SUPPLEMENTAL INFORMATION
ADDENDUM NO. 1

PROJECT: RFQ No. 17-18-001 - Catastrophic Inmate Medical Insurance

CONTACT: Fiona Charleton, Purchasing Agent
912-754-2159 fcharleton@effinghamcounty.org

DATE ISSUED: 23 August, 2016

RFQ No. 17-18-001 dated August 10, 2016 is hereby amended as noted herein : BIDDER TO ACKNOWLEDGE RECEIPT OF ADDENDUM BY SIGNING ON THE SIGNATURE LINE BELOW AND INCLUDING A COPY WITH SUBMITTED BID. FAILURE TO DO SO MAY, AT THE OWNER'S DISCRETION, SUBJECT THE BIDDER TO DISQUALIFICATION

1) QUESTION: Please provide :Claims Paid history (documents from insurance company) for: 2011 – 2012 – 2013 – 2014 - 2015
   ANSWER: There have been no filed claims or reimbursements made under the policy – please see attached letter.

2) QUESTION: Please provide :Name of insurance company (not the insurance agent) for:
   - 2011 – 2012 – 2013 – 2014 - 2015

   ANSWER:
   - 2011 - 2012 – Unimerica Insurance Company
   - 2012 - 2012 – Unimerica Insurance Company
   - 2013 - 2014 – Unimerica Insurance Company
   - 2014 - 2015 – Unimerica Insurance Company
   - 2015 - 2016 – Unimerica Insurance Company

3) QUESTION: Please provide: Copy of current Catastrophic insurance policy
   ANSWER: Attached.

4) QUESTION: Please provide: Copy of current insurance policy for coverage provided by TransformHealthCS
   ANSWER: Attached

5) QUESTION: Please provide: Premium paid for Catastrophic insurance for
   - 2011 – 2012 – 2013 – 2014 - 2015

   ANSWER:
   - 2011 - $13,996.80
   - 2012 - $13,541.00
   - 2013 - $13,541.00
   - 2014 - $10,207.68
   - 2015 - $14,582.40

6) QUESTION: Please provide: Claim reports from your current insurance carrier for the past 3 years
   ANSWER: See question 1.

7) QUESTION: Please provide: Premium history for the past 3 years
   ANSWER: See question 5

Catastrophic Inmate Medical Insurance

August 23, 2016

Re: Effingham County Jail Policy # UNI-200908

To whom it may concern:

This letter serves to confirm that over the last 5 years there have been no filed claims or reimbursements made under the Inmate Medical policy for Effingham County Jail. We were notified 8.25.14 by Tabatha Bruner with Transform Health of claim activity for Inmate [redacted] however the amounts paid did not exceed the deductible.

NAME REDACTED

Thank you,

Carey Boucher

Carey Boucher, Account Manager
Hunt Insurance Group, LLC, Administrators of CIMI

CATASTROPHIC INMATE MEDICAL INSURANCE

September 16, 2015

Re:	Specific Stop Loss Coverage
County:	Effingham County Jail
Address:	601 N. Laurel St. Springfield, GA 31329
Effective/Expiration:	10/01/2015 – 09/30/2016
Liability per Inmate:	$250,000
Specific Deductible:	$35,000
Annual Premium:	$14,582.40
Buy-Backs Included:	AIDS/HIV/Pregnancy.
Average Daily Maximum (ADM):	$12,000 days 1-3 and $8,000 for each day thereafter

We have approved the Specific Excess Loss coverage for the county listed above. The new policy declarations for **Effingham County Jail** will be issued upon receipt of the signed Plan Document, Subsequent Policy Period Offer and applicable premium.

Please let me know if you have any questions regarding this matter, and thank you for choosing Optum.

