HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

POLICY NUMBER	402851-C
NAME OF POLICYHOLDER	San Joaquin Valley Insurance Authority
TYPE OF COVERAGE	Stop Loss Insurance
EFFECTIVE DATE	January 01, 2013
POLICY TERM	January 01, 2013 through December 31, 2013
POLICY DELIVERED IN	California and governed by the laws of that state.

HM Life Insurance Company agrees to pay the benefits provided by this Policy, in accordance with the provisions of this Policy.

The consideration for this Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are actually Paid by the Policyholder through the Covered Underlying Plan(s), exceed the levels defined in this Policy. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

This Policy begins at 12:01 AM current Eastern Time on the first day of the current Policy Term and ends at 11:59 PM current Eastern Time on the last day of the current Policy Term, and may be renewed for subsequent Policy Terms. If this Policy is renewed the terms and conditions of this Policy may be revised.

This Policy will terminate automatically upon the failure of the Policyholder to pay any premium within the Grace Period. Termination of this Policy for any reason other than non-payment of premium will occur following written notice by the Policyholder or us.

All provisions on this and the following pages are a part of this Policy. The definitions of terms apply whenever the terms are used anywhere in this Policy. "We", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

HM Life Insurance Company

By

President

This Policy is Non-Participating

REQUIRED CALIFORNIA NOTICE

To Our California Policyholders and Certificate Holders:

We are here to serve you . . .

As our policyholder or certificate holder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact HM Life Insurance Company at the following address and toll-free telephone number:

HM Life Insurance Company
120 Fifth Avenue, Fifth Avenue Place
Pittsburgh, PA 15222-3099

Telephone number: 1-800-328-5433

If you are not satisfied . . .

Should you feel you are not being treated fairly and you have been unable to contact or obtain satisfaction from us or the agent, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

Consumer Services Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Telephone number: 1-800-927-HELP

Notice of Non-Coverage
California Life and Health Insurance Guarantee Association Act

This policy is NOT covered by The California Life and Health Insurance Guarantee Association

EXCLUSIONS FROM COVERAGE

The following are not covered by the California Life and Health Insurance Guarantee Association:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by individuals and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or any portion of it that is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

A determination as to whether an insurance contract is covered under the Guarantee Association or whether an annuity contract is allocated or unallocated must initially be made by the insurer based on its knowledge of the specific contract offered.

Also, you are not protected by this Association if:

- The insurer was not authorized to do business in this state when it issued the policy or contract;
- The policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- You are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.

If you have questions concerning this Notice, you may contact:

California Life and Health Insurance Guarantee Association P.O. Box 17319 Beverly Hills, CA 90209-3319 (213) 782-0182	or	Consumer Service Division California Department of Insurance 300 South Spring Street Los Angeles, CA 90013 (800) 927-4357 or (213) 897-8921

Questions as to specific policies or annuities should be directed to the insurance company offering the product.

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Part 1. DECLARATION PAGE

A. POLICY INFORMATION

1.	Policy Number	402851-C
2.	Policyholder	San Joaquin Valley Insurance Authority
3.	Current Policy Term	January 01, 2013 through December 31, 2013
4.	Covered Underlying Plan(s)	San Joaquin Valley Insurance Authority Health Plan
5.	Claims Administrator	Anthem Blue Cross of CA

B. SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

Incurred & Paid: Eligible Claims Expenses Incurred from January 01, 2013 through December 31, 2013 and actually Paid from January 01, 2013 through March 31, 2014.

2. Specific Eligible Claims Expenses include:

Health Care	Yes
Dental	No
Vision	No
Prescription Drug Card	Yes
Short Term Disability	No
Other:	No

3. Number of Covered Units

Composite	3,557

4. Specific Deductible

Per Participant	$450,000

5. Specific Payable Percentage (in excess of Specific Deductible) 100%

6. Maximum Specific Benefit

Per Participant in excess of the Specific Deductible	
Per Policy Term	$4,550,000
Per Lifetime	Unlimited

C. AGGREGATE BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

   Incurred & Paid: Eligible Claims Expenses Incurred from January 01, 2013 through December 31, 2013 and actually Paid from January 01, 2013 through March 31, 2014.

2. Aggregate Eligible Claims Expenses include:

Health Care	Yes
Dental	No
Vision	No
Prescription Drug Card	Yes
Short Term Disability	No
Other:	No

3. Number of Covered Units

Composite	3,557

4. Aggregate Payable Percentage (excess of Deductible): 100%

5. Aggregate Attachment Point (Corridor) 125%

6. Annual Aggregate Deductible equals A or B whichever is greater, where:

   A= The sum of the Monthly Aggregate Deductible Amounts applicable to each Policy Month in the current Policy Term

   B = The Minimum Aggregate Deductible

   Note: The Annual Aggregate Deductible cannot be finally determined until the Aggregate Monthly Deductible Amounts have been calculated for each Policy Month of the Policy Term.

7. Monthly Aggregate Factor

   Per Composite Unit per Policy Month $803.33

8. Maximum Aggregate Eligible Claims Expense

   Per Participant $450,000

9. Maximum Aggregate Benefit (in excess of the Annual Aggregate Deductible per Policy Term) $1,000,000

D. PREMIUM

Specific Premium per Month

Composite:	$11.74

Specific Rate Guarantee Period: 12 Months

Aggregate Premium per Month Per Covered Unit: $.85

The Specific Premium per Month and the Aggregate Premium per Month per Covered Unit only apply to the current Policy Term.

