



ProSelect Insurance Company

dba Coverys Insurance Company
 One Financial Center, 13th Floor, Boston MA 02111
 Phone: 800.225.6168 Fax: 617.428.9801

MEDICAL STOP LOSS DECLARATIONS New Business Declarations

FIRST NAMED INSURED AND ADDRESS:

San Joaquin Valley Insurance Authority
 2220 Tulare Street, 14th Floor
 Fresno, CA 93721

PRODUCER:

Keenan & Associates
 2355 Crenshaw Blvd
 Torrance, CA 90501

POLICY PERIOD: 01/01/26 to 01/01/27 at 12:01 A.M.
 Standard Time at Named Insured address above.

DESCRIPTION OF BUSINESS:
 General Government, NEC

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE COVERAGE STATED IN THIS POLICY.

*****THE POLICY SHALL NOT BE EFFECTIVE UNLESS THE FIRST INSTALLMENT PAYMENT***
 IS RECEIVED ON OR BEFORE THE DUE DATE DISPLAYED ON THE INVOICE.**

MEDICAL STOP LOSS

POLICY NUMBER: 002CA00001585M

FORMER POLICY NUMBER: N/A

Coverage	Limit Structure	Coverage Included
Coverage A: Aggregate Excess Loss	N/A Minimum Annual Aggregate Attachment Point Limit (Estimated based upon Aggregate Factors multiplied by Number of Covered Persons)	<input type="checkbox"/> Medical
		<input type="checkbox"/> Dental
		<input type="checkbox"/> Vision
	N/A Annual Aggregate Attachment Point	<input type="checkbox"/> Prescription Drugs
	N/A Aggregate Excess of Loss	<input type="checkbox"/> Weekly Disability
N/A Aggregate Excess of Loss Aggregate Attachment Point Percentage	<input type="checkbox"/> Other	
N/A Aggregate Attachment Point Percentage		
	Aggregate Factors:	
	Covered Unit Description:	
	Monthly Aggregate Composite	N/A
	Aggregate Terminal Liability	N/A
	Total	N/A

Joseph G. Murphy
 President & CEO

Elizabeth B. Brodeur
 Secretary



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Coverage B: Specific Excess Loss	Per Covered Person Attachment Point	<input checked="" type="checkbox"/>	Medical
	\$475,000.00 Individual Attachment Point	<input type="checkbox"/>	Dental
	N/A Family Attachment Point	<input type="checkbox"/>	Vision
	N/A Aggregate Specific Attachment Point	<input checked="" type="checkbox"/>	Prescription Drugs
	Unlimited Specific Excess Loss Annual Maximum		
	100% Aggregate Attachment Point Percentage		
Drug or Alcohol Abuse Excess of Loss	N/A Per Covered Person Drug or Alcohol Abuse Excess of Loss Limit		
	<input type="checkbox"/> Terms & Conditions of the Plan		
	N/A Days Maximum		
	N/A Aggregate Drug or Alcohol Abuse Excess of Loss Limit		
	<input checked="" type="checkbox"/> Included as part of Specific Excess of Loss		
Run-In Period Loss	From N/A to N/A Run-In Period		
	N/A Run-In Excess of Loss Limit Per Covered Person		
	N/A Aggregate Run-In Excess of Loss Limit		
Run-Out Limit	From N/A to N/A Run-Out Period		
	N/A Run-Out Excess of Loss Limit Per Covered Person		
	N/A Aggregate Run-Out Excess of Loss Limit		
Covered Party Eligibility	<input type="checkbox"/>	Retired Employees	
	<input checked="" type="checkbox"/>	COBRA Continuee	
	<input checked="" type="checkbox"/>	Disabled Persons	
	<input checked="" type="checkbox"/>	Employees Not Actively at Work	
	<input type="checkbox"/>	Late Entrants	
	<input checked="" type="checkbox"/>	Transplants	
	<input type="checkbox"/>	Other	
Third Party Administrator	Anthem		

FORMS AND ENDORSEMENTS

- Medical Stop Loss Policy (MSL 001)
- Advance Reimbursement Endorsement (MSL 004)
- Case Management Fees Endorsement (MSL 006)
- Schedule of Potentially Catastrophic Losses (MSL 013)
- State Healthcare Surcharge Endorsement (MSL 015)
- Experimental or Investigational Exclusion (MSL 018)
- No New Laser and Rate Cap at Renewal Endorsement (MSL 022)
- Mirroring Endorsement (MSL 024)

POLICY PREMIUM: **\$4,016,870.88** Estimated Annual Premium

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 Secretary

MEDICAL STOP LOSS POLICY

Throughout this POLICY the words YOU and YOUR refer to the FIRST NAMED INSURED as defined in the DECLARATIONS. The words WE, US and OUR refer to the insurer named on the DECLARATIONS.

Capitalized words and phrases have special meaning as defined in Section IV. Defined Terms within this POLICY.

This POLICY is issued in return for the payment of premium and is subject to the DECLARATIONS and to all of the terms, conditions, definitions and exclusions stated in this POLICY. Read the entire POLICY carefully to determine YOUR rights and duties and what is and is not covered.

IMPORTANT NOTICE

Coverage applies only to the portion of PLAN BENEFIT AMOUNTS in excess of the ATTACHMENT POINT, as defined in Section II. Our Limit of Insurance, for each POLICY PERIOD. WE are not a fiduciary. WE are not a party to YOUR PLAN. WE do not have the right or obligation to perform any such function or provide any reports required by the Employee Retirement Income Security Act of 1974, et. al.