Sincerely,

Naomi Zellers

UNIMERICA INSURANCE COMPANY

SUBSEQUENT POLICY PERIOD OFFER

OPTUM™

Employer: EFFINGHAM COUNTY JAIL
Effective Date: OCTOBER 01, 2015

SPECIFIC COVERAGE		Option 1	Option 2	Option 3
Specific Deductible Amount		**$35,000**	**$40,000**	**$45,000**
Specific Maximum		$250,000	$250,000	$250,000
EMPLOYEE	140	$8.68	$7.66	$6.77
FAMILY	0	$.00	$.00	$.00
Total Lives/Annual Premium	140	$14,582.40	$12,868.80	$11,373.60
Benefits Covered		MED	MED	MED
Specific Contract Basis		12/18	12/18	12/18

CONDITIONS AND ASSUMPTIONS

~ MINIMUM ANNUAL PREMIUM: 90% OF ANNUAL PREMIUM SHOWN ABOVE
HOSPITAL AVERAGE DAILY MAXIMUM: $12,000 (DAYS 1-3) & $8,000 (DAY 4 & EACH DAY THEREAFTER)
INCLUDES COVERAGE FOR AIDS/HIV & PREGNANCY

~ Other compensation or bonuses may be indirectly reflected in this quote. Contact your broker/agent if you have any questions relating to their compensation for this offer.

~ CURRENT plan has been quoted.

~ The Plan will have Network: Medicaid discount Case Manager: N/A TPA: N/A

~ Retirees N/A covered for medical benefits.

~ The Subsequent Policy Period Offer is based on data submitted, plus other information furnished relevant to underwriting the risk, including all claims or possible claims, paid, pending or denied pending additional information, or which the employer or its authorized representative should otherwise be aware of. Any inaccuracy in the data submitted or failure to disclose any such information can change the terms, conditions, rates or factors of this offer or can void the offer and coverage.

~ This document may contain Protected Health Information (PHI) and should only be shared with individuals designated to view such information per HIPAA regulations.

Until we obtain the signed Subsequent Policy Period Offer, the rates and factors are subject to change as additional information is received. This Offer is valid for the stated effective date noted above provided the employer or its authorized representative elects one of the above options, signs the acknowledgment and we receive the completed Offer by 9/25/2015

Circle Coverages & Options Elected	Signature: [signature]
Dated: 9/1/2015	Title: Chairman

Inmate Medical Benefit Plan Document

PLAN SPONSOR: **Effingham County Jail**

EFFECTIVE DATE: **October 1, 2015**

DEFINITIONS:

A. AVERAGE DAILY MAXIMUM (ADM) means the maximum allowable amount on a per day basis shown in the Schedule of Insurance.

B. EDUCATIONAL OR REHABILITATIVE CARE means care for restoration (by education or training) of one's ability to function in a normal or near normal manner following any illness or injury. This type of care includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

C. EXPERIMENTAL PROCEDURE means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are: (a) limited to research; (b) not proven in an objective manner to have therapeutic value or benefit; (c) restricted to use by medical facilities capable of carrying out scientific studies; (d) of questionable medical effectiveness; or (e) would be considered inappropriate medical treatment. To determine, in its sole discretion, whether a procedure is experimental, the Plan will consider, among other things, commissioned studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institute of Health, the Council of Medical Specialty Societies and any other association or program or agency that has the authority to review or regulate medical testing or treatment.

D. HOSPITAL means an acute care facility which meets all of the following criteria:

1. such hospital is not located at a jail, prison, correctional institution, house of correction, or similar facility or upon the grounds or premises of such facility;
2. operates as a hospital pursuant to applicable law;
3. operates primarily for the reception, care, and treatment of sick or injured persons who are not sick or injured "Inmates";
4. provides 24-hour nursing service by "Registered Nurses" on duty or on call;
5. has a staff of one or more "Physicians" at all times;
6. provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical and psychiatric ward conditions on premises; and
7. is not primarily a psychiatric hospital, long-term care facility; extended care facility; nursing rest or custodial care or convalescent home; a place for the aged, drug addicts, alcoholics or runaways; or similar establishments.

E. ILLNESS means a sickness or disease. "Illness" does not include learning disabilities, attitudinal disorders, or disciplinary problems.

