect data Policyholder provides to employees or to Company, including incorrect benefit descriptions and eligibility determinations.

**Evidence of Insurability.** If evidence of insurability is required in connection with an application for coverage under the terms of a Policy, then, and only to the extent required, Policyholder will apply the evidence of insurability rules appropriately, obtain the necessary forms from any applicant for such coverage, and provide those forms to the Company.

**Claim Administration.** Upon receipt of notice of a potential claim under a Policy, Policyholder will confirm employees' eligibility for coverage and provide required claim documentation at the Company's request. The Company shall be responsible for all claim reviews, determinations and payments.

**Certificates of Insurance and Summary Plan Description.** If Policyholder requests that Company provides Summary Plan Description(s) ("SPD") for distribution to ERISA plan participants, Company will provide the SPD using our standard language and format unless otherwise directed by Policyholder. If Company agrees to electronically post certificates of insurance and/or SPDs for access by Policyholder's employees, Policyholder is responsible for assuring that each covered employee is informed how the documents can be accessed and that each employee has access or otherwise receives a copy(ies) of these documents. Any legal advice as to the style, format, content or distribution of the SPD or distribution of the certificate of insurance must be provided by Policyholder's legal counsel. Company is unable to provide legal advice to Policyholder's plan and assume no responsibility for meeting ERISA's disclosure requirements.

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**GENERAL ADMINISTRATION – ALL PRODUCTS:**

**Indemnity.** Each party shall indemnify and hold the other harmless against any and all losses, claims, damages, costs or expenses (including reasonable attorneys' fees) which the indemnified party may become obligated to pay resulting from 1) the indemnifying party's error or omission in performing obligations under this Agreement, except to the extent that the indemnified party has caused or significantly contributed to such error or omission, and 2) any breach by the indemnifying party of any of its obligations under this Agreement regardless of whether such breach is either willful or negligent. Notwithstanding any other provision herein, Policyholder's obligation hereunder to indemnify and hold harmless Company is only to the extent permitted by the laws and Constitution of the State of Texas, and only to the extent the Texas Legislature waives Policyholder's existing immunity. Nothing in this indemnification provision requires that the Policyholder incur any debt, assess or collect funds, or create a sinking fund.

**Record Keeping.** Policyholder agrees to maintain accurate books and records documenting the administration of the Policies, including employee demographics, eligibility records, dependent data, coverage amounts, enrollment history, payroll deductions, benefit elections and beneficiary designations (as applicable). Such records must be maintained for a period of seven (7) years following termination of the Policies to which they relate. Upon reasonable notice, Company shall have the right to review, inspect and audit, at our expense, the books, records, data files or other information maintained by Policyholder or Policyholder's vendor related to the Policies.

**Transmission of Data.** Policyholder is responsible for the accuracy and security of data transmitted to Company, including data transmitted by any third party service provider Policyholder engages to assist in administration of Policyholder's benefit plans. Each party will establish and maintain (1) administrative, technical and physical safeguards against the destruction, loss or alteration of data, and (2) appropriate security measures to protect data, which measures are consistent with all state and federal regulations relating to personal information security, including, without limitation, the Gramm-Leach-Bliley Act.

**Premium payment.** If Policyholder engages a third party to submit premium to Company, Company will not consider the premium paid until it is received in our Home Office.

**General terms.** This Agreement will remain in effect during the duration of the Policy and will terminate automatically upon termination of all Policies. This Agreement may be amended only in writing signed by both parties. In the event of any conflict or inconsistency between the terms of this Agreement and the terms of any Policy, the terms of the Policy shall control.

**Payment Terms.** Policyholder will make payments to Company within thirty (30) days as required by Texas Government Code Section Sec. 2251.021(a) and in accordance with the terms of any Policy.

**Governing law.** This Agreement shall be governed by the laws of the State of Texas and shall be binding upon and inure to the benefit of Company, Policyholder and their respective administrators, representatives, successors and assigns. Any legal action arising out of or relating to the Agreement shall be brought only in the state or federal courts located in the State of Texas, and the parties irrevocably consent to the jurisdiction and venue of such courts.