E. SPECIAL RISK LIMITATIONS:

Disabled/Hospital Confined, actively at work, activity of daily living, out of hospital, or similar requirements waived with Disclosure	Yes
Retirees Included	Yes

F. AFFILIATES

Name	Covered Underlying Plan(s)
County of Fresno	Same as Policyholder's
County of Tulare	Same as Policyholder's

Part 2. BENEFITS

Unless otherwise indicated in the Covered Claims Basis section(s) in the Specific Benefit Schedule or the Aggregate Benefit Schedule, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are Incurred and or actually Paid after the Effective Date of this Policy and which are actually Paid by the Policyholder during the Policy Term. The Specific Benefit Schedule, Aggregate Benefit Schedule and Policy Term are shown on the Declaration Page.

A. SPECIFIC BENEFIT

We will pay the Policyholder the following Specific Benefit, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Specific Benefit payable with respect to a Participant will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for that Participant during the current Policy Term reduced by the Specific Deductible for the Participant times the Specific Payable Percentage.

We will pay Specific Benefits as they become due following satisfaction of the Specific Deductible, subject to the terms and conditions of this Policy.

The Specific Benefit payable does not include any amount actually Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.

In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by any one Participant exceed the Maximum Specific Benefit.

B. AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal the total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term minus (A plus B), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per Covered Unit.

Times the Aggregate Payable Percentage.

The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

Part 3. EXCLUSIONS AND LIMITATIONS

No Deductible of this Policy will be satisfied and no benefit of this Policy will be paid for:

1. UNDERLYING PLAN: Any amount actually Paid by the Policyholder for an expense Incurred:

    a. When the Covered Underlying Plan is not in effect; or

    b. By a person who is not a Participant when the expense is Incurred; or

    c. That is not specifically covered under the terms of the Covered Underlying Plan, or that the Policyholder is not required to pay in accordance with the terms of the Covered Underlying Plan; or

    d. Prior to the initial Incurred date shown in Covered Claims Basis on the Declaration Page.

2. NONDISCLOSURE: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant who:

    a. Was a Participant at the time of the initial underwriting of this Policy, but whose Known medical conditions were not accurately Disclosed to us at that time by the Policyholder or the Policyholder's Claims Administrator.

    b. Was a Participant at the end of the Policy Term, but whose Known medical conditions were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator prior to the date this Policy is renewed for a subsequent Policy Term.

    c. Becomes a Participant after the Effective Date of this Policy, but whose Known medical conditions were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator before the date the Policyholder acquires another Affiliate, establishes another class of employees eligible for coverage through the Covered Underlying Plan(s).

3. OTHER COVERAGE: The amount of any expenses for benefits to any Participant with coverage under any other plan which, when combined with the benefits payable by such other plan, would cause the total paid by that plan and the Covered Underlying Plan(s) to exceed 100% of the Participant's actual expenses.

4. ADMINISTRATIVE COSTS: Any amount, which is actually Paid by the Policyholder for:

    a. Administrative costs, including but not limited to, administrative costs for claim payments, networks, case management fees in excess of the usual and customary charge, PPO access fees and Prescription Drug administration fees; or

    b. Capitation fees; or

    c. The expense of litigation; or

    d. Extra contractual damages, compensatory damages, or punitive damages.

5. LOST PROVIDER DISCOUNTS: Provider discounts of any kind lost due to untimely payment of claims by the Policyholder or the Policyholder's authorized representative.

Part 4. CLAIMS ADMINISTRATOR

The Policyholder must retain a Claims Administrator at all times. All Claims Administrators must be approved by us. The Claims Administrator performs as the Policyholder's agent and we will not be held liable for any act or omission of the Claims Administrator.

We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

The Claims Administrator will:

1. Supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims in accordance with the terms of the Covered Underlying Plan;

2. Maintain accurate records of all claim payments;

3. Maintain separate records of expenses not covered; and

4. Provide us with the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:

    a. notice of claims that reach 50% of the Specific Deductible; and

    b. number of Covered Units or Covered Family Units;

    c. total amount of claims paid.

5. Secure and keep renewed, at their expense, all licenses, permits, authorizations or certificates of authority in the states where the Claims Administrator conducts the business of insurance in accordance with statutory requirements.

We will not be responsible for any compensation due to the Claims Administrator for functions performed by the Claims Administrator for the Policyholder.

This Policy will not be deemed to make us a party to any agreement between the Policyholder and the Claims Administrator.

For the purpose of any notice required from us under the provisions of this Policy, notice to the Policyholder's Claims Administrator will be considered notice to the Policyholder and notice to the Policyholder will be considered notice to the Policyholder's Claims Administrator.

Part 5. CLAIM PROVISIONS

A. NOTICE OF CLAIM

The Policyholder or the Policyholder's Claims Administrator must notify us within 20 days of the date:

1. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan for a Catastrophic Claim, Large Claim or Shock Loss; or

2. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan that exceed 50% of the Specific Deductible.

