GRANULAR LIFE INSURANCE COMPANY

269 East Grand Avenue, South San Francisco, CA 94080
866-984-2067
granularinsurance.com

STOP LOSS INSURANCE POLICY

SCHEDULE OF INSURANCE

In the event of a conflict between this SCHEDULE OF INSURANCE and the Policy, the SCHEDULE OF INSURANCE will control.

Policyholder Number:	2022-186-CA
Policyholder:	SAN JOAQUIN VALLEY INSURANCE AUTHORITY
Principal Address:	2220 Tulare Street, 14th Floor Fresno, CA 93721
Subsidiaries and Associated Entities to be included in the Policy coverage:	County of Fresno, CA 93710 / County of Tulare, CA 93721
Policy Term	January 1, 2023 through December 31, 2023
Claim Administrator(s):	Anthem Insurance Companies, Inc. 21555 Oxnard Blvd Woodland Hills, CA 91367
Cost Containment Vendor:	Sigmatico, LLC 1603 Capitol Ave, Suite 413 Cheyenne, Wyoming 82001
Prescription Benefit Manager:	EmpriRx 2355 South Crenshaw Blvd Torrance, CA 90510
Provider Network(s)	Anthem Insurance Companies, Inc. 21555 Oxnard Blvd Woodland Hills, CA 91367
Referenced Based Pricing Vendor:	None

Covered Units (inititial enrollment):

Employee
Employee & Family

Other groups considered as covered Employees:

Cobra Continuees
Disabled Persons
Retirees
Employees not Actively at Work

STOP LOSS INSURANCE:

A. SPECIFIC COVERAGE SCHEDULE Yes ____X____ No _____

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

1. Incurred and Paid Period (Benefit Basis):

   Eligible Claims Expenses Incurred from 1/1/2023 through 12/31/2023 and paid from 1/1/2023 through 6/30/2024

2. Specific Eligible Claim Expenses Include:

Medical	Yes
Vision	No
Dental	No
Prescription Drug Plan	Yes

3. Specific Attachment Point per Covered Person other than any Covered Persons named below to which a Special Risk Limitation applies:

   Covered Person $450,000 100%

4. Specific Payable Percentage: 100%

5. Maximum Specific Benefit Limits (in excess of the Specific Attachment Point)

   a) Specific Reimbursement Percentage Payable after Specific Attachment Point: 100%
   b) Specific Annual Maximum Reimbursement per Covered Person: Unlimited
   c) Specific Lifetime Maximum Limit per Covered Person: Unlimited
   d) Maximum Limit of Liability: Unlimited

Other Limitations (covered as specified in application):

Disabled / Hospital Confined, Actively at Work, Activity of Daily Living, Out of Hospital

B. AGGREGATE COVERAGE SCHEDULE Yes _____ No ___X___

C. Premium

Premium Due and Payable: the 1st day of each month, subject to Grace Period

Specific Premium Rate per Policy Month per Covered Unit:

Employee	$16.52
Employee & Family	$33.17

The Specific Premium Rate per Policy Month per Covered Unit only apply to the Policy Term shown in this Schedule.

D. Endorsements attached to the Policy:

The following endorsement(s) are included:

Advanced Funding Endorsement

Experience Refund Endorsement

No New Special Risk Limitations Endorsement

Plan Mirroring Endorsement

Renewal Rate Cap Endorsement

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Policy Number: 2022-186-CA

Policy Term January 01, 2023 through December 31, 2023

All insurance begins at 12:00 a.m. and ends at 11:59 p.m. local time at the Policyholder's address as shown in the Schedule of Insurance.

This Policy is governed by the laws of the jurisdiction in which it is issued.
Policy Issued In: California

In consideration of the Application made by the Policyholder (referred to as the Policyholder, You, or Your) and the payment of premiums due in accordance with the terms of this Policy, Granular Life Insurance Company (referred to as the Company, We, Us, or Our) agrees to pay benefits as described herein in accordance with the terms, provisions, and Limitations and Exclusions as explained in this Policy. This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are Paid by the Policyholder through the covered underlying Plan(s), exceed the levels defined in this Policy and the Schedule of Insurance. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

This is a Stop Loss Policy. The Policyholder or Claim Administrator is responsible for making employee benefit Plan determinations. Granular Life Insurance Company has no duty or authority to administer, settle, adjust or provide advice regarding claims filed under Policyholder's Plan. **This Policy insures the Policyholder only and does not provide coverage for any individual insured under the Policyholder's Plan.**

Granular Life Insurance Company has relied upon the information disclosed by the Policyholder in the Application regarding the Policyholder's self-funded employee welfare benefit plan and persons eligible for benefits under that Plan in order to issue this Policy.

This Policy may be renewed for subsequent Policy Terms in accordance with the renewal terms outlined in this Policy. Such renewal may be subject to revisions in the terms and conditions of coverage under this Policy.

THIS POLICY IS A LEGAL CONTRACT.
PLEASE REVIEW YOUR POLICY CAREFULLY.

Signed for Granular Life Insurance Company by

Dennis M. Weinberg, CEO

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SECTION 1 – DEFINITIONS

The definitions of terms apply wherever the terms are used anywhere in this Policy.

Actively at Work means an employee associate or member is employed by the Policyholder, and is capable of performing his regular duties for the full number of hours and at the full rate of compensation as set by the Policyholder's employment practices, either at one of the individual's usual places of business or at some other location to which the Policyholder business requires the individual to travel. Any person who is absent from work due to a regularly scheduled vacation, holiday, or Policyholder approved paid leave of absence will be considered to be Actively at Work.

Alternate Specific Attachment Point means a separate Specific Attachment Point for the Covered Persons identified under Special Risk Limitations in the Schedule of Insurance, which You must retain before any Specific Coverage benefits become payable under this Policy with respect to those Covered Persons.

Aggregate Coverage means the benefit provided by Us to You under this Policy for reimbursement of Eligible Claims Expenses that exceed the Annual Aggregate Attachment Point.

Annual Aggregate Attachment Point means the amount of Eligible Claims Expenses covered under this Policy that are wholly retained by You, before an Aggregate Coverage benefit will be paid to You.

It is the greater of:

1. the sum of Monthly Aggregate Attachment Points for each month of the Policy Term, determined by multiplying the total number of Covered Units by the Monthly Aggregate Factor amounts; or
2. the Minimum Annual Aggregate Attachment Point shown in the Application and Schedule of Insurance.

Benefit Period means the time period as shown in the Schedule of Insurance that identifies the time period during which Eligible Claims Expenses must be Incurred by a Covered Person and Paid by You, as applicable, to be eligible for reimbursement under this Policy. This period does not alter the Policy's effective date or Policy Term, but includes any Run-In or Run-Out Periods shown in the Schedule of Insurance.

Claim Administrator means the firm or person, shown in the Schedule of Insurance, that has entered into a written agreement with You to pay claims for Your Plan. The Claim Administrator acts on Your behalf and as Your agent and not as Our agent.

Cost Containment Vendor means a third party separate from the Claim Administrator contracted by You to reduce or control the cost of services or supplies provided to Covered Persons under the Plan. The Cost Containment Vendor is shown in the Schedule of Insurance.

Covered Person means a person who meets the terms and conditions of eligibility for coverage set forth in Your Plan, who is enrolled, covered, and for whom required premium contributions to the Plan have been made.

Covered Service means any service, supply or treatment for which the Covered Person has Incurred an Eligible Claims Expense during the Benefit Period and for which benefits are payable through the Plan.

Covered Unit means a category of participants under Your Plan as shown in the Schedule of Insurance. Covered Unit will be used for the purposes of determining the premiums payable by You or the Annual Aggregate Attachment Point or the Monthly Aggregate Attachment Point.

Eligible Claims Expense(s) means an expense Incurred for a Covered Service under the terms of the Plan, which You or Your Claim Administrator have Paid for a Covered Person.

