Request for Board of Commissioners' Action

From: Faye Hughes, County Administrator **Date:** July 12, 2017

Subject: Catastrophic Inmate Medical Policy **Item Number:** VIII-C_

Attached is the annual policy for catastrophic inmate medical. This policy covers medical services for inmates that exceed the coverage of the healthcare provider onsite at the jail. As stated on the application the coverage has a deductible of $50,000 but is limited to $200,000 payout per person.

If the Board agrees, the Chairman will need a motion to approve the premium of $10,676.25 and authorize his endorsement on the application.

Motion made by _____

Second made by _____

Any discussion: _____

_____

Votes_____ yes _____ no Motion carried/ failed

APPLICATION AND SCHEDULE FOR
EXCESS LOSS INSURANCE

GERBER LIFE INSURANCE COMPANY
WHITE PLAINS, NY 10605

Application is hereby made to the Gerber Life Insurance Company ("Company") for Excess Loss Insurance. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Contract Number: GER-P16-911R

2. Contractholder: Cook County Georgia Law Enforcement Center

3. Address: 1000 County Farm Road
City: Adel State: GA Zip Code: 31620

4. Subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) to be included (list legal name and addresses):
None

5. Name and Address of Designated Third Party Administrator:
Consociate Group, 111 East Decatur Street, Decatur, IL 62525

6. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):
65 Composite

6.(a) Eligible employees: 65 Composite

7. **GENERAL SCHEDULE OPTIONS:**

(a) Contract Period 08/01/2017 (Effective date) to 07/31/2018 (Termination date)

(b) *Disabled Persons [X] are [ ] are not covered.
*Retired Employees [ ] are [X] are not covered.
*Cobra Continuees [ ] are [X] are not covered.
*(required to be disclosed)

(c) Aggregate Benefit [ ] Yes [X] No

Benefit Period: Employee Benefit Plan expenses must be
Incurred from N/A through N/A , and
Paid from N/A through N/A
Claims Incurred prior to the Contract Effective Date are limited to: N/A
Claims Paid after the end of the Contract Period are limited to: N/A

7. **GENERAL OPTIONS: (Continued)**

Aggregate eligible expenses include:

[ ] Medical [ ] Prescription Card Service
[ ] Dental Care [ ] Weekly Disability Income
[ ] Vision Care [ ] Other

Aggregate Monthly Factors:

	Composite	Medical
Aggregate Payable Percentage (excess of Deductible)		N/A
Maximum Eligible Claim Expense Per Covered Person:		N/A
Minimum Aggregate Deductible:		N/A
Maximum Aggregate Benefit (excess of Deductible):		N/A

Optional Benefits

i.	Monthly Aggregate Accommodation	[ ]	Yes	[X]	No
ii.	Aggregate Terminal Liability	[ ]	Yes	[X]	No
iii.	Blended Aggregate Accommodation	[ ]	Yes	[X]	No
iv.	Blended Aggregate Terminal Liability	[ ]	Yes	[X]	No

(d) Specific Benefit [X] Yes [ ] No

Medical Only [X] Medical & Prescription Drug Only [ ]

Benefit Period: Employee Benefit Plan expenses must be
Incurred from 8/1/2017 through 7/31/2018 , and
Paid from 8/1/2017 through 1/31/2019

Claims Incurred prior to the Contract Effective Date are limited to: N/A
Claims Paid after the end of the Contract Period are limited to: N/A

Specific Deductible (per person): $50,000

Specific Payable Percentage (excess of Deductible): 100%

Maximum Specific Benefit per person in excess of Specific Deductible: $200,000

Aggregating Specific Deductible: N/A

Optional Benefits

i. Advance Funding for Specific Excess Loss: [X] Yes [ ] No

ii. Terminal Liability Option included: [ ] Yes [X] No

8. **PREMIUMS:**

(a) Aggregate Premium

Premium Per Month Per Unit:		N/A
Minimum Annual Aggregate Premium		N/A
Monthly Aggregate Accommodation		
Premium Per Month Per Unit		N/A
Annual Premium in Advance		N/A
Aggregate Terminal Liability		
Blended Aggregate Terminal Liability		
Premium Per Month Per Unit		N/A

(b) Specific Premium

Premium Per Day Per Inmate	Composite	$0.45
Minimum Monthly Specific Premium		$800.70
Minimum Annual SpecificPremium		N/A
Advance Funding for Specific Excess Loss		Included
Specific Terminal Liability		N/A

9. **SPECIAL RISK LIMITATIONS:**

Specific Coverage for mental and nervous disorders, HIV, substance abuse and maternity coverage are excluded.

Excess loss coverage will begin once the inmate has been booked and incarcerated as defined in the Statement of Inmate Medical Benefits.

Aggregate None

10. **IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:**

(a) All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within 90 days of the requested Effective Date.

(b) Applicant has provided full disclosure of all information requested by the Company and has, to the best of its knowledge and belief, complied fully with all disclosure requirements.

(c) If Applicant is electing coverage for disabled and/or retired persons, only those who have been disclosed to The Company will be covered.

(d) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:
(1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or
(2) if a dependent or Cobra Continuee, he or she is able to perform the normal functions of a person of like sex and age.

(e) Issuance of the Contract is in reliance upon the information provided by the Applicant or its Agent. Should subsequent information become known which, if known prior to issuance of the Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Insured.

(f) The Contract, if issued, may be void, if, whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

(g) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Gerber Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

(h) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.

(i) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each Contract Month during the Contract Year.

11. **IT IS FURTHER UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION THAT:**

(j) Applicant acknowledges that the Contract which is the subject of this Application is a reimbursement Contract. Applicant must first pay claims before submitting them for reimbursement.

(k) Oral statements not expressly incorporated herein are not part of this Contract. Only the President or Executive Officer of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.

(l) NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Fraud Warning Any person who, knowingly and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information, may be guilty of insurance fraud.

Dated at _____ this _____ day of _____,20_____

_____ Billy Greene _____
Signed Licensed Agent *Print Licensed Agent Name*

_____ _____
Agent Tax ID *Agent License Number and Issuing State*

Dated at _____ this _____ day of _____,20_____

_____ _____
Signed for the Applicant/Policyholder *Printed Name and Title*

ACCEPTANCE

Dated at _____ this _____ day of _____,20_____

_____ _____
Accepted on behalf of the Company by *Print Name and Title*

Inmate *Excess* Medical Insurance

Premium Invoice for

Cook County, GA

Invoice Date: 7/12/17

		Col. (A)	Col. (B)	Col. (C)	Col. (D)			
County	Payment for year beginning :	# County Inmates	Rate / Inmate/Day	# Days	Monthly Premium	Deductible	Effective Date	Comment
		(A)	x (B)	x (C)	= (D)			
Cook County, GA	August 1, 2017	**65**	0.45	365	**$10,676.25**		8/1/12 0:00	**Annual Premium**
Adjustments, if any:								
Month:								
Total								

Please make check payable to:
P.E.R.U.
3730 Roswell Road
Suite 275
Marietta, GA 30062

Thank you for your business!

Please return one copy of this invoice with your payment. Premium is due by the 15th.

CRS Inc.
Correctional Risk Services, Inc.