Failure to give notice within such time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible. The notice to us must include:

1. The identity of or unique identifier associated with the Participant.

2. A description of the illness or accident and the prognosis.

3. A listing of the Eligible Claims Expenses Incurred by or Known to the Policyholder to date through the Covered Underlying Plan(s).

B. PROOF OF LOSS

The Policyholder or the Policyholder's Claims Administrator must provide satisfactory proof of loss to support a claim within 90 days after the end of the current Policy Term or the end of the Paid period shown in Covered Claims Basis for the current Policy Term, if later. Claims not filed within this time limit will be denied and no benefits will be paid by us.

Upon presentation of satisfactory proof of loss the Policyholder represents that all monies necessary to pay for services and supplies have been paid to the Participant or respective providers of medical services or supplies to which the claim for reimbursement under the Policy relates.

Part 6. MATERIAL CHANGES

We reserve the right to approve any Material Change or Change. The Policyholder or the Policyholder's Claims Administrator must notify us of any Change in writing prior to the effective date of such Change.

Upon receipt of a Material Change we reserve the right to:

1. Accept the Change without revising the Premium Rates and/or other terms and conditions of this Policy; or

2. Accept the Change and revise the Premium Rates and/or other terms and conditions of this Policy; or

3. Not accept the Change and pay benefits under this Policy as if the Change had not occurred.

If we accept the Change we will consider the Change approved on the date of the Change.

Payment of any benefits under this Policy based on a Change is subject to the Policyholder's written acceptance of any necessary adjustment to the premium.

Part 7. TERMINATION AND RENEWAL

A. TERMINATION

This Policy and all coverage under this Policy will terminate 11:59 PM current Eastern Time on the earliest of the following dates:

1. The end of the last period for which premiums were paid.

2. The Premium Due Date next following receipt by us of written notice from the Policyholder that this Policy is to be terminated.

3. The end of any Policy Term, following 30 days prior written notice to the Policyholder of termination.

4. The Premium Due Date following 30 days prior written notice to the Policyholder that we are planning to terminate this Policy because:

   a. there are fewer than 50 Covered Units; or

   b. we have refused to accept a Material Change; or

   c. the Policyholder has refused to accept any necessary adjustment to the premium due to a Material Change; or.

5. The date the Covered Underlying Plan(s) and all coverage under such plan(s) end.

6. The date of cancellation of the administrative agreement between the Policyholder and the Policyholder's Claims Administrator, unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection in writing.

7. On any date mutually agreed to by the Policyholder and us.

If this Policy terminates prior to the end of the current Policy Term, the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and actually Paid by 11:59 PM current Eastern Time up to the date this Policy terminates. However, if this Policy terminates prior to the end of the Policy Term, the Aggregate Benefit, if any, will not be pro-rated and the full Minimum Aggregate Deductible will still apply to Eligible Claims Expenses Incurred and or actually Paid by 11:59 PM current Eastern Time on the date this Policy terminates.

B. RENEWAL

Unless terminated during or prior to the end of current Policy Term, this Policy may be renewed at the end of any Policy Term. At renewal we reserve the right to revise the terms and conditions that apply to the Policy including the rates, Deductibles, and the terms and conditions of this Policy by providing written notice to the Policyholder.

Renewal is subject to:

1. Receipt of any requested Claim Information prior to the beginning of the subsequent Policy Term; and

2. The Policyholder's written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term.

Part 8. PREMIUMS

A. AMOUNT OF PREMIUMS

Premium is calculated based upon the number of Covered Units reported in any given Policy Month. The number of Covered Units for each Policy Month will be determined in accordance with the definition of Covered Unit. The estimated number of Covered Units for the first Policy Month shown in the Specific Benefit Schedule and Aggregate Benefit Schedule is based on the estimated initial enrollment.

B. CHANGES IN PREMIUM RATES

We reserve the right to change any rate or percentage used in determining the monthly premium. The change may occur on one of the following dates:

1. On any Premium Due Date, if the number of Covered Units changes by more than 10% on the Effective Date of this Policy or the number on the date of the last Policy Anniversary, whichever is the later date.

2. Retroactively to the beginning of the Policy Term, if we determine that claim payments are not being made in accordance with the terms and conditions of the Covered Underlying Plan(s).

3. On the date of any Material Change approved by us.

4. The date of an administrative agreement between the Policyholder and a new Claims Administrator is effective provided we have consented to the Policyholder's selection in writing.

5. On any Policy Anniversary.

6. At the end of any Policy Term.

We will give the Policyholder 30 days prior written notice of any change in any rate or percentage used in determining the monthly premium.

C. PAYMENT OF PREMIUMS

All premiums are due on the applicable Premium Due Date. Each premium is payable by the Policyholder on or before the Premium Due Date direct to us at our Home Office. The payment of each premium as it becomes due will maintain this Policy in force through the date immediately preceding the next Premium Due Date.

D. GRACE PERIOD

A Grace Period of 31 days will be allowed for the payment of each premium after the first premium. Should a premium which is otherwise due not be paid during the Grace Period, this Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid at 11:59 PM current Eastern Time, without further notice to the Policyholder. Our liability will be limited to Eligible Claims Expenses that are Paid by the Policyholder prior to 11:59 PM current Eastern Time on last day of the Policy Month for which premiums were last paid.