This term does not include an expense:

1. Not specifically included under the terms of the Plan;
2. Excluded under the terms of the Plan;
3. Excluded under the terms of this Policy, or shown in Special Risk Limitations;
4. Paid but subsequently recovered by You from any third party; or
5. That exceeds the Maximum Allowable Charge.

Eligible Claims Expenses will also include state health care surcharges incurred by the Policyholder under the Plan.

Eligible Claims Expenses will also include the following fees Incurred and Paid for a Covered Person by the Policyholder with respect to:

1. Hospital bill audits;
2. Access to Provider Networks, excluding access fees paid as a monthly per Covered Person fee;
3. Access to transplant Provider Networks;
4. Negotiation of out-of-network bills;
5. Claims repricing; or
6. Cost Containment Vendors.

You must demonstrate to Our reasonable satisfaction that the services that generated the fees resulted in a cost savings to the Plan and Us. We will consider the actual fees paid by You to be an Eligible Claims Expense, subject to a maximum amount on such fees equal to 25% of cost savings to the Plan.

Experimental or Investigational means medical services, supplies or treatments that meet the Plan's definition of Experimental or Investigational, but only if We have agreed to accept that definition, in writing on or before the first day of the Policy Term..

Family means an employee and the eligible dependents of such person who are covered, or who become eligible for coverage in Your Plan.

Incurred means the date on which services, supplies, or treatment for an Eligible Claims Expense were provided to a Covered Person under Your Plan.

Key Policy Factors means, as applicable, the Specific Premium Rate per Policy month per Covered Unit, the Monthly Aggregate Factors per Covered Unit, and the Specific Attachment Point(s), as shown in the Schedule of Insurance.

Material Change means any amendment or change in Your business that may result in an adverse effect, financial or economic, effect on Our liability or risk under this Policy. A Material Change includes a change to any of the following:

1. The Plan description, eligibility requirements, limitations or exclusions, and any amendments or addendums thereto;
2. The Claim Administrator;
3. The Cost Containment Vendor;
4. The Prescription Benefit Manager;
5. The Provider Network;
6. The Reference Based Pricing Vendor;
7. An increase or decrease in the number of Covered Persons that exceeds 15% of the Covered Units shown in the Schedule of Insurance;
8. Your insolvency, filing for bankruptcy, or inability to pay general obligations or obligations under the Plan;
9. A merger, acquisition, change of ownership, or similar transaction involving You or any of the subsidiaries or associated entities named in the Schedule of Insurance;

Maximum Allowable Charge means charges that meet the definition of Reasonable and Customary under Your Plan, but only if We have agreed to accept that definition in writing on or before the first day of the Policy Term.

Medically Necessary means a medical treatment, service, device, drug, or supply that meets the definition of Medically Necessary under Your Plan, but only if We have agreed to accept that definition in writing on or before the first day of the Policy Term.

Minimum Annual Aggregate Attachment Point means the amount shown in the Schedule of Insurance which is the minimum amount of Eligible Claims Expenses for the Policy Term that You must retain before We reimburse you for any Benefits You Paid under the Plan.

Monthly Aggregate Attachment Point means the Monthly Aggregate Factor multiplied by the number of Covered Units reported by You or Your Claim Administrator at the start of the Policy month.

Monthly Aggregate Factor means the factor shown in the Schedule of Insurance that is multiplied by the number of Covered Units for each Policy month, and used in calculating the Annual Aggregate Attachment Point.

Monthly Expected Claims means the amount of expected claims per month per Covered Unit. The initial Monthly Expected Claims are as shown in the Schedule of Insurance. We will recalculate the Monthly Expected Claims on the effective date of any Material Change.

Paid means the date Eligible Claims Expenses have been processed and approved for payment by the Policyholder or the Policyholder's Claim Administrator in accordance with the Policyholder's or Claim Administrator's standard business practices, and funds have been disbursed by the Policyholder or the Claim Administrator for payment of the claim expenses to a Covered Person or Provider. Disbursement is considered to have occurred when the draft or check is mailed, or the wire or other legal electronic transfer of funds has been issued by You to the payee.

In addition, the account upon which payment is drawn must contain sufficient funds on the date the check, draft, wire, or other electronic transfer is issued to permit the check, draft, wire, or other electronic transfer to be honored by the institution upon which it is drawn in order for an expense to be considered Paid. If for any reason a draft or check is voided or returned, or a wire or electronic transfer is not honored, the expense will not be considered Paid.

Prescription Benefit Manager means a third party seperate from the Claim Administrator contracted by You to administer the prescription drug benefit program under Your Plan. The Prescription Benefit Manager is shown in the Schedule of Insurance.

Plan means a self-funded, written employee welfare benefit plan which the Policyholder provides for Covered Persons and their eligible dependents, and which has been provided to Us prior to issuing this Policy for the purpose of determining Our liability.

Policy means this Stop Loss Insurance Policy issued by the Company to the Policyholder.

Policyholder, You and Your means the Policyholder shown on the face page of this Policy.

Policy Term means the time period shown on the face page of this Policy and the Schedule of Insurance, unless coverage terminates earlier in accordance with the Termination provision of this Policy.

Prescription Drug Plan means either a benefit provision of the Plan or a separate benefit plan maintained by You, under which prescription drug expenses are paid independently of other medical expenses.

Provider means any hospital, physician or other person or facility that is licensed and operating within the scope of that license to provide health care services.

Provider Network means a list of the doctors, other health care Providers, and hospitals that a plan has contracted with to provide medical care to its members.

Reference Based Pricing Vendor means a third party separate from the Claim Administrator contracted by You to administer Your Plan benefit payments using a reference based pricing mechanism.

Specific Annual Maximum Reimbursement means the maximum amount of Eligible Claims Expenses We will apply towards the Specific Coverage for a Covered Person during the Benefit Period. The Specific Annual Maximum Limit is shown in the Schedule of Insurance.

Specific Payable Percentage means the percentage of Eligible Claims Expense We will consider eligible for reimbursement after the application of the Specific Attachment Point subject to any Specific Risk Limitation.

Specific Coverage means benefits provided by Us to You under this Policy for reimbursement of Eligible Claims Expenses that exceed the Specific Attachment Point(s).

Specific Attachment Point means the amount of Eligible Claims Expense which must be Incurred by a Covered Person and Paid under the Plan which is wholly retained by You, and which must be met before benefits are reimbursable under the Specific Coverage of this Policy, as shown on the Schedule of Insurance.

Specific Lifetime Maximum Limit means the maximum amount of Eligible Claims Expense We will apply towards the Specific Coverage benefit for a Covered Person during the Covered Person's lifetime. The Specific Lifetime Maximum Limit is shown in the Schedule of Insurance.

SECTION 2 – INSURANCE COVERAGE

A. Specific Coverage

Subject to all the terms, conditions and limitations of this Policy and any attached endorsements, We will pay You a Specific Coverage benefit as it becomes due for claims for Eligible Claims Expenses in excess of the Specific Attachment Point. All claims are subject to Our Claim Audit provision under Section 8, Claims.

When Benefits Will be Paid.
Upon acceptance of acceptable Proof of Loss as described in Section 8, Claims, and subject to all terms, conditions, and limitations of this Policy, We will reimburse You for Eligible Claims Expenses that are:

1. Incurred while the Plan is in force;
2. Paid on behalf of a Covered Person according to the terms of the Plan; and
3. Incurred and Paid during the Benefit Period shown in the Schedule of Insurance.

Amount of Benefits Payable.
Subject to the Maximum Specific Benefit Limit(s) shown in the Schedule of Insurance, the Specific Coverage benefit payable shall be equal to the product of:

1. The Specific Payable Percentage, multiplied by
2. The Eligible Claims Expenses Paid to or on behalf of a Covered Person under the Plan during the Benefit Period that exceeds the Specific Attachment Point.

To Whom Benefits Will be Paid.
Specific Coverage benefits will be paid directly to You or Your designated representative. We will not make payment to any Covered Person, Provider or anyone other than You or Your designated representative.

B. Aggregate Coverage

Subject to all the terms, conditions and limitations of this Policy and any attached endorsements, We will reimburse You for Eligible Claims Expenses that exceed the Annual Aggregate Attachment Point. All claims are subject to Our Claim Audit.