F. INJURY means bodily injury resulting from an accidental, unforeseen event. For purposes of this Plan Document, an attempted suicide shall be deemed to be an accidental, unforeseen event

G. INMATE means a person(s) arrested by a designated licensed authority or in the care, custody and control of the "Plan Sponsor". Such persons (i) will remain "Inmates" up until the date of discharge from incarceration as designated by the governing body or judicial entity that sentenced such "Inmate" or any date earlier as deemed appropriate by the same governing body; or a judicial entity with lawful jurisdiction; and will cease to be "Inmates" as of the date of discharge from incarceration, even if such date of discharge occurs while such "Inmate" is hospitalized.

H. INPATIENT means an "Inmate" who meets all of the following criteria:

1. such "Inmate" is admitted as an inpatient to the "Hospital"; or is being held for observation and or testing at a hospital facility.
2. such "Inmate" incurs expenses for room and board that are charged to the "Named Insured" or the lawfully appointed designee of the Plan Sponsor.

I. MEDICALLY NECESSARY means necessary and appropriate for the diagnosis or treatment of an "Illness" or "Injury" based on generally accepted current medical practice. A service, medicine or supply will not be considered "Medically Necessary" if it:

1. is provided only as a convenience to the "Inmate";
2. is not appropriate for the "Inmate's" diagnosis or symptoms; or
3. exceeds (in scope, duration or intensity) that level of care, which is needed to provide safe, adequate and appropriate diagnosis or treatment.

J. MENTAL OR NERVOUS DISORDER means a mental or emotional disease or disorder that is listed in the current edition of the Diagnostic and Statistical manual for Mental Disorders of the American Psychiatric Association and denotes the following:

1. a disease of the brain with predominant behavioral symptoms;
2. a disease of the mind or personality, evidenced by abnormal behavior; or
3. a disorder of conduct evidenced by socially deviant behavior.

K. ON SITE CLINIC means a clinic or medical facility providing any kind of healthcare, psychological, nutritional, or psychiatric services located at a jail, prison, correctional institution, house of correction, or similar facility or upon the grounds or premises of such facility.

L. ORGAN TRANSPLANT PROCEDURES means any transplant procedure including, but not limited to, kidney, cornea, heart, lung, heart-lung, liver, pancreas and bone marrow transplants.

M. OUTPATIENT SURGICAL CENTER means any outpatient same-day surgery center which meets both of the following criteria:

1. has facilities that are operated primarily for the purpose of performing surgical procedures and is licensed by the State in which it resides.
2. such center is not located at a jail, prison, correctional institution, house of correction, or similar facility or upon the grounds or premises of such facility.

N. PHYSICIAN means a person performing services within the scope of his or her license, who is a duly licensed: (1) doctor of medicine (MD), (2) doctor of osteopathy (DO), or physician assistant (PA).

O. PLAN COVERAGE PERIOD means a 12 month period commencing on the Effective Date shown above or such shorter period of time if this plan is terminated earlier.

P. PLAN ADMINISTATOR means the Plan Sponsor who shall undertake the administration of claims or a Third Party Administrator hired by the Plan Sponsor to perform the said duties. The Administrator shall:

1. Supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims,
2. Maintain accurate records of all claims payments,
3. Provide case management to appropriately manage the care of all "Hospital Inpatient Services".

Q. REASONABLE AND CUSTOMARY means the usual charge made by a group, entity or person who renders or furnishes similar services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies to persons; (1) who reside in the same geographical area (as determined by the Center for Medicare and Medicaid ("CMS") Guidelines); and (2) whose "Illness" or "Injury" is comparable in nature and severity.

In determining whether a charge is reasonable, one or more of the following factors may be considered:

1. the level of skill, extent of training and experience required to perform the procedure or service;
2. the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services;
3. The severity of the nature or "Illness" or "Injury" being treated; the amount charged for the same or comparable services, medicines or supplies in other parts of the country.
4. the cost to the provider of providing the service, medicine, or supply;

R. REGISTERED NURSE means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." after his/her name.

S. SUBSTANCE ABUSE means alcohol, drug or chemical abuse, overuse or dependency.

T. SURGERY means:

1. an invasive diagnostic procedure performed by a "Physician"; or
2. The treatment of "Illness" by manual or instrumental operations performed by a "Physician" while the patient is under general or local anesthesia.