Part 9. GENERAL PROVISIONS

A. HOLD HARMLESS

1. The Policyholder agrees to hold us harmless from any legal expenses incurred or judgments awarded arising out of any dispute involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), to the extent such legal expenses or judgments were not incurred as a result of our negligence or intentional wrongful acts.

   If we are notified that we have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s) we will give the Policyholder written notice of the dispute within a reasonable time. We will make all probative material available to the Policyholder upon written request from the Policyholder. We will cooperate with the Policyholder in matters pertaining to the dispute. However, such cooperation with the Policyholder will not waive our right to solely defend or settle any such action in any manner we deem prudent.

2. We agree to hold the Policyholder harmless from any legal expenses incurred or judgments(s) awarded arising out of any breach of this Policy by us arising out of our negligence or wrongful acts to the extent such legal expenses or judgments(s) were not incurred as a result of the Policyholder's intentional negligence or intentional wrongful acts.

   If the Policyholder is notified that they have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), the Policyholder will give us written notice of the dispute within a reasonable time. The Policyholder will make all probative material available to us upon our written request. The Policyholder will cooperate with us in matters pertaining to the dispute. However, such cooperation will not waive the Policyholder's right to solely defend or settle any such action in any manner they deem prudent.

B. TAXES

The Policyholder agrees to hold us harmless from any state premium taxes incurred with respect to funds paid to or by the Policyholder through the Covered Underlying Plan(s). If any state premium tax is assessed against us with respect to such funds, the Policyholder must reimburse us for the amount of the state premium tax liability including any interest, penalty and costs incurred by us as a result of the assessment. Taxes incurred with respect to premiums paid for this Policy will be our responsibility.

C. NOTICE OF OBJECTION

Any objection, notice of legal action, or complaint received on a claim processed by the Policyholder or the Policyholder's Claims Administrator and on which it reasonably appears a benefit will be payable to the Policyholder under this Policy, must be brought to the immediate attention of our claims department.

D. POLICY NON-PARTICIPATING

This Policy is non-participating and does not share in our surplus earnings.

E. OFFSET

We have the right to offset any benefits payable to the Policyholder under this Policy against premiums due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for non-payment of premium.

F. REIMBURSEMENT

In the event that the Policyholder recovers from a third party with respect to any Eligible Claims Expenses for which benefits were paid under this Policy, the Policyholder must repay us. The full amount of any and all such funds recovered must be returned to us first before any Deductible under this Policy will be satisfied. No part of any Eligible Claims Expense which is actually Paid by the Policyholder and for which the Policyholder has been reimbursed by a third party may be used to meet any Deductible under this Policy. This provision will survive the termination of this Policy.

G. WAIVER

Our failure to insist upon the Policyholder's or the Policyholder's Claim Administrator's strict compliance with any requirement or condition of this Policy at any time or under any circumstance will not constitute a waiver of any such requirement or condition by us at any time under the same or different circumstances.

H. ARBITRATION

In the event of a dispute between the parties to this Policy as to whether coverage is provided under this Policy for a claim made by or against the Policyholder, both parties may, by mutual consent, agree in writing to arbitration of the disagreement.

If both parties agree to arbitrate, each party will select an arbitrator. The two arbitrators will select a third arbitrator. If they cannot agree within 30 days upon a third arbitrator, both parties must request that selection of a third arbitrator be made by a judge of a court having jurisdiction.

Unless both parties agree otherwise, arbitration will take place in Allegheny County, Pittsburgh, PA.

Local rules of law as to procedure and evidence will apply.

A decision agreed to by any two will be binding. Each party will:

1. Pay the expenses it incurs; and

2. Bear the expenses of the third arbitrator equally.

Part 10. RECORDS AND REPORTS

A. REPORTING

The Policyholder or the Policyholder's Claims Administrator must:

1. Keep appropriate records regarding administration of the Covered Underlying Plans; and

2. Allow us to review and copy, during normal business hours, all records affecting our liability under this Policy; and

3. Submit all proofs, reports, and supporting documents requested by us, including, but not limited to, a monthly summary of all Eligible Claims Expenses which were processed by the Policyholder or the Policyholder's Claims Administrator on a timely basis.

Clerical error, whether by the Policyholder or by us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

B. AUDITS

We reserve the right to inspect and audit all of the Policyholder's and the Policyholder's Claims Administrator's records and procedures that pertain to this Policy prior to or after processing a claim for benefits. We also reserve the right to require proof that payment of Eligible Claims Expenses has been made to the Participant or the provider of the Covered Services that are the basis for any claim by the Policyholder under this Policy.

C. UNDERWRITING INFORMATION

We rely on the underwriting information and Claim Information provided by the Policyholder or the Policyholder's Claims Administrator:

1. To issue this Policy; and

2. To accept a person as a Participant; and

3. To renew this Policy.

Should additional information become Known after one of these events that affect the rates, deductibles, or the terms and conditions of this Policy, we reserve the right to revise the rates, deductibles, and the terms and conditions of this Policy retroactive to the effective date of the current Policy Term by providing written notice to the Policyholder.