When Benefits will be Paid.
Upon acceptance of Proof of Loss, and subject to all terms, conditions and limitations of this Policy, We will reimburse You for Eligible Claims Expenses under Aggregate Coverage after the end of the Benefit Period, provided the Annual Aggregate Attachment Point for claims Paid, as described below, is satisfied. Eligible Claims Expenses must be:

1. Incurred while the Plan is in force;
2. Paid on behalf of a Covered Person according to the terms of the Plan; and
3. Incurred and Paid during the Benefit Period shown in the Schedule of Insurance.

Amount of Benefits Payable.
The Aggregate Coverage benefit payable shall be equal to the product of:

1. The Aggregate Payable Percentage, multiplied by
2. The amount of Eligible Claims Expenses, paid by you, less, the Annual Aggregate Attachment Point for the Benefit Period.

The following are not considered Eligible Claims Expenses under Aggregate Coverage and are not eligible for reimbursement:

1. Benefits payable or paid under any Specific Coverage issued to You by Us or any policy issued by another insurer providing the same or similar coverage; or
2. Eligible Claims Expenses in excess of any Specific Attachment Point.

The Aggregate Payable Percentage and Benefit Period is shown in the Schedule of Insurance. In no event will We reimburse You more than the Maximum Aggregate Reimbursement as shown in the Schedule of Insurance.

To Whom Benefits will be Paid.
Aggregate Coverage benefits will be paid directly to You or Your designated representative. We will not make payment to any Covered Person, Provider or anyone other than You or Your designated representative.

SECTION 3 – EXCLUSIONS AND LIMITATIONS

The following are not Eligible Claims Expenses regardless of whether such expenses are paid under the Plan, and are not eligible for reimbursement under this Policy:

1. Any portion of an expense which You are not obligated to pay under the Plan, or which is reimbursable to You pursuant to or because:
   a. Other insurance is liable;
   b. Another group health benefit program is liable;
   c. The Covered Person is covered under, Medicare, the Railroad Retirement Program, or any similar federal, state or local program or statute, or treatments that are provided and covered under the programs listed above ;
   d. Services or supplies for the treatment of an occupational injury or sickness which are paid under any Workers' Compensation, occupational disease law or similar law;
   e. Any coordination of benefits or non-duplication of benefits provision of the Plan; or
   f. The Covered Person was not covered by, or not yet eligible to be covered by, Your Plan.
2. Expenses covered by Plan changes made prior to Our approval of these changes.
3. An amount which is Paid by the Policyholder in excess of the amount a Provider of hospital, surgical or medical services bills a participant for a Covered Service, unless required by a negotiated fee agreement.
4. Preferred Provider Organization (PPO) access fees.

5. Benefits paid under the Plan which are in excess of Maximum Allowable Charges;
6. Benefits paid under the Plan that result from any treatment, service or supply that is not Medically Necessary.
7. Expenses associated with the administration of the Plan including, but not limited to, claim payment fees, premium functions, medical review and consultant fees, any tax liability, interest, or penalty imposed by any regulatory or taxing authority.
8. Expenses paid by You or the Claim Administrator relating to any litigation concerning the Plan, including, but not limited to, attorneys' fees, legal or investigative expenses, expert fees, extra-contractual damages, compensatory damages, and punitive damages.
9. Expenses Incurred by any Covered Person, or expenses Paid by the Plan for a Covered Person who is covered under or eligible to be covered under COBRA:
    a. whose continuation of coverage was not offered in accordance with COBRA regulations or any amendments thereto;
    b. whose coverage under COBRA is continued beyond the timeframes specified by federal law for any reason including clerical error of the Policyholder;
    c. who do not receive a valid COBRA extension offer within the required number of days following the date of notice of a COBRA qualifying event;
    d. who fail to make a valid, signed COBRA election within the required number of days following the receipt of COBRA election rights from the Policyholder; or
    e. who fail to remit COBRA premium within the minimum periods specified by federal law.
10. Benefits paid for expenses for medical services, supplies, or treatment received outside of the United States except in an emergency, and only if otherwise covered by Your Plan.
11. Expenses Incurred for any illness or injury resulting from war or an act of war, whether declared or undeclared.
12. Expenses for injury or complications from an injury sustained by a Covered Person during the commission of a felony or while engaged in an illegal occupation, or participating in a riot or insurrection.
13. Expenses Incurred for Experimental or Investigational medical services, supplies or treatment or hospital confinement that results from Experimental or Investigational treatment.
14. Liabilities, expenses, or losses relating to the violation of any federal or state statute, rule or regulation by You or the Claim Administrator.
15. Expenses that, if reimbursed by Us, would violate any applicable federal law or state statute.
16. Claim payments not administered or paid according to the Plan, or for which there is no documented Proof of Loss.
17. Expenses that are the result of Provider error(s).
18. Expenses that are the result of facility-acquired conditions preventable through the use of evidence-based guidelines, taking into consideration but not limited to Centers for Medicare and Medicaid Services (CMS) guidelines.

We will not reimburse You for any expenses paid by You when a Covered Person is covered by other insurance or health benefit plan which, when combined with the benefits payable by such other insurance or plan, would cause the total paid by that plan and Your Plan to exceed 100% of the Covered Person expenses.

We will not reimburse You for the portion of any expense due to Your or Your Claim Administrator's failure to provide payment to Providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. We will reimburse only for the amount of the discounted amount had timely payment been made by You or Your Claim Administrator.

SECTION 4 – PREMIUM PAYMENT

Payment of Premiums. The premium rate(s) for coverage provided under this Policy is shown in the Schedule of Insurance. The premium due each month is calculated based upon the types of Covered Units shown in the Schedule of Insurance and number of Covered Units reported in the Policy month.

The first premium is due and payable on or before the first day of the Policy Term and subsequent premium payments are due on the first day of each month. The terms of this Policy will not be binding on Us until We receive Your first premium. Subject to the Grace Period, each premium must be paid on or before its due date in order for coverage under this Policy to remain in effect.

Grace Period. A Grace Period of 31 days will be allowed for the payment of each premium due after the first premium has been paid during which grace period the policy shall continue in force, but the Policyholder shall be liable to Us for the payment of any premium accruing for the period this Policy continues in force. If a premium is not paid by the end of the Grace Period, this Policy will automatically terminate as of the last day of the Grace Period. We will deduct the amount of any premium due for the Grace Period from any payment for benefits We may owe You under this Policy.

Reinstatement. In the event that this Policy is terminated due to nonpayment of premium, at Your request We may agree to reinstate this Policy. We may undertake a reassessment of Our liability or risk under this Policy prior to reinstatement. You must make full payment of past due premiums. Past reinstatements create no right or presumption of future reinstatement.

Premium Change. The initial premium rate(s) are stated in the Schedule of Insurance. We may change the premium rate(s) if:

1. You make a Material Change that affects this Policy; or
2. Coverage changes due to the addition or deletion of endorsements to the Policy; or
3. The coverage provided under this Policy is changed from what was initially issued based on the Application for coverage.

Premium Adjustments. Adjustments in premium due to enrollment changes should specify the adjustment for each Covered Unit by coverage type and the Policy month for which the adjustment applies, and include the corresponding premium adjustment. Any retrospective request by the Policyholder for a premium adjustment due to a misstatement of Covered Units must be made within 90 days following the end of the Policy Term. Such requests must be in writing and accompanied by evidence that an adjustment should be made.

Premium Data. You must provide Us with a premium data report with each premium payment, in a form agreed to by Us, that shows:

1. The number(s) of participants in the Plan on the first day of each month, segregated by premium rate category shown in the Schedule of Insurance; and
2. An adjustment of premium for the prior month, calculated by multiplying the previous month's actual number of participants by the appropriate premium rate(s); and
3. The amount of premium payment.

We use premium data reports solely to process premium. Such premium data reports do not replace any reports required, or which may be required, under the Policyholder Reporting provision of this Policy.