PLAN BENEFIT DESCRIPTION:

The Plan covers the following Allowable Medical Expenses incurred by an "Inmate" for the treatment of an "Injury" or "Illness" during the Plan Coverage Period. Such charges are covered at the Plan Benefit Coinsurance and subject to:

- the Limitations shown in the Schedule of Benefits;
- the Exclusions; and
- All other terms and conditions of the Plan.

SCHEDULE OF BENEFITS:

Plan Benefit Coinsurance:	100% of "Allowable Medical Expenses"
Inpatient Hospital Services:	Limited to the lesser of the amount paid or an "Average Daily Maximum" (ADM) per admission of $12,000 days 1-3 and $8,000 for each day thereafter.
Outpatient Surgical Services:	Limited to $24,000 per outpatient surgical visit.

ALLOWABLE MEDICAL EXPENSES:

Inpatient Hospital Services:

The following services provided and billed by a "Hospital" while the "Inmate" is an "Inpatient". All services and supplies must be administered by or under the direction of a "Physician".

A. Emergency Room Services and Ambulance Services as long as the "Inmate" is admitted to the "Hospital" on an "Inpatient" basis for further services and or treatment within 24 hours.

B. The use of any type of room and board; operating, treatment, recovery and daily room and board.

C. Services and supplies that are routinely provided by the "hospital" to "inpatients."

D. Supplies including but not limited to:
   - Dressings
   - Sutures
   - Casts
   - Other supplies which are deemed "medically necessary."

E. Diagnostic Testing including but not limited to:
- Radiological
- Ultrasonographic
- Laboratory
- Radiation Therapy or treatment

(Psychometric behavioral and educational testing is not included.)

F. Other Charges:
- Oxygen and other gases and their administration thereof
- Anesthetics and their administration thereof

G. Hemodialysis (services and charges by the "hospital") as long as it is done on an "inpatient" basis.

H. Processing and administration of blood or administration of blood components

Outpatient Surgical Services:

Services provided and billed by a "Hospital" or an "Outpatient Surgical Center" for "Surgery". The "Inmate" must be discharged within 24 hours of admission. All services and supplies must be administered by or under the direction of a "Physician".

EXCLUSIONS:

A. Any expenses which are not "Medically Necessary".

B. Any expenses in excess of the "Reasonable and Customary" charge.

C. Any expenses which were incurred prior to the Effective Date of the Plan.

D. Consulting Fees.

E. Expenses which are covered, recoverable, or attributable to, any other medical or hospitalization benefit policy or insurance.

F. Dental, Vision or hearing services unless the services are the direct result of an "Injury", or "Illness".

G. Services that do not qualify as "Hospital Inpatient Services" or "Outpatient Surgical Services", including, but not limited to:
1. "Physician" office visits
2. Services rendered at the site of the emergency
3. Healthcare services or medicine administered or provided at a jail or correctional facility
4. Prescription drugs provided to an "inmate" not on an "inpatient" or "surgical outpatient" basis.

H. "On site Clinic" services expenses.

I. "Experimental Procedures", drugs, or research studies, or any services or supplies not considered legal in the United States.

J. "Organ Transplant Procedures" or any organ donations.

K. "Mental or Nervous Disorders", rehabilitation treatment.

L. "Substance Abuse" expenses, programs for the rehabilitation treatment thereof.

M. Dependent care and any related expenses.

N. Any expenses related to or from War, whether declared or undeclared, hostilities, invasion or civil war.

O. Any expenses resulting from and "injury" or "illness" that is a direct result of a nuclear or radioactive accident.

P. Any expenses which are incurred after the "inmate" is released from custody or control from the correctional authorities.

Q. "Expenses for, in connection with, or arising out of providing security or guarding of any "inmate" while such "inmate" is an "inpatient" in a "hospital" or such "inmate" is receiving "outpatient surgical services". "Injuries" sustained by the "inmate" as a direct result of the "inmate" needing to be restrained or controlled will be considered covered expenses so long as it can be shown that only reasonable force was exercised by law enforcement personnel.