**Sovereign Immunity.** This Agreement is expressly made subject to Policyholder's Sovereign Immunity, Title 5 of the Texas Civil Practices and Remedies Code, and all applicable federal and state law. The Parties expressly agree that no provision of this Agreement is in any way intended to constitute a waiver of any immunities from suit or from liability that the Policyholder has by operation of law. Nothing in this Agreement is intended to benefit any third party beneficiary.

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Accepted and Agreed to:

Policyholder Name *(Please print.)* Tarrant County

 Policyholder Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Print signer's name and title \_\_\_\_\_

RELIASTAR LIFE INSURANCE COMPANY  
RELIASTAR LIFE INSURANCE COMPANY OF NEW YORK

 Company Authorized Signature  Date \_\_\_\_\_

Print signer's name and title Mona Zielke, Vice President

# EXCESS RISK APPLICATION

ReliaStar Life Insurance Company  
("ReliaStar Life")

Home Office: Minneapolis, Minnesota 55440

Plan Sponsor hereby applies for the Excess Risk Policy.

## PLAN INFORMATION

Name of Plan Sponsor (exact legal name) Tarrant County  
Address (number and street) 100 E Weatherford Street  
City Fort Worth State TX Zip 76196  
 Corporation  Partnership  Sole Proprietorship  Other. Specify: Municipal Corporation

Nature of Plan Sponsor's Business General Government, NEC SIC Code 9199

Are subsidiaries, affiliates or other associated entities to be included?  Yes  No

If "Yes," give Names. \_\_\_\_\_

Relationship to Plan Sponsor \_\_\_\_\_

Please provide the number of individuals covered as noted below:

Eligible Individuals	_____	Covered Persons Only	_____	Covered Persons with Dependents	_____
Enrolled Individuals	<u>4,242</u>	Covered Persons Only	<u>4,242</u>	Covered Persons with Dependents	_____
Individuals Covered Elsewhere	_____	Covered Persons Only	_____	Covered Persons with Dependents	_____

The initial Contract Period is from January 1, 2025 through December 31, 2025

## CLAIM ADMINISTRATOR INFORMATION (Claim Administrator for coverages checked below for the Employee Benefit Plan)

Name of Claim Administrator (exact legal name of entity) BlueCross BlueShield (TX), CVS Caremark (run out), United HealthCare Corporation (run out)

Address (number and street) N/A

City N/A State N/A Zip N/A

\* Claim Administrator must be approved by ReliaStar Life prior to acceptance of this Application

## INDIVIDUAL EXCESS RISK

Individual Excess Risk:  Yes  No

Benefits To Be Covered:  Medical  Other (Please specify) Prescription Drugs

### Initial Coverage Period:

Incurred and Paid in 12 months  Incurred in 12 months and Paid in 15 months  
 Incurred in 15 months and Paid in 12 months  Incurred in 36 months and Paid in 12 months  
 Paid in 12 months  
 Other \_\_\_\_\_

Individual Excess Risk Deductible \$ 500,000 per Individual

Individuals subject to the Individual Adjusted Deductible as identified in the disclosure process  
n/a

Claims for Individuals subject to the Individual Adjusted Deductible that exceed the Individual Excess Risk Deductible amount are excluded under any Aggregate Excess Risk Insurance.

Benefit percentage 100%




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**ACKNOWLEDGEMENT & SIGNATURES**

By signing this Application below, the Plan Sponsor Applicant represents that all statements, answers and information made above in this application and in the Disclosure Agreement are complete and true to the best of its knowledge and belief. Plan Sponsor Applicant further acknowledges and agrees (i) that such statements, answers and information in this Application and in the Disclosure Agreement, together with a copy of the Employee Benefit Plan and other information attached to this application or furnished to ReliaStar Life, are submitted by the Plan Sponsor Applicant as an inducement to, and will be relied upon by, ReliaStar Life, in underwriting this risk and determining whether to accept this application and issue the Excess Risk Policy being applied for; (ii) if such statements, answers and information is/are incomplete or untrue, and such incompleteness or falsity is material to the risk to be insured by ReliaStar Life, any policy issued by ReliaStar Life may be rescinded and/or any benefits that might otherwise be payable thereunder may be denied; and (iii) the Plan Sponsor Applicant has fully read and understands this completed Application and the Disclosure Agreement.