SECTION 5 – EFFECTIVE DATE AND TERMINATION

Policy Effective Date:

This Policy takes effect on the date shown in the Policy Term on the face page of this Policy and the Schedule of Insurance.

Coverage under this Policy is not effective until:

1. Your payment of the first premium;
2. Our receipt of a completed and signed Application;
3. Our receipt, examination, and acceptance of the Plan and any other required information that We requested, which is material to underwriting or premium rating.

Policy Termination:

Termination by Policyholder. You may terminate this Policy by giving Us at least 31 days advance written notice.

Automatic Termination. This Policy will automatically terminate without notice on:

1. The last day of the Grace Period if you fail to pay the required premium by the end of the Grace Period; or
2. The last day of the Policy Term.

Termination by the Company. This Policy will terminate on the earliest of the following circumstances:

1. The date We notify You that We are terminating the Policy due to a Material Change.
2. The date You have refused to accept any necessary adjustment to the premium or other terms and conditions of the Policy due to a Material Change, in accordance with that provision.
3. The date the Plan terminates.
4. You or the Claim Administrator fail to satisfy any of Your or the Claim Administrator's obligations under this Policy. We will give You 60 days advance notice of termination.
5. The date You file for bankruptcy, or become subject to liquidation, receivership or conservatorship.
6. The date the contractual agreement between You and the Claim Administrator terminates unless We have agreed in writing to a new Claim Administrator.
7. The date mutually agreed to by the Policyholder and the Company.

Termination will not affect a claim for reimbursement of Eligible Claims Expenses Incurred and Paid while coverage was in effect. We will not refund any portion of the premium paid by You if this Policy is terminated prior to the last day of the Policy Term.

If this Policy is terminated prior to the last day of the Policy Term, the Policy Term will be shortened to reflect the revised termination date of the Policy. The Benefit Period, as shown in the Schedule of Insurance will also be reduced as necessary to match the shortened Policy Term.

Renewal. Unless this Policy is terminated during or prior to the end of the Policy Term, You may request and We may agree to renew this Policy upon Your request.

Renewal is subject to Your completion of a renewal Application and Our receipt of any requested claim information prior to the beginning of the subsequent Policy Term, as well as Your written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term. We reserve the right to revise the terms and conditions, including Key Policy Factors, that apply to the renewal Policy.

SECTION 6 – MATERIAL CHANGES

Material Change. You must give Us written notice within 31 days of any Material Change which may have a material financial or economic adverse effect on Our liability under this Policy. Failure to provide such notice may result in termination of this Policy or denial of Specific Coverage benefits. Notice must be provided to Our address shown in this Policy.

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

1. Accept the Material Change and recalculate Key Policy Factors as shown in the Schedule of Insurance and/or other terms and conditions of this Policy.
2. Not accept the Material Change and terminate this Policy.
3. Not accept the Material Change and pay benefits under this Policy as if the Material Change had not occurred.
4. Accept the Material Change without revising the Premium Rates and/or other terms and conditions of this Policy

If We accept the Material Change, We will consider the Material Change approved on the date of Our acceptance of the Material Change. You must provide written acceptance of any necessary adjustment to the premium or provisions of this Policy.

Plan Amendments. You must give Us written notice of any amendment to the Plan at least 31 days prior to the effective date of the amendment. If the amendment changes the benefits under the Plan, the Key Policy Factors will be recalculated. Any revision(s) to Your Key Policy Factors due to an amendment of Plan will become effective on the effective date of the amendment. If We receive a written notice of an amendment to the Plan after the effective date of such amendment, We will advise if benefits are payable based on Your Key Policy Factors calculated (1) without the amendment, or (2) with the amendment.

SECTION 7 – POLICYHOLDER REPORTING

Reporting Requirements. You are required to provide periodic reports on Eligible Claims Expenses and enrollment information for Covered Persons in the Plan to Us as described below.

High Dollar Reporting Threshold. For Specific Coverage benefit reporting, You or the Claim Administrator must give notice to Us when the total amount of Eligible Claims Expenses Incurred for a Covered Person equals or exceeds the High Dollar Reporting Threshold of $225,000 per Covered Person or has the potential to exceed that amount. Your failure to provide notice within 15 days may result in an adjustment of any Specific Coverage benefits payable to You to reflect any savings We could have obtained had notice been given within the time frame specified.

You or the Claim Administrator are required to provide Us with notice of any claim that exceeds the High Dollar Reporting Threshold within 15 days of the earlier of the date:

1. A Covered Person's Eligible Incurred Expenses exceed High Dollar Reporting Threshold; or
2. You or the Claim Administrator or Your medical management, utilization review, Prescription Benefit Manager, precertification vendors, or any other party acting on Your behalf, are notified that a Covered Person has been diagnosed with, or treated for, a condition which, if Paid, may result in an Eligible Claims Expense under this Policy that would equal or exceed the High Dollar Reporting Threshold.

On a monthly basis, You or the Claim Administrator and the Prescription Benefit Manager are required to provide Us with a detailed claims report in an electronic format prescribed by Us that shows, for each Covered Person who meets or exceeds the High Dollar Reporting Threshold:

1. Proof of payment of any expenses submitted to Us for reimbursement; and
2. Information used to determine how the claim was paid by You or the Claim Administrator and the Prescription Benefit Manager.

You shall provide any additional information We may require to fulfill Our obligations under this Policy.

In addition, on a monthly basis, You or the Claim Administrator and the Prescription Benefit Manager are required to provide Us with the following:

1. A report including detailed demographic information for all Covered Persons in the Plan as listed for the Classes identified in the Schedule of Insurance.
2. Aggregate stop loss summary reports, including the total amount of Eligible Claims Expenses for all Covered Person Incurred within the Benefit Period, and Paid by You or on Your behalf during that month.

SECTION 8 – CLAIMS

Claim Audit. The Policyholder or the Policyholder's Claim Administrator shall keep appropriate records regarding administration of the Plan. We may periodically examine any of Your or the Claim Administrator's records relating to the benefits under this Policy and any claims filed under the Plan. You shall allow Us reasonable access to review and copy all records affecting Our Liability under this Policy. We have the right to audit all claims with respect to Eligible Claims Expenses Paid under the Plan, in the event of a claim for benefits. You and the Claim Administrator shall maintain books and records related to this Policy for a period of no less than the later of 6 years or the term permitted by the state of jurisdiction, after the Policy expires or is terminated according to the provisions of this Policy. This clause shall survive the termination of this Policy, provided there are outstanding liabilities under this Policy.

Notice of Claim. Except for claims exceeding the High Dollar Reporting Threshold, which are subject to the notice requirements in Section 7, Policyholder Reporting, You will submit to Us written notice of claims within 30 days of loss or as soon as reasonably possible. Failure to furnish written notice will not invalidate or reduce any claim, if it was not reasonably possible to provide such written notice within the time period required.

Proof of Loss. You or the Claim Administrator must request payment and provide complete and accurate Proof of Loss, in form and content acceptable to Us, to support a claim no later than within 90 days after the end of the Benefit Period. You shall provide any additional information We may require to fulfill Our obligations under this Policy. Claims not filed within this time limit may be denied and result in no benefits being paid by Us. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Offset. Any payment or overpayment of a claim made to the Policyholder in error or due to the receipt of incorrect information must be promptly refunded to the Company upon notice to the Policyholder of the error or overpayment. We may offset any claims payable to You under this Policy or any previous Stop Loss Insurance Policy with Us, against premiums due and unpaid by You. This right will not prevent the termination of this Policy for non-payment of premium under the Automatic Termination provision in Section 5, Effective Date and Termination.

Payment of Claims. All benefits payable under this Policy will be made to You or Your designated representative and to no one else. In no event will We be liable for any claims which are not Incurred or Paid by the Policyholder within the Benefit Period indicated in the Schedule of Insurance. Eligible claims shall be paid immediately upon receipt of due written proof of such loss.

Responsibility for Claims under Your Plan. While the determination of benefits under the Plan is Your sole responsibility, We will interpret the terms and conditions of the Plan as it applies to this Policy. We have the authority to approve or deny reimbursements under this Policy.