R. Any custodial care, "Educational or Rehabilitative Care" or nursing services expenses while primarily confined to receive such services.

S. Any expenses that result from services solely for cosmetic or aesthetic purposes.

T. Expenses for vocational or recreational therapy or vocational rehabilitation.

U. Expenses for preventative care, including routine physical examinations, prenatal examinations and educational programs.

V. The following expenses for conception and childbirth:
- Any drug, treatment or procedure that either promotes or prevents conception or childbirth
- Artificial insemination, treatment of infertility, impotency and sterilization
- Abortion (unless the life of the mother would be endangered if the fetus was carried to term)
- Care of newborn infants.

Allowable Medical Expenses related to complications of pregnancy are covered.

W. The following cosmetic, weight loss or body transforming services
- Weight modification, surgery for obesity
- Wiring of teeth, Gastric bypass, lap band or any related surgery
- Breast augmentation , reduction and sex/gender changes

X. Marriage, Family or Child Counseling.

Y. Any payment of, or because of punitive or exemplary charges.

Z. If this plan is new to the "Plan Sponsor", expenses for an "illness" of an "inmate" who is hospitalized on the effective date or within 72 hours after the effective date of this plan. This would not apply to a new inmate arriving during the 72 hour period.

Plan Sponsor **Effingham County Jail**

Plan Document Reviewed and Approved by:

_____ 9-24-2015
Name and Title Date

Initial number of Inmates on the Effective Date: 140

Unimerica Insurance Company
Minnetonka, Minnesota

AMENDMENT NO: 7

Amendment to be attached to and made a part of Group Policy No. UNI-200908, issued by Unimerica Insurance Company (herein called Company) to Effingham County Jail (herein called Policyholder).

It is agreed by and between the Company and the Policyholder that

1. The page entitled "Schedule Of Benefits" as contained in the Policy is hereby replaced with the attached page entitled "Schedule Of Benefits".

2. This Amendment will hereby be effective as of October 1, 2015.

Dated on this 30th day of November, 2015.

Unimerica Insurance Company

Secretary

Unimerica Insurance Company
A Stock Company
Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343
Phone: 1-800-454-0233

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: Effingham County Jail
Policy Number: UNI-200908
Effective Date: October 1, 2015
Administrator: Hunt Insurance Group, LLC
Coverage specified herein is applicable only during the Policy Period from October 1, 2015 to October 1, 2016, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE ☒ Yes ☐ No

Benefit Period: Covered Expenses Incurred from October 1, 2015 through September 30, 2016 and Paid from October 1, 2015 through March 31, 2017.

Specific Deductible per Covered Person: $35,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: ☐ Unlimited ☒ Other $250,000

Specific Excess Loss Insurance includes:
☒ Medical ☐ Stand Alone Prescription Drug Program

Common Accident Provision: ☐ Yes ☒ No
Common Accident means if more than one Covered Person in the same immediate family incurs Covered Expenses as a result of the same accident, the Specific Deductible will be applied only once to all Covered Expenses Paid because of that accident for all Covered Persons in the family during the same Benefit Period.

Description	Rates
Covered Persons	$ 8.68

Minimum Annual Specific Premium	☒ Yes	☐ No	$13,124
Specific Accommodation Reimbursement Endorsement	☒ Yes	☐ No	
Specific Terminal Liability Endorsement	☐ Yes	☒ No	
Aggregating Specific Deductible Endorsement	☐ Yes	☒ No	
Specific Step-Down Deductible Endorsement	☐ Yes	☒ No	
Independent Review Organization Extended Liability Endorsement	☐ Yes	☒ No	

AGGREGATE EXCESS LOSS INSURANCE ☐ Yes ☒ No

Benefit Period: Covered Expenses Incurred from through ,
and Paid from through .