Part 11. LIABILITY AND INDEMNIFICATION

A. LIABILITY

We will have neither the right nor the obligation under this Policy to directly pay any Participant or provider of Covered Services for any benefit that the Policyholder has agreed to provide through the terms of the Covered Underlying Plan(s). Our sole liability under this Policy is to the Policyholder.

B. INDEMNIFICATION

To the extent we suffer any liability, loss or expense due to a misstatement or failure to provide any Known or requested information, or failure to provide any additional information requested by us on a Participant or a person for whom we have requested Disclosure or Claim Information, the Policyholder agrees to indemnify us up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

To the extent the Policyholder suffers any liability, loss or expense due to our breach of this Policy or due to our negligence or wrongful acts, we agree to indemnify the Policyholder up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

Part 12. ENTIRE CONTRACT, CHANGES

The entire contract consists of:

1. The pages of this Policy including any amendments, endorsements or riders; and

2. The Application; and

3. Submitted Claim Information; and

4. Disclosure Statements and Disclosure Forms; and

5. Attached documents necessary for the administration of this Policy.

This Policy or the Policyholder's coverage under this Policy may be amended at any time by mutual consent between the parties. No change in this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to this Policy. This approval must be shown on or attached to this Policy. No Agent or Claims Administrator has authority to change this Policy or to waive any of its provisions.

Part 13. INCONTESTABLE CLAUSE

In the absence of fraud, any statement made by the Policyholder is a representation and not a warranty. No statement made by the Policyholder affecting this Policy will be used to deny a claim or to deny the validity of this Policy unless contained in a written instrument signed by the Policyholder and a copy of the written instrument has been given to the Policyholder.

Part 14. LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy until 60 days after written proof of loss has been furnished to us. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

Part 15. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claims Administrator will not impose upon us any liability other than the liability defined in this Policy.

Part 16. ASSIGNMENT

The Policyholder's rights and benefits under this Policy cannot be assigned.

Part 17. DEFINITIONS

AFFILIATE means a company subsidiary to, affiliated with, or controlled by the Policyholder. Eligible Affiliates are shown in the Declaration Page. Additions and terminations may only be made by amendment to coverage under this Policy. Termination of an Affiliate is treated as termination of coverage for that company only.

AGENT means the Policyholder's representative, including but not limited to, the agent, producer or broker of record, or Claims Administrator.

AGGREGATE ATTACHMENT POINT (Corridor) means the percentage of anticipated Aggregate Eligible Claims Expenses which the Policyholder must pay before an Aggregate Benefit becomes payable to the Policyholder. The Aggregate Attachment Point (Corridor) shown in the Aggregate Benefit Schedule, is used to determine the Monthly Aggregate Deductible Amount for the Policy Term.

AGGREGATE BENEFIT means a benefit that is paid when Aggregate Eligible Claims Expenses actually Paid by the Policyholder on all Covered Units in a Policy Term exceed the Annual Aggregate Deductible shown in the Aggregate Benefit Schedule.

AGGREGATE ELIGIBLE CLAIMS EXPENSE means Eligible Claims Expenses that are actually Paid by the Policyholder during the current Policy Term used to calculate the Aggregate Benefit for that Policy Term. The term does not include any eligible Claims Expenses that exceed the Maximum Aggregate Eligible Claim Expense (Per Participant) as shown in the schedule.

AGGREGATE FACTOR means the dollar amount shown in the Aggregate Benefit Schedule.

AGGREGATE PAYABLE PERCENTAGE means the percentage of the Aggregate Benefit, otherwise payable to the Policyholder that will be paid when Aggregate Eligible Claims Expenses, which are actually Paid by the Policyholder in the current Policy Term, exceed the Aggregate Attachment Point (Corridor).

ALTERNATE SPECIFIC DEDUCTIBLE means a separate Specific Deductible, if any, shown in Special Risk Limitations for certain participants identified in the Policy which must be satisfied prior to any Specific Benefit becoming payable with respect to such participants.

ANNUAL AGGREGATE DEDUCTIBLE means the dollar amount of Aggregate Eligible Claims Expenses that must be actually Paid by the Policyholder during any Policy Term for all Covered Units before an Aggregate Benefit becomes payable to the Policyholder.

This amount cannot be finally determined until the end of the current Policy Term; that calculation is based on the formula shown in the Aggregate Benefit Schedule.

APPLICANT means the entity; that has contracted with us to provide Stop Loss coverage.

APPLICATION means the written request of an entity through its duly authorized representative(s) for insurance under this Policy on a form acceptable to us.

CATASTROPHIC CLAIM means any Known claim for a Covered Claim Expense Incurred, or expected to be Incurred by a Participant that may reasonably be assumed will exceed 10% of the Annual Aggregate Deductible in the current or next Policy Term.

CLAIM INFORMATION means to provide Complete Details following a Diligent Review of the data requested by us in connection with the application for, or renewal of, this Policy on any claim incurred, paid or pended 30 days prior to the beginning of any Policy Term or prior to a Material Change, Claim Information includes but is not limited to Catastrophic Claims, Large Claims and Shock Losses.

CLAIMS ADMINISTRATOR means the third party administrator designated by the Policyholder and approved by us. The Claims Administrator is shown in the Declaration Page.