SECTION 9 – CLAIM ADMINISTRATOR RESPONSIBILITIES

Claim Administrator Responsibilities. The Claim Administrator acts on Your behalf and as Your agent. We shall have no liability for any act or omission by the Claim Administrator. We agree to recognize the Claim Administrator as an agent of the Policyholder. By doing so we do not waive any rights under this Policy.

The Claim Administrator shall:

1. Investigate, audit, calculate, and pay claims in accordance with the Plan, and maintain an accurate record of all claims processed, including expenses not covered under the Plan;
2. Keep and make available to the Company any information possessed by the Claim Administrator to assist the Company in underwriting or administering this Policy, make payments under this Policy, and project future expected claims under the Plan; and
3. Submit a monthly report in an electronic format acceptable to Us, that meets the Reporting Requirements under Section 7, Policyholder Reporting, showing a detailing listing of Paid claims and enrollment numbers detailed by coverage type.

You are solely responsible for the actions of the Claim Administrator and any other agent acting on Your behalf. The Claim Administrator is not Our agent, and does not act on Our behalf. We are not responsible for any compensation owed to, or claims by, the Claim Administrator or other agents for services provided to, or on behalf of, You or the Plan. This Policy does not make Us a party to any agreement between You and the Claim Administrator, nor does it make the Claim Administrator a party to this Policy.

Claim Administrator Changes. You must give Us written notice of any replacement of a Claim Administrator listed in this Policy at least 31 days prior to the effective date of the replacement. If We do not receive such notice from You prior to the effective date of the replacement, We will have the right to terminate this Policy in accordance with the Termination by the Company provision in Section 5, Effective Date and Termination.

SECTION 10 – GENERAL PROVISIONS

Arbitration. Any controversy or dispute involving Us that arises out of or relates to this Policy, shall be decided by arbitration at a mutually agreed time and place, under the rules of the American Arbitration Association. The Policyholder and the Company will each appoint one member of the arbitration panel. The third will be selected by the first two members or by the American Arbitration Association if the two parties cannot agree on the third arbitrator. A majority vote of the panel will decide the dispute and there will be no right of appeal. Any decision of the arbitration panel shall be binding and fully enforceable as if rendered in Court of competent jurisdiction. Each party shall pay its own expenses, including attorney fees, witnesses, experts, and proofs. The parties will share the cost of the arbitration proceedings. This provision shall survive the termination of this Policy.

Assignment. This Policy and amounts payable shall not be sold, assigned, or transferred by You without Our prior written consent.

Clerical Error. Clerical error, whether by You or by Us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. However, upon discovery of such error, an equitable adjustment of premium or benefits will be made. In the event that claims data and/or enrollment information furnished to Us was missing or incorrect, We may recalculate the Key Policy Factors as shown in the Schedule of Insurance using the corrected information.

Conformity with State Statutes. Any provision of this Policy which, on the effective date of this Policy, conflicts with any law of the state where this Policy is issued, shall be deemed to be automatically amended to conform to the minimum requirements of such law.

Entire Contract. The entire contract between You and Us consists of:

1. The Policy including the Schedule of Insurance; and
2. Your Application (a copy of which is attached to this Policy); and
3. Any endorsements included with and made part of this Policy.

In the absence of fraud, all statements made by You shall be deemed representations and not warranties. No such statement shall be used in defense of a claim under this Policy unless it is contained in the written Application and is signed by You and is attached to this Policy.

Indemnification. You agree to indemnify, defend and hold Us harmless from any liability, damages of any kind, interest, penalties, or expenses (including without limitation, attorney fees) arising from, relating to or concerning in any way whatsoever, any dispute or legal action by or involving a Covered Person or a Provider.

Independent Review Organization Extended Benefit. If previously denied Eligible Claims Expenses for a Covered Person are Paid due to a reversal by an independent review organization, and such expenses are then Paid after the Benefit Period, the Benefit Period to pay such expenses will be extended for a period not to exceed 12 months, and such expenses will be excluded from any other benefit period in a subsequent policy. We will consider the date the claim was originally denied as the “Paid” date under this Policy, provided:

1. Such expenses are not eligible for payment under any other policy or group health benefit program; and
2. Such expenses are otherwise payable under the terms of this Policy.

If You terminate this Policy for any reason prior to the last day of the Policy Term shown on the face page of this Policy, this provision will not apply.

Legal Action. Legal action may not be taken to recover on this Policy until 60 days after the date Proof of Loss has been furnished in accordance with the terms of this Policy. Legal action must be taken within 3 years after the time Proof of Loss is required to be furnished.

Misrepresentation/Misstated Data. We have relied upon underwriting information provided by You or the Claim Administrator If:

1. You make any material misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation that You, the Claim Administrator or any other party acting on Your behalf provide to Us, and which We rely upon during the underwriting of this Policy; or
2. After this Policy is issued, We learn of any expense or claim that was Incurred or Paid, but not reported to Us during the underwriting of this Policy,

We may deny a claim, rescind this Policy or revise the Key Policy Factors and terms, conditions and limitations of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten. Any such revisions may be made retroactive to the effective date of this Policy. This Policy will be incontestable after 2 years from the Policy Effective Date, except for fraudulent misstatements. No statements made by the Policyholder shall be used to void this Policy or deny a claim for loss after it has been in force for 2 years from the Policy Effective Date unless the statement is contained in a written statement signed by the Policyholder.

Non-Participating. This Policy does not pay a dividend and You shall not be entitled to share in Our surplus earnings.

Parties to the Contract. The Policyholder and the Company are the only parties to this Policy. The Company's sole liability under this Policy is to the Policyholder. We will neither have the right or obligation under this Policy to directly pay any Covered Person participant or Provider of Covered Services for any benefit that You have agreed to provide through the terms of the Plan. This Policy does not create any right or legal relationship between the Company and any Covered Person under the Plan. This Policy will not make Us a party to the Plan, or any contract or agreement between the Policyholder and a third party. The Company's obligations under this Policy are limited to the terms, conditions and limitations herein. We are not a plan administrator or a fiduciary with respect to the Plan as those terms are used in the Employee Retirement Income Security Act of 1974, as amended.

Policy Amendments/Changes. No change in this Policy is valid unless it is in writing, approved and signed by one of Our executive officers, and endorsed on or attached to this Policy. Agents or brokers do not have the right to change this Policy, waive any of its provisions, or bind Us in any way.

Reimbursement. Your rights under the Plan to recover sums Paid during the Benefit Period on behalf of a Covered Person are assigned by You to Us to the extent We reimbursed such sums under this Policy. You agree to promptly recover such sums on Our behalf, at Your cost, by initiating legal action or other effective means. Within 10 days of initiating any action or other means for recovery, You shall notify Us, and We shall have the right to intervene in any suit or other proceeding to protect Our reimbursement rights. We shall be entitled to receive full reimbursement of expenses We paid under this Policy.

Any portion of an Eligible Claims Expense which You recover from a third party:

1. Is not eligible for reimbursement under this Policy; and
2. Cannot be used to satisfy any Attachment Point under this Policy; and
3. Must be repaid to Us if We previously reimbursed You for it.

Any repayment amount You owe Us may be reduced, with Our consent, by any reasonable and necessary expenses You incurred in obtaining the recovery from the third party. Any repayment

amount You owe to Us shall survive the termination of this Policy.

State Assessment Loads. State and Federal laws may assess stop loss insurance carriers based on the number of that state's residents who are covered under stop loss policies. We may increase or adjust the premium rate(s) to cover expected , or retrospective, or incurred state assessment costs.

State Health Care Surcharges. If You pay a state health care surcharge in connection with the payment of Eligible Claims Expenses, the health care surcharge shall be included as an Eligible Claims Expense. Penalties or fines of any kind, including but not limited to, penalties or fines associated with the failure to pay or late payment of any health care surcharge or the underlying expenses will not be considered Eligible Claims Expenses.