Plan Sponsor Applicant      Tarrant County

Name of Signer (*Please print*)      Tim O'Hare      Title      County Judge

 Signature      \_\_\_\_\_      Date      \_\_\_\_\_

# DISCLOSURE AGREEMENT

ReliaStar Life Insurance Company, Minneapolis, MN  
A member of the *Voya*® family of companies  
(the "Company")



Policy Effective Date January 01, 2025

Plan Sponsor Name Tarrant County

## INSTRUCTIONS FOR COMPLETION

Please provide the information described in the Disclosure Reports Section below and then have an authorized representative of the Plan Sponsor submit the Disclosure Agreement. Prior to submitting this Disclosure Agreement and Disclosure Reports to the Company, please consult with your current Claim Administrator(s), Utilization Review Firm(s), Case Management, and Pharmacy Benefits Manager(s) (collectively, "Claim Vendors"), and Plan Sponsor's Broker or other insurance advisor. The Disclosure Reports must be provided to the Company no earlier than 90 calendar days prior to the Policy's Effective Date or renewal date, as applicable. Please note the required monthly claim reporting provided on behalf of the Plan Sponsor to Company will suffice for renewal purposes. Should the Company require any additional information, it will notify the Plan Sponsor and/or its designated representative in writing no later than 20 calendar days following receipt of the Disclosure Reports. Any firm quote is void unless accepted by the Plan Sponsor in writing within 30 days from the date quoted by the Company.

**DISCLOSURE REPORTS** *Plan Sponsor has provided the following reports or data (which include claimant name and primary ICD-10 diagnosis) on the following date(s):* N/A

- Any individual with paid claims that has exceeded 50% of the stop loss deductible during the applicable current policy year (minimum 9 months);
- Any individual with denied and/or pending claims that has exceeded \$25,000 during the applicable current policy year (minimum of 9 months);
- Any individual evaluated and/or listed for an organ, stem cell or bone marrow transplant;
- Any individual, including claim amounts for that individual, who is or was in case management or whose condition or diagnosis would be referred to case management during the applicable current policy year (minimum 9 months) by your claims Administrator based upon the ICD-10 codes used by your Claims Administrator for referral to case management;
- Any individual, including claim amounts for that individual, whose condition or diagnosis during the applicable current policy year (minimum 9 months) is represented by any of the ICD-10 codes contained in the attached list.

## DISCLOSURE AGREEMENT

The Plan Sponsor represents to the Company, to the best of its knowledge and belief, and after making a diligent and good faith inquiry, that it has fully read and understands this Disclosure Agreement; and as of the date of submitting this Disclosure Agreement there are no known potential catastrophic claims other than those disclosed on the submitted Disclosure Reports.

The Plan Sponsor understands and agrees that the Company will rely on this Disclosure Agreement and the attached Disclosure Reports to:

- underwrite this risk,
- determine whether or not to issue (or renew) a Policy, and
- If the Company agrees to issue or renew a Policy, determine the terms, conditions, limitations and rates of or for such Policy.

The Plan Sponsor further understands and agrees that if there are any undisclosed claimants known to the plan sponsor that are material to the risk to be insured by the Company, any Policy issued or renewed by the Company may be rescinded, any benefits that might otherwise be payable thereunder may be denied, and/or the premium rates, deductibles, terms, conditions and limitations of the Policy may be revised by the Company; and, the requirement to submit any required Disclosure Report may not be waived by the Company without a written representation by the Plan Sponsor that there are no reports or data with respect to any individual required to be included on any of the Disclosure Reports above.