COMPLETE DETAILS means detailed information including, but not limited to the Participant's name and social security number, date of birth, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the Policyholder's or the Policyholder's Claims Administrator's control), and provider name on any Participant covered by, or eligible for coverage, under a Covered Underlying Plan. For purposes of privacy, a unique identifier may be used to identify the Participant in lieu of the person's name, social security number and date of birth.

COVERED CLAIMS BASIS means the time period shown in the Specific Benefit Schedule and the Aggregate Benefit Schedule during which an Eligible Claims Expense must be Incurred and the time period during which an Eligible Claims Expense must be actually Paid by the Policyholder in any Policy Term. The Covered Claim Basis is shown in the Specific Benefit Schedule and the Aggregate Benefit Schedule.

COVERED SERVICE or SERVICES means a service, supply or treatment for which the Participant has incurred an Eligible Claims Expense and for which benefits are payable through the Covered Underlying Plan(s). This does not include any service excluded under Special Risk Limitations.

COVERED UNDERLYING PLAN(S) means the employer's plan of benefits which are identified in this Policy. This does not include any plan excluded under Special Risk Limitations.

COVERED UNIT or COVERED UNIT(S) means a group of one or more Participants composed of one or more of the following types of Covered Units:

1. Composite - the employee, associate or member and all members of his or her family.

The number of Covered Units is used to calculate the premium due each month. The estimated number and type of Covered Units for the first Policy Month of the current Policy Term is shown under Number of Covered Units in the Specific Benefit Schedule and the Aggregate Benefit Schedule.

DEDUCTIBLE(S) means the Specific Deductible, Alternate Specific Deductible, or Aggregate Deductible, as shown in the Specific Benefit Schedule, the Aggregate Benefit Schedule or under Special Risk Limitations.

DILIGENT REVIEW means a complete review by the Policyholder or Policyholder's Claims Administrator of the Covered Underlying Plan prior to the beginning of any Policy Term for Known potential Large Claims. The potential for a Large Claim is Known if prior to the beginning of any Policy Term or prior to a Material Change a reasonable person could assume the Policyholder or the Policyholder's Claims Administrator has actual information about such claim.

DISCLOSURE FORM OR DISCLOSURE STATEMENT means the document signed by the Policyholder following a Diligent Review that provides information, upon which we will rely, in part, to issue the Policy.

DISCLOSURE OR DISCLOSED means to provide Complete Details and any other documentation requested following a Diligent Review including but not limited to census information and Claim Information prior to the beginning of any Policy Term or prior to a Material Change.

EFFECTIVE DATE means the date shown on the cover page of this Policy.

ELIGIBLE CLAIMS EXPENSE means an expense for a Covered Service which is Incurred by a Participant and for which benefits have been actually Paid by the Policyholder in accordance with the terms of the Covered Underlying Plan(s). This term does not include an expense:

1. Not specifically included under the terms of the Covered Underlying Plan; or

2. Excluded under the terms of the Covered Underlying Plan; or

3. Excluded under the terms of this Policy including Excluded Claims Expenses, if any, shown in Special Risk Limitations.

EXCLUDED CLAIMS EXPENSES means expenses which are Incurred by a Participant for services, supplies and treatment for, or related to, the condition, or resulting complications, of an injury or sickness described in Special Risk Limitations.

INCURRED means the date a Participant receives a service, supply or treatment for an Eligible Claims Expense.

KNOWN means information affecting the administration or underwriting of this Policy, which a reasonable person can assume the Policyholder or the Policyholder's Claims Administrator had knowledge of prior to a request for Disclosure or Claim Information.

LARGE CLAIM, SHOCK CLAIM OR SHOCK LOSS means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that the Policyholder or the Policyholder's Claims Administrator reasonably assumes will result in a significant medical expense in the current or next Policy Term.

MATERIAL CHANGE or CHANGE means an action by the Policyholder that may have an economic impact on our liability under this Policy. Material Changes include, but are not limited to, the following:

1 Changes in:

   a. The information Disclosed or submitted by the Policyholder upon which our assessment of risk was based; or

   b. The Covered Underlying Plan(s); or

   c. The Claims Administrator.

2. An increase or decrease of the number of Covered Units by more than 10% from the Effective Date of this Policy or the date of the last Policy Anniversary, whichever is the later date.

3. A merger, acquisition, divestiture or similar transaction involving the Policyholder.

4. A bankruptcy proceeding involving the Policyholder or an Affiliate.

5. Any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of a Participant or a change in law or legislation changes the nature of the risk assumed by us under this Policy.

This term does not include a change in the Covered Underlying Plan required by state or federal law.

MAXIMUM AGGREGATE BENEFIT means the maximum dollar amount we will pay the Policyholder for the Aggregate Benefit in the current Policy Term. The Maximum Aggregate Benefit is shown in the Aggregate Benefit Schedule.

MAXIMUM AGGREGATE ELIGIBLE CLAIMS EXPENSE means the maximum dollar amount of Eligible Claims Expenses that are actually Paid by the Policyholder for a Covered Unit during the current Policy Term which can be used either to satisfy the Annual Aggregate Deductibles or included in the calculation of the Aggregate Benefit for that Policy Term. The Maximum Aggregate Claims Expense is shown in the Aggregate Benefit Schedule.