Your Bankruptcy or Insolvency. Eligible Claims Expenses will not be affected by Your bankruptcy or insolvency. In the event of Your bankruptcy or insolvency, subject to the terms, conditions, and limitations of this Policy, We may pay to Your receiver, trustee, liquidator, or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have paid all required premiums and have Paid all Eligible Claims Expenses under the Plan, and have complied with all Your obligations under this Policy. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claim Administrator will not impose upon Us any liability other than the liability defined in this Policy.

U.S. Economic and Trade Sanctions. Should any coverage provided by this Policy be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

GRANULAR LIFE INSURANCE COMPANY

269 East Grand Avenue, South San Francisco, CA 94080
866-984-2067
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Advanced Funding Endorsement

Endorsement Number: 2022-ADF-186
Policyholder: SAN JOAQUIN VALLEY INSURANCE AUTHORITY
Attached to and part of Policy Number: 2022-186-CA as of the Effective Date below.
Effective Date: January 1, 2023

This Endorsement is made part of the Stop Loss Insurance Policy identified above. It modifies the insurance provided under the Policy.

In consideration of the payment of any additional premium as required, it is hereby understood and agreed that the following changes are made and incorporated into the Policy:

The Company agrees to provide the Policyholder with Advanced Funding according to the conditions established in this Endorsement.

SECTION 1 - DEFINITIONS is amended to include the following for the purpose of this endorsement only:

Advanced Funding means the process by which the Company issues funds to the Policyholder for a Loss Incurred for a Covered Person during a Policy Term after:

1. The Policyholder has Paid an amount equal to the Specific Attachment Point for a Covered Person during a Policy Term (including any Aggregating Specific Deductible or other additional Policyholder liability under the Policy), and
2. The Policyholder has Incurred a Loss greater than $10,000 over the Specific Attachment Point which has not been Paid.

Loss means an expense for a Covered Service under the terms of the Policyholder's Plan, which has not yet been Paid under the Plan.

SECTION 2 – INSURANCE COVERAGE is amended to include Advanced Funding coverage.

To request Advanced Funding, the Policyholder must provide the Company with satisfactory Proof of Loss and any information requested by the Company to determine the Company's liability for the Loss.

The claim for the Loss must be fully processed by the Policy or Claim Administrator and be ready for payment under the Plan within the Benefit Period during which the claim was Incurred. The claim for which Advanced Funding was requested must be Paid by the Policyholder within 10 business days of receipt of Advanced Funding from the Company. If such payment is not made by the Policyholder within 10 days, the Policyholder shall immediately refund to the Company the advanced funds and the Company may revoke Advanced Funding privileges.

It is the Policyholder's responsibility to request and apply Advanced Funding in a manner consistent with all current Plan and Policy provisions. No provision herein shall be deemed to alter the requirements contained in the Policy that Eligible Claims Eligible be Paid by the Policyholder within the Policy Term and Benefit Period.

It is the Policyholder's sole responsibility to request and apply Advanced Funding in a manner that will secure discounted fees for services or supplies. Failure to provide payment to Providers in their required

time frame that results in non-receipt of any discounted fees for services or supplies will not increase the Company's liability.

Any claims approved for Advanced Funding by the Company will be considered reimbursed by the Company and will not be further eligible for reimbursement at time of payment under the Policy.

Advanced Funding is only available while the Policy is in force.

Advanced Funding is not available during the last 30 days of the Benefit Period. The Company must receive the request for Advanced Funding and satisfactory Proof of Loss, including any other information to determine the Company's liability for the claim, no later than the 30th day prior to the end of the Benefit Period.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Signed for GRANULAR LIFE INSURANCE COMPANY by

Dennis M. Weinberg, CEO

GRANULAR LIFE INSURANCE COMPANY

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Experience Refund Endorsement

Endorsement Number: 2022-EXR-186
Policyholder: SAN JOAQUIN VALLEY INSURANCE AUTHORITY
Attached to and part of Policy Number: 2022-186-CA as of the Effective Date below.
Effective Date: January 1, 2023

This Endorsement is made part of the Stop Loss Insurance Policy identified above. It modifies the insurance provided under the Policy.

In consideration of the payment of any additional premium as required, it is hereby understood and agreed that the following changes are made and incorporated into the Policy:

SECTION 1 - DEFINITIONS is amended to include the following:

Losses means the total amount reimbursed by Us under the Policy for the term indicated in this Experience Refund Endorsement. Losses will include any Eligible Claim Expense that was reimbursed under this Policy and loss reserves established by Us for the Policy period.

Deficit Carry Forward means the amount by which Losses exceeded 73% of gross premium paid by You for the most recent twelve-month Policy Term(s) immediately preceding this Policy Term provided that We were the insurer.

SECTION 2 – INSURANCE COVERAGE is amended to include Experience Refund coverage:

We will refund to You between January 1, 2023 and December 31, 2023 a portion of the net profit from the Policy period if the following conditions are satisfied:

1. The gross premium due and paid for the Policy year is not less than $1,000,000;
2. The Policy is renewed for a subsequent Policy year by Us; and
3. The results of the refund calculation are in a positive balance. If the refund calculation results in a negative balance, no refund will be paid.

The amount of the refund will be 30% of the result of the following calculation:

1. 73% of gross premium due and paid by You for the Policy year shown above,
2. Minus 100% of the Losses for the Policy year, minus the amount of the Deficit Carry Forward.

The calculation of the Experience Refund will be completed on the later of 12 months after the end of the Policy year shown above, or the date when the Losses for that Policy year are finally determined and the Policyholder and the Company have agreed to settle and commute their interests and liabilities under the Policy.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Signed for GRANULAR LIFE INSURANCE COMPANY by

Dennis M. Weinberg, CEO

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No New Special Risk Limitations at Renewal Endorsement

Endorsement Number: 2022-NNL-186
Policyholder: SAN JOAQUIN VALLEY INSURANCE AUTHORITY
Attached to and part of Policy Number: 2022-186-CA as of the Effective Date below.
Effective Date: January 1, 2023

This Endorsement is made part of the Stop Loss Insurance Policy identified above. It modifies the insurance provided under the Policy.

In consideration of the payment of any additional premium as required, it is hereby understood and agreed that the following changes are made and incorporated into the Policy's Schedule of Insurance upon the next renewal:

We will not establish any new Special Risk Limitations unless requested in writing by You. Upon renewal, existing Special Risk Limitations will remain as shown in the current Schedule of Insurance, provided that:

1. Your Plan contains no changes that would materially affect or alter the risk assumed by Us under the existing Policy;
2. Your renewal policy contains no material changes from the existing Policy;
3. There are no material changes between the demographic distribution of the group covered under Your existing Policy and the group to be covered under the renewal policy; and
4. No new unit, division, subsidiary, affiliated company or class of Covered Persons or Dependents is added to this Policy.

We may change or modify this Endorsement should You amend or change Your Plan in any way that materially affects Our risk or liability with regards to the Policy or this Endorsement, or if Your renewal policy contains any of the material changes described above.

This Endorsement is subject to termination by the Company upon any Material Change to the Policy as described in Section 5, Effective Date and Termination in the Policy.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Signed for GRANULAR LIFE INSURANCE COMPANY by

Dennis M. Weinberg, CEO

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Plan Mirroring Endorsement

Endorsement Number: 2022-PLM-186
Policyholder: SAN JOAQUIN VALLEY INSURANCE AUTHORITY
Attached to and part of Policy Number: 2022-186-CA as of the Effective Date below.
Effective Date: January 1, 2023

This Endorsement is made part of the Stop Loss Insurance Policy identified above. It modifies the insurance provided under the Policy.

In consideration of the payment of any additional premium as required, it is hereby understood and agreed that the following changes are made and incorporated into the Policy:

SECTION 1 - DEFINITIONS is hereby amended as follows:

Eligible Claims Expense(s) is amended to delete "5. That exceeds the Maximum Allowable Charge" from the list of items that do not meet the definition of an expense under the terms of the Plan.

Experimental or Investigational means medical services, supplies or treatments that meet the definition of Experimental or Investigational or similar definition under Your Plan.