To be eligible for a claim of reimbursement under the Policy, the Plan Sponsor or the Claims Administrator must request payment and provide complete and accurate Proof of Loss, in the form and content acceptable to the Company, to support a claim within 180 days after the end of the Coverage Period of the Policy.

## ICD-10 CODES FOR DISCLOSURE NOTIFICATION

The following ICD-10 Codes for Disclosure Notification provide conditions or diagnosis which must be disclosed. Please list all Plan Participants who have been diagnosed with or treated for any of the Codes listed under the following categories during the current Benefit Period. Where a range of Codes is shown, any and all conditions or diagnosis within that range must be disclosed.

### **A00-B99 Infectious Diseases**

B17.1-B17.11 Hepatitis C

### **C00-D49 Neoplasms**

C00-C14 Malignancies of oral cavity and pharynx  
C15-C26 Malignant neoplasm of digestive organs  
C30-C39 Malignant neoplasm of respiratory  
C43-C44 Melanoma  
C50-C50 Breast Malignancies  
C51-C68 Genitourinary Malignancies  
C69-C72 Malignancies of Nervous System  
C81-C96 Leukemias, Lymphomas and Myelomas

### **D50-D89 Hematologic Disorders**

D57.1 Sickle Cell Anemia  
D61.01 Aplastic Anemia  
D66 Hemophilia/Hereditary Factor VIII Deficiency  
D81.0 Severe Combined Immune Deficiency (SCID)  
D82.1 DiGeorge Syndrome  
D83.1 Immune Deficiency T Cells (AIDS)  
D84.1 Alpha 1-Antitrypsin

### **E70-E88 Metabolic Disorders**

E75.22 Gaucher's Disease  
E84.0 Cystic Fibrosis

### **G00-G99 Disease of the Nervous System**

G12.21 Lou Gehrig's disease (ALS)  
G61.0 Guillain-Barre Syndrome  
G82.50 Quadriplegia  
G91.1 Obstructive Hydrocephalus

### **I00-I99 Disease of Circulatory System**

I27.0 Primary Pulmonary Hypertension  
I42.0-I42.9 Cardiomyopathy  
I46.9 Cardiac Arrest  
I60.9 Subarachnoid Hemorrhage

### **J00-J99 Disease of Respiratory System**

J96.00-J96.92 Respiratory Failure

### **K00-K95 Disease of Digestive System**

K70.0-K74.69 Chronic Liver Disease  
K72.00-K72.91 Liver Failure

### **M86 Diseases of Musculoskeletal System and Connective Tissue**

M86 Osteomyelitis

### **N00-N99 Disease of Genitourinary System**

N18.1-N18.9 Chronic Renal Failure

### **O00-O9A Pregnancy, Childbirth & Puerperium**

O30.10--O30.109 Triplet Pregnancy  
O30.20-O30.209 Quadruplet Pregnancy  
O60.00--O60.14 Preterm Labor

### **P00-P96 Perinatal Conditions**

P07.00-P07.36 Preterm Infant  
P22.0 Respiratory Distress Syndrome of Newborn

### **Q00-Q99 Congenital Malformations**

Q20-Q28 Congenital Heart Diseases  
Q39.0-Q39.4 Tracheoesophageal Fistula  
Q89.7 Multiple Anomalies

### **S00-T88 Injury, Poisoning and Trauma**

S06.0-S06.9 Brain Injuries  
S12-S14 Spinal Cord Injuries  
S88 Amputations  
T07 Multiple Trauma Injuries  
T20-T32 Burns  
T79 Early Complications of Trauma

### **T86-Z94 Complications Peculiar to Certain Specified Conditions**

T86.00-T86.02 Graft vs. Host Disease  
T86.00-T86.09 Graft vs. Host Disease  
T86.90-T86.92 Complications of Transplants  
T86.90-T89.99 Complications of Transplants  
Z94 Transplants