MAXIMUM SPECIFIC BENEFIT means the maximum dollar amount we will pay the Policyholder per Participant for the Specific Benefit. The Maximum Specific Benefit is shown in the Specific Benefit Schedule.

MINIMUM AGGREGATE DEDUCTIBLE means A times B times C, where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule.

B = The number of Covered Units reported by the Policyholder to the Policyholder's Claims Administrator for the first Policy Month of the current Policy Term.

C= The number of months applicable to the current Policy Term.

Times 100%.

MONTHLY AGGREGATE DEDUCTIBLE AMOUNT means, for each Policy Month in the Policy Term, A times B where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule

B = The number of Covered Units reported by the Policyholder to the Policyholder's Claims Administrator at the start of that Policy Month.

PAID means the date:

1. Eligible Claims Expenses have been adjudicated and approved by the Policyholder or the Policyholder's Claims Administrator; and

2. A check or draft for remuneration has been issued and deposited in the U.S. Mail (or other similar conveyance), or is otherwise delivered to the payee electronically or in person; or a credit transaction has been agreed to by the Policyholder or the Policyholder's Claims Administrator and received by to the payee electronically or in person; and

3. Sufficient funds are on deposit the date the check or draft is issued to permit the check or draft to be honored; or a sufficient line of credit exists to honor the check, draft or transaction.

A claim will not be considered actually Paid until all of these conditions are satisfied. A draft or check returned to the Policyholder or Claims Administrator for any reason, or any credit transaction not honored by the payee for any reason will not be considered actually Paid.

For purposes of this definition, "payee" means a Participant that received the Covered Service or the health care provider that provided the Covered Service to the Participant.

PARTICIPANT or PARTICIPANTS means a person who is an employee, associate or member of the Policyholder or Affiliate, and the dependents of such persons who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

POLICY means this contract between the Policyholder and us with respect to Stop Loss Insurance.

POLICY ANNIVERSARY means each anniversary of the Effective Date of this Policy, unless changed by agreement between the Policyholder and us.

POLICYHOLDER means the entity shown on the cover page of this Policy.

POLICY MONTH means successive intervals of time, while this Policy is in effect, determined on a monthly basis starting on the Effective Date of this Policy. Each new interval will begin on a day that corresponds to the Effective Date of this Policy. If there is no such day in any applicable month, then the last day of the month will be used.

POLICY TERM means the time period shown in the Declaration Page. For purposes of this definition:

1. An initial Policy Term is the period of time from the effective date of the policy to the date of the first Policy Anniversary.

2. A current or renewal Policy Term is the period of time either from the effective date of the Policy, or the date of the last Policy Anniversary, to the date of the next Policy Anniversary.

Each Policy Term after the initial Policy term will begin on the Policy Anniversary. The initial Policy Term will begin on the Effective Date of this Policy.

PREMIUM DUE DATE means the Effective Date of this Policy and the first day of each following Policy Month.

SPECIAL RISK LIMITATION means any modification of the terms or conditions of this Policy.

SPECIFIC BENEFIT means the benefit paid when Eligible Claims Expenses actually Paid by the Policyholder for a Participant in any Policy Term exceed the Specific Deductible.

SPECIFIC DEDUCTIBLE means the dollar amount which must be satisfied prior to any Specific Benefit becoming payable. The Specific Deductible is shown in the Specific Benefit Schedule.

SPECIFIC PAYABLE PERCENTAGE means the percentage of the Specific Benefit, otherwise payable to the Policyholder, that will be paid when Eligible Claims Expenses, which are actually Paid by the Policyholder for a Participant, exceed the Specific Deductible. The Specific Payable Percentage is shown in the Specific Benefit Schedule.

STOP LOSS INSURANCE means the coverage provided under this Policy, which provides benefits to the Policyholder when Eligible Claims Expenses which are actually Paid by the Policyholder through the Covered Underlying Plan(s) exceed the levels defined in this Policy.

UNDERLYING PLAN(S) means the employee benefit plans of the Policyholder which provide the benefits identified in the Specific Benefit Schedule or the Aggregate Benefit Schedule to the Policyholder's or an Affiliate's employees, associates or members and their dependents. This Policy insures the Policyholder for excess losses through the employee benefit plans identified in this Policy as a Covered Underlying Plan. This term does not include any employee benefit plan of the Policyholder that is not identified as a Covered Underlying Plan in this Policy.

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

RENEWAL RIDER

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder.

It is hereby agreed effective January 01, 2013 that Policy 402851-C replaces Policy 402851-B for the Policy term beginning January 01, 2013 and ending December 31, 2013 in its entirety.

All other terms and conditions of the Policy will continue to apply including but not limited to reapplication of the Specific Deductible and Aggregate Deductible in the next Policy Term.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

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SPECIFIC ADVANCE FUNDING RIDER

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed:

The only Covered Expenses eligible for Specific Advance Funding are those that exceed the sum of the Specific Deductible per Participant or the Alternate Specific Deductible shown in the Special Risk Limitations.