Maximum Allowable Charge means charges that meet the definition of Reasonable and Customary or similar definition under Your Plan.

Medically Necessary means a medical treatment, service, device, drug, or supply that meets the definition of Medically Necessary or similar definition under Your Plan.

SECTION 2 – INSURANCE COVERAGE is amended to include the following provision:

Subject to all terms, conditions and limitations of this Policy, and upon Our acceptance of Proof of Loss, We will reimburse You for Eligible Claims Expenses that are:

1. Paid according to the terms of Your Plan; and
2. Incurred and Paid during the Benefit Period of Your Policy.

Your voluntary determination to make a payment for or assumption of liability of a claim expense that falls outside the parameters of Your Plan documentation does not cause such claims to be Eligible Claims Expenses under the Policy, and does not assign any responsibility to Us to reimburse You for such payments.

Upon receipt of Your request, We may consider reimbursement for claim payments outside the parameters of Your Plan documentation, including but not limited to gene and cell therapy or specialty pharmaceuticals.

For the purposes of identifying Plan benefits that are eligible for reimbursement, all conflicts between the Policy and Your Plan, if any, shall be resolved in accordance with the terms and conditions of the Plan. All remaining terms and conditions in the Policy shall remain in full force and effect.

SECTION 3 – EXCLUSIONS AND LIMITATIONS, is amended to delete the following items identified in the Policy as not qualifying as an Eligible Claims Expense and not reimbursable under the Policy:

5. Benefits paid under the Plan which are in excess of Maximum Allowable Charges.
6. Benefits paid under the Plan that result from any treatment, service or supply that is not Medically Necessary.
10. Benefits paid for expenses for medical services, supplies, or treatment received outside of the United States except in an emergency, and only if otherwise covered by Your Plan
11. Expenses Incurred for any illness or injury resulting from war or an act of war, whether declared or undeclared.
12. Expenses for injury or complications from an injury sustained by a Covered Person during the commission of a felony or while engaged in an illegal act, or participating in a riot or insurrection.
13. Expenses Incurred for Experimental or Investigational medical services, supplies or treatment or hospital confinement that results from Experimental or Investigational treatment.
17. Expenses that are the result of Provider error(s).
18. Expenses that are the result of facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to Centers for Medicare and Medicaid Services (CMS) guidelines.

We will not reimburse You for the portion of any expense due to Your or Your Claim Administrator's failure to provide payment to Providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. We will reimburse only for the amount of the discounted amount had timely payment been made by You or Your Claim Administrator.

SECTION 5 – EFFECTIVE DATE AND TERMINATION is amended to add:

We reserve the right to withdraw this Endorsement immediately upon written notice to You if:

1. You fail to provide to Us a copy of your current Plan within 30 days of the Effective Date of this policy;
2. You amend or edit Your Plan to the extent that materially affects Our risk under this Endorsement; or
3. You submit to Us any stop loss reimbursement claim where a benefit was paid reliant upon the use of a discretionary clause or similar provision contained in Your Plan; or
4. You submit to Us any stop loss reimbursement claim where benefits were paid using the terms and conditions of any document other than Your Plan, such as an employee handbook, that has not already been provided for Us to review, or upon the guidance or advice of any third party.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Signed for GRANULAR LIFE INSURANCE COMPANY by

Dennis M. Weinberg, CEO

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Renewal Rate Cap Endorsement

Endorsement Number: 2022-RRC-186
Policyholder: SAN JOAQUIN VALLEY INSURANCE AUTHORITY
Attached to and part of Policy Number: 2022-186-CA as of the Effective Date below.
Effective Date: January 1, 2023

This Endorsement is made part of the Stop Loss Insurance Policy identified above. It modifies the insurance provided under the Policy.

In consideration of the payment of any additional premium as required, it is hereby understood and agreed that the following coverage is provided under the Policy:

If the Stop Loss Policy is renewed, the Company guarantees that the Specific Premium Rate per Policy Month per Covered Unit and the Aggregating Specific Deductible will not be increased more than 40% over the Specific Premium Rate per Policy Month per Covered Unit and Aggregating Specific Deductible shown on the Stop Loss Application and Schedule of Insurance, provided that:

1. The Policyholder's Plan contains no changes that materially alter the risk under the current Stop Loss Policy issued by the Company;
2. The renewal Stop Loss Policy contains no Material Changes from the current Policy including, but not limited to, changes to:
   a. The Policy Term;
   b. Eligible Claims Expenses;
   c. Coverage for retirees;
   d. Annual Aggregate Attachment Point, the Specific Attachment Point Class or the Specific Attachment Percentage, or Aggregating Specific Deductible in the Schedule of Insurance;
   e. The Specific Payable Percentage or Aggregate Payable Percentage in the Schedule of Insurance;
   f. The commission payable;
   g. Any designated Claim Administrator, Cost Containment Vendor, or Prescription Benefit Manager;
   h. Any Provider Network or Referenced Based Pricing Vendor;
   i. The Maximum Specific Benefit Limits in the Schedule of Insurance; or
   j. The demographic distribution of the Covered Persons covered under the current Stop Loss Policy and the group covered under the renewal Stop Loss Policy.
3. No new unit, division, subsidiary, affiliated company or class of Covered Persons or member of a Covered Unit is added to this Stop Loss Policy; and
4. There is no change in any assessment or tax levied against Us by the state in which this Stop Loss Policy was delivered.

The Company guarantees the limit shown above for the Specific Premium Rate per Policy Month per Covered Unit and the Aggregating Specific Deductible shall be maintained for each Policy renewal for a period of 1-5 years from the end of the Policy Term.

Any Material Change that occurs during the Policy Term will result in an adjustment to the Renewal Rate Cap described herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Signed for GRANULAR LIFE INSURANCE COMPANY by

Dennis M. Weinberg, CEO

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STOP LOSS INSURANCE POLICY

APPLICATION

☐ NEW BUSINESS ■ RENEWAL

The undersigned Applicant requests Stop Loss Insurance provided by GRANULAR LIFE INSURANCE COMPANY ("Company"). If this Application is accepted and approved by the Company, the Applicant agrees to be bound by the terms and conditions of the Stop Loss Insurance Policy as issued by the Company. This Application shall be deemed attached to and becomes part of the Policy issued.

APPLICANT INFORMATION

Legal Business Name: SAN JOAQUIN VALLEY INSURANCE AUTHORITY

Name of Primary Contact: _____ Email: _____

	StreetAddress	*City*	*State*	*Zip*
Principal Address	2220 Tulare Street, 14th Floor	Fresno	CA	93721

Telephone No.: _____ Federal Tax ID No.: 27-1557908

Applicant is a: ☐ Corporation ☐ Other (please specify): _____

Subsidiaries and Associated Entities to be included in the Policy coverage (list names and locations):

County of Fresno, CA 93710 / County of Tulare, CA 93721

Requested Effective Date: 1/1/2023

Full Legal Name of Claim Adminstrator(s)

(if none, leave blank) Anthem Insurance Companies, Inc.

Contact Name: _____

	StreetAddress	*City*	*State*	*Zip*
Address	21555 Oxnard Blvd	Woodland Hills	CA	91367

Full Legal Name of Cost Containment Vendor

(if none, leave blank) Sigmatico, LLC

Contact Name: _____

	StreetAddress	*City*	*State*	*Zip*
Address	*1603 Capitol Ave*	*Cheyenne*	*WY*	82001

Full Legal Name of Prescription Benefit Manager

(if none, leave blank) EmpriRx

Contact Name

	StreetAddress	*City*	*State*	*Zip*
Address	2355 South Crenshaw Blvd	Torrance	CA	90510

Has the Applicant contracted with a Provider Network? ■ Yes ☐ No

If yes:

Provider Network(s): Anthem Insurance Companies, Inc.