Aggregate Excess Loss Insurance includes:
☐ Medical ☐ Stand Alone Prescription Drug Program ☐ Dental Care
☐ Vision Care ☐ Weekly (Disability) Income ☐ Other

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: $

Minimum Annual Aggregate Deductible: $ or % of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $

Monthly Aggregate Factors					
	Medical	Prescription Drugs	Dental	Vision	Weekly Income
	$				

Aggregate Excess Loss Premium: $ per Employee per month

Aggregate Terminal Liability Endorsement Premium: ☐ Yes ☐ No
Aggregate Accommodation Endorsement Premium: ☐ Yes ☐ No
Independent Review Organization Extended Liability Endorsement ☐ Yes ☐ No

SPECIAL CONDITIONS:
Retirees are not covered for Medical Benefits.

SPECIFIC ACCOMMODATION REIMBURSEMENT ENDORSEMENT

Policyholder: Effingham County Jail

Effective Date: October 1, 2015

The Company, without waiving any rights under the Excess Loss Insurance Policy to which this Endorsement is attached has established Specific Accommodation Reimbursement. The terms and conditions upon which Specific Accommodation Reimbursement will be granted are as follows:

Covered Expenses that exceed the Specific Deductible and that are eligible for reimbursement must be adjudicated according to the terms of the Plan Document by the Policyholder and be processed for Payment prior to the end of the Benefit Period.

Any request for Specific Accommodation Reimbursement, along with necessary documentation, including proof that the Specific Deductible has been Paid by the Policyholder, must be received by the Company no later than ten (10) calendar days after the expiration of the Benefit Period. Each request must total more than $1,000.00 per person.

Upon receipt of the Company's reimbursement the Policyholder must pay the Plan's Payment within five (5) days. The Company's reimbursement may not be deposited until the Plan's Payment has been Paid. If the Policyholder does not pay the Plan's Payments within the five (5) day period, the reimbursement check must be returned to the Company. Upon request by the Company, the Policyholder must supply documentation of the Plan Payments.

If any of the reimbursement is not used to pay eligible Covered Expenses, due to any reason, these amounts must be refunded to the Company within five (5) days of receipt of the reimbursement.

Except as specifically set forth above, all terms and conditions of the Excess Loss Insurance Policy shall remain in full force and effect.

If the Policyholder fails to comply with all of the above conditions, the right to receive Specific Reimbursement Accommodation shall be rescinded.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Secretary

Unimerica Insurance Company

TRANS-6 OP ID: SC

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/29/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Glenn/Davis & Associates Inc 23452 Hwy 80 East Statesboro, GA 30461 Sean P. Davis	CONTACT NAME: Sean P. Davis PHONE (A/C, No, Ext): 912-489-3716 FAX (A/C, No): 912-489-3717 E-MAIL ADDRESS:
INSURED TransformHealthCs, Inc. 1203 Brampton Avenue Statesboro, GA 30458	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Evanston Insurance Company INSURER B : Ironshore Indemnity Inc INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY							
	CLAIMS-MADE X OCCUR			SM910362	10/22/2015	10/22/2016	EACH OCCURRENCE	$ 1,000,000
	X Professional Liab						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						MED EXP (Any one person)	$ 2,500
	POLICY PRO-JECT LOC						PERSONAL & ADV INJURY	$ 1,000,000
	OTHER:						GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
B	X UMBRELLA LIAB OCCUR							
	EXCESS LIAB CLAIMS-MADE			002551500	10/22/2015	10/22/2016	EACH OCCURRENCE	$ 5,000,000
	DED RETENTION $						AGGREGATE	$ 5,000,000
							RetroDate	$ 10/22/15
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N N / A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$
A	Professional Liab			SM910362	10/22/2015	10/22/2016	EachLimit	1,000,000
	RetroDate 10/22/15						Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

EFFINPR

Effingham County Jail
321 Highway 119 South
Springfield, GA 31329

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ACORD 25 (2014/01)

All other terms and conditions in RFQ 17-18-001 remain unchanged.

Effingham County reserves the right to reject any and all proposals, to waive any technicalities or irregularities and to award the offer based upon the most responsive, responsible submission.

Please sign receipt of this Addendum No. 1 below:

_____	_____	_____
Print Name	Signature	Date

END OF ADDENDUM NO. 1