Specific Advance Funding is available if all of the following conditions have been met:

1. The Specific Deductible per Participant or the Alternate Specific Deductible per Participant has been met.

2. Claims submitted for an advance must be fully processed by the Claims Administrator and ready for payment according to the terms of the Covered Underlying Plan within the current Policy Term.

3. Each request for an advance must be equal to or greater than $1,000.

4. Claims must be Incurred during the current Policy Term and we must receive the request for an advance no later than 15 days prior to the end of the current Policy Term. Any request received after this period is not eligible for Advance Specific Funding.

5. The Covered Expense for which funds were advanced must be actually Paid within 5 working days after receiving the advance for such expense. We will consider any Covered Expense actually Paid within this time period to have been Paid within the current Policy Term, or at the end of the Paid period for that term, if later, even if such payment occurs after the end of the current Policy Term. If the Policyholder does not pay the Covered Expense within this time period, the advance must be refunded to us within 5 working days.

6. Any funds advanced by us not used to pay a Covered Expense due to any type of discounting must be refunded to us within 5 working days.

7. Premiums must be paid prior to the Premium Due Date. Should a premium which is otherwise due not be paid prior to the end of the Grace Period:

    a. The Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid; and

    b. The Policyholder must reimburse us for the any funds advanced by us within 5 working days.

All other terms and provisions of the Policy will apply.

HM Life Insurance Company

By

President

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BRIDGE RENEWAL RIDER

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed that the Covered Claims Basis in the Specific Benefit Schedule is amended by the addition of:

> If you renew this Policy the Covered Claims Basis for this Policy Term will be revised so that Eligible Claims Expenses include only such expenses Incurred from January 01, 2013 through December 31, 2013 and actually Paid January 1, 2013 through December 31, 2014 .

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

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CANCER CLINICAL TRIAL RIDER

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed that the definition of Eligible Claims Expenses is amended by the addition of:

This term includes the following items and services in connection with an approved cancer clinical trial:

1. Otherwise covered physician fees, laboratory expenses, and expenses associated with a hospitalization; and

2. Evaluation and treatment of the patient associated with the underlying disease; and

3. The cost of care consistent with the usual standards of care whenever a patient receives medical care associated with an approved cancer clinical trial; and

4. Care that would be covered by the Covered Underlying Plan if such items and services were provided other than in connection with an approved cancer clinical trial.

The term does not include the following items and services in connection with a cancer clinical trial:

1. The costs of the investigational drugs or devices themselves; or

2. The costs of any non-health service that might be required for a Participant to receive the treatment or intervention (e.g., transportation, hotel, meals, and other travel expenses); or

3. The costs of managing the research; or

4. Any cost which would not be covered under the Covered Underlying Plan's benefits for non-investigational treatments.

An approved cancer clinical trial must include a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets all of the following requirements:

1. The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been funded, authorized or approved by one of the following:

    a. The National Institutes of Health (NIH) including the National Cancer Institute (NCI); or

    b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption; or

    c. The United States Department of Veterans Affairs (VA); or

    d. Centers for Disease Control and Prevention (CDC); or

2. The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.

3. The available clinical or pre-clinical data indicate that the treatment or intervention provided pursuant to the approved cancer clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of cancer.

4. The facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.

5. The trial consists of a scientific plan of treatment that includes specific goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of the quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval from one of the federal entities identified above.

6. The trial must:

    a. Evaluate a service which is otherwise an Eligible Claims Expense; and

    b. Have a therapeutic intent (i.e., not designed exclusively to test toxicity or disease pathophysiology); and

    c. Enroll diagnosed Participants.

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

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1-800-328-5433

EXTENDED LIABILITY RIDER

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed that the Covered Claims Basis in the Specific Benefit Schedule and the Aggregate Benefit Schedule is amended by the addition of:

If an Eligible Claim Expense is denied by the Policy and that denial is subsequently reversed by an Independent Review Organization (IRO) the Covered Claims Basis for the Policy Term in which such Eligible Claim Expense was denied will include all such Eligible Claim Expenses reversed by an Independent Review Organization (IRO).

Independent Review Organization (IRO) means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act.

If the Policy terminates prior to the end of the current Policy Term:

1. The Covered Claims Basis in the Specific Benefit Schedule and Aggregate Benefit Schedule is limited to Eligible Claims Expenses Incurred and actually Paid by 11:59 PM current Eastern Time up to the date the Policy terminates; and

2. No Deductible of the Policy will be satisfied and no benefit will be paid under the Policy for Eligible Claim Expenses denied prior to the date the Policy terminates that are subsequently reversed by an Independent Review Organization (IRO).

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

POLICY AMENDMENT NO. 1

Attached to and made a part of Policy 402851-C
issued to San Joaquin Valley Insurance Authority as Policyholder.

It is agreed that the Stop Loss Insurance Policy 402851-C issued to San Joaquin Valley Insurance Authority is amended as follows:

1. The Affiliates within Section F of the Declaration Page is amended to read as follows:

F. AFFILIATES

Name	Covered Underlying Plan(s)
County of Fresno	Same as Policyholder's
County of Tulare	Same as Policyholder's
City of Tulare	Same as Policyholder's
City of Ceres	Same as Policyholder's

This amendment is effective January 1, 2013.

HM Life Insurance Company

By

President