Contact Name

	StreetAddress	*City*	*State*	*Zip*
Address				

Has the Applicant contracted with a Referenced Based Pricing Vendor? ☐ Yes ■ No

If yes:

Name

	StreetAddress	*City*	*State*	*Zip*
Address				

Covered Units:
- ■ Employee
- ■ Employee + Family

Other groups to be covered as Employees:
- ■ Retirees
- ■ COBRA Continuees
- ■ Disabled Employees
- ■ Employees not Actively at Work
- ☐ Others - please describe _____

STOP LOSS INSURANCE COVERAGE

A. SPECIFIC COVERAGE ■ Yes ☐ No

For first time applicants please review the following important information:

- Upon receipt of a renewal application, the Benefit Basis for the Policy may be revised.

Requested Coverage Period:

1. Incurred and Paid Benefit Basis: ■ Yes ☐ No *(select the appropriate description below)*

■ Eligible Claims Expenses Incurred from 1/1/2023 (Date) through 12/31/2023 (Date) and paid from 1/1/2023 (Date) through 6/30/2024 (Date)

☐ Eligible Claims Expenses Incurred on or before _____ (Date) and paid from _____ (Date) through _____ (Date)

☐ Eligible Claims Expenses paid prior to _____ (Date)

The "Run-out Period" is the three month period immediately following the end of the current or any subsequent Policy Term. "Incurred Period" is the period from _____ (Date) to the end of the current Policy Term.

2. Specific Eligible Claim Expenses Include:

Medical	■ Yes	☐ No
Vision	☐ Yes	■ No
Dental	☐ Yes	■ No
Prescription Drug Plan	■ Yes	☐ No

Other - please describe _____

3. Specific Attachment Point (for all Eligible Claims Expenses except those to which a Special Risk Limitation applies):

	☐ per Specific Attachment Point Class	■ per Covered Person
Covered Person	$450,000	100%

Class	Specific Attachment Point
Class 1	$
Class 2	$
Class 3	$
Unsegmented	$

4. Specific Payable Percentage: 100%

5. Maximum Specific Benefit Limit (in excess of the Specific Attachment Point)

■ Specific Reimbursement Percentage Payable after Specific Attachment Point: 100%

■ Specific Annual Maximum Reimbursement per Covered Person:

Class A $_____

Class B $_____

Class C $_____

Covered Person Unlimited

■ Specific Lifetime Maximum Limit per Covered Person:

Class A $_____

Class B $_____

Class C $_____

Covered Person Unlimited

■ Maximum Limit of Liability: Unlimited

6. ☐ Run-In Limit: _____ of plan benefits Incurred per Covered Person prior to the Policy Effective Date.

7. ☐ Run-Out Limit: _____ of plan benefits Incurred per Covered Person prior to the Policy Effective Date.

8. ☐ Special Risk Limitations
subject to the Alternate Specific Attachment Point and/or Benefit Period limitation shown below

Covered Person/Name/Identifier	Alternate Specific Attachment Point	Benefit Period Limitation
--None--	--None--	--None--

■ Other Limitations:

The following categories will be covered if checked.

■ Disabled/Hospital Confined

■ Actively at Work

■ Activity of daily living

■ Out-of-hospital

☐ Others - please describe _____

B. AGGREGATE COVERAGE SCHEDULE ☐ Yes ■ No

For first time applicants please review the following important information:

- Upon receipt of a renewal application, the Benefit Basis for the Policy may be revised.

For all Eligible Claims Expenses:

1. Incurred and Paid Benefit Basis: ☐ Yes ☐ No *(select the appropriate description below)*

   ☐ Eligible Claims Expenses Incurred from _____ (Date) through _____ (Date) and paid from _____ (Date) through _____ (Date)

   ☐ Eligible Claims Expenses Incurred on or before _____ (Date) and paid from _____ (Date) through _____ (Date)

   ☐ Eligible Claims Expenses paid prior to _____ (Date)

   The "Run-out Period" is the three month period immediately following the end of the current or any subsequent Policy Term. "Incurred Period" is the period from _____ (Date) to the end of the current Policy Term.

2. Aggregate Eligible Claims Expenses Include:

Medical	☐ Yes	☐ No
Vision	☐ Yes	☐ No
Dental	☐ Yes	☐ No
Prescription Drug Plan	☐ Yes	☐ No

   Other - please describe: _____

3. Annual Aggregate Attachment Point: _____ _____%

4. Aggregate Payable Percentage: _____

5. Minimum Annual Aggregate Attachment Point: _____

6. Maximum Aggregate Reimbursement (per Policy Term): _____

7. Monthly Aggregate Factors per Covered Unit:

Covered Unit	Medical	Vision	Dental	Prescription Drug	Other	Monthly Expected Claims
Employee						
Employee & Family						

8. Other Limitations

The following categories will be covered if checked.

- ☐ Disabled/Hospital Confined
- ☐ Actively at Work
- ☐ Activity of daily living
- ☐ Out-of-hospital
- ☐ Others - please describe _____

PREMIUM

- ■ Premium Due and Payable: the 1st day of each month, subject to Grace Period
- ☐ Premium Due and Payable: on or before the Effective Date of the Policy, subject to Grace Period
- ☐ Minimum Annual Specific Premium: _____
- ☐ Minimum Annual Aggregate Premium: _____
- ■ **Specific Premium Rate per Policy Month per Covered Unit:**

Covered Unit	Rate
Employee	$16.52
Employee & Family	$33.17

- ☐ **Aggregate Premium Rate per Policy Month per Covered Unit:**

The premium rate per policy month per covered unit for the coverage applied for shown above will only apply to the coverage period identified in this application.

Endorsements attached to the Policy:

The Following endorsement(s) are requested in consideration of an additional premium:

- ■ Advanced Funding Endorsement
- ☐ Aggregating Specific Deductible Endorsement
- ☐ Alternative Network Reimbursement Funding Endorsement
- ■ Experience Refund Endorsement
- ☐ Monthly Aggregate Accommodation Benefit Endorsement
- ■ No New Special Risk Limitations Endorsement
- ■ Plan Mirroring Endorsement
- ☐ Reference Based Pricing Extension Endorsement
- ■ Renewal Rate Cap Endorsement
- ☐ Retained Corridor Endorsement
- ☐ Terminal Liability Endorsement
- ☐ Transplant Vendor Endorsement

APPLICANT STATEMENTS

The undersigned is an authorized representative of the Applicant and represents to the best of his knowledge and belief that the statements and disclosures set forth herein are true and complete and include all material information. Further, the undersigned understands that any Policy issued based on this Application is done so in reliance upon the statements, disclosures, and representations made herein and are made part of this Application.

The Applicant agrees that if the information supplied on this Application changes materially between the date of this Application and prior to the inception date of the policy, the Applicant will immediately notify the Company of the changes. It is understood that as a result, the Company may, upon review of such changes, withdraw or modify any outstanding quote, terms, or proposal.

The receipt by the Company of premium with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this Application, its sole obligation shall be to refund such premium to the undersigned.

The undersigned has read this Application for a Stop Loss Insurance Policy and understands that no insurance coverage is in effect until this Application is approved and accepted by the Company.

ARBITRATION DISCLOSURE: Any disagreement or dispute between the Company and the Policyholder involving the Policy will be settled by binding arbitration.

Full Legal Name of Applicant: SAN JOAQUIN VALLEY INSURANCE AUTHORITY

Signature of Authorized Representative: [signature]

Print Name: Steve Brandau

Title: President, Board of Directors

Date: 1/25/2023

AGENT/BROKER INFORMATION

Print Full Legal Name of Individual Agent or Broker: First Everett Middle Peter Last McNamara

Address: Street Address 3120 Gibbons Drive City Alameda State California Zip 94501

Telephone No.: (510) 508-2959 E-mail Address: pmcnamara@keenan.com

Resident State: California License Number: 0A94087

Signature of Agent or Broker: Everett Peter McNamara Date: 1-26-2023

FRAUD WARNING NOTICE: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject the person to criminal and civil penalties.

The laws of several states require the following statements to appear on the application form. These statements apply only to residents of the noted states.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The lack of such a statement does not constitute a defense in any prosecution for a fraudulent insurance act.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.