WE have no duty to settle or adjust claims filed under YOUR PLAN. OUR sole responsibility is to the FIRST NAMED INSURED in accordance with the provisions of this POLICY. WE do not have the right or obligation under this POLICY to directly reimburse any payor, beneficiary or other party. YOU may not assign reimbursement under this POLICY, and WE shall not recognize any such assignment. Please review this POLICY carefully and discuss the coverage with YOUR insurance agent.

Section I. Medical Stop Loss

A. Insuring Agreements

1. Coverage A - Aggregate Excess Loss

WE will reimburse YOU, in excess of the applicable ATTACHMENT POINT, up to the applicable Aggregate Excess of Loss stated in the DECLARATIONS, if stated, for all PLAN BENEFIT AMOUNTS PAID during the POLICY PERIOD or within the RUN-OUT PERIOD, as shown in the DECLARATIONS, for COVERED PERSONS.

2. Coverage B - Specific Excess Loss

WE will reimburse YOU, in excess of the applicable ATTACHMENT POINT stated in the DECLARATIONS, if stated, for PLAN BENEFIT AMOUNTS PAID during the POLICY PERIOD or within the RUN-OUT PERIOD, as shown in the DECLARATIONS, for COVERED PERSONS.

Additionally, WE will reimburse YOU, in excess of the applicable ATTACHMENT POINT stated in the DECLARATIONS, if stated, for PLAN BENEFIT AMOUNTS PAID during the POLICY PERIOD, for COVERED PERSONS for Drug or Alcohol Abuse Excess Loss benefits, if provided by YOUR PLAN.

Coverage under this POLICY applies only if:

1. PLAN BENEFITS, excluding weekly disability income benefits, are INCURRED during the POLICY PERIOD or within the RUN-IN PERIOD as shown in the DECLARATIONS;
2. PLAN BENEFITS related to weekly disability income benefits, if shown in the DECLARATIONS, are payable during the POLICY PERIOD;

3. The ATTACHMENT POINTS, stated in the DECLARATIONS have been wholly retained by YOU and have been PAID by YOUR TPA named in the DECLARATIONS;
4. YOUR portion of the Aggregate Attachment Point Percentages, stated in the DECLARATIONS, has been retained by YOU;
5. YOU have provided proof of loss and of PLAN BENEFIT AMOUNTS PAID by YOUR TPA; and
6. YOU give US written notice of PLAN BENEFIT AMOUNTS that have reached 50% of the ATTACHMENT POINT within thirty (30) days after the date of loss.

If YOUR PLAN terminates, this POLICY will end immediately.

B. Reporting Requirements

As a condition precedent to OUR obligations under this POLICY, YOU must provide US with a written record of all PLAN BENEFIT AMOUNTS PAID by the fifteenth (15) of every month and a final report within thirty (30) days of the end of the POLICY PERIOD.

The following shall not be considered notice under this POLICY:

1. Reports made to US orally by or on behalf of any INSURED; or
2. Reports, documents or surveys authored by or furnished to US in connection with any engineering, loss control, risk management, quality assurance services or any application for insurance.

C. Terminal Liability Option

If this POLICY is non-renewed or cancelled, the FIRST NAMED INSURED shall have the right to have issued an endorsement providing a terminal liability option to extend reporting of PLAN BENEFIT AMOUNTS PAID during the POLICY PERIOD. To effectuate such coverage, YOU must:

1. Gives US written notice at least ninety (90) days before such cancellation or non-renewal; and
2. Pay to US all premiums due for the POLICY, if any, and for the terminal liability option as established by OUR rules, rates and rating plans then in effect. Payment of any premium due for the POLICY and payment of the premium for the terminal liability option shall be made as invoiced by US, or the terminal liability option will terminate and not be reinstated.

The terminal liability option applies only to PLAN BENEFITS otherwise covered by this POLICY, that are INCURRED during the POLICY PERIOD or within the RUN-IN PERIOD as shown in the DECLARATIONS.

Section II. Our Limit of Insurance

A. With respect to Coverage A, the following shall apply:

Subject to the Aggregate Excess of Loss, if stated in the DECLARATIONS, reimbursement for Coverage A shall be provided to YOU, to which this POLICY applies, for PLAN BENEFIT AMOUNTS

covered by this POLICY less:

1. The greater of the Minimum Annual Aggregate Attachment Point Limit or Annual Aggregate Attachment Point; less
2. All amounts in excess of the Per Covered Person Attachment Point reimbursed by US under Coverage B, Specific Excess Loss; less
3. Any payments made by YOU which are not covered by this POLICY; less

4. The Aggregate Excess of Loss Aggregate Attachment Point Percentage retained by YOU; regardless of the number of COVERED PERSONS.

The Aggregate Excess of Loss, if stated in the DECLARATIONS, is the total amount that WE will pay in excess of the ATTACHMENT POINT for PLAN BENEFIT AMOUNTS to which Coverage A applies.

- B. With respect to Coverage B, the following shall apply:

1. a. The Specific Excess Loss Annual Maximum, if stated in the DECLARATIONS, is the total that WE will reimburse YOU for all PLAN BENEFIT AMOUNTS to which this POLICY applies during the POLICY PERIOD per COVERED PERSON.
- b. WE will reimburse YOU for all amounts in excess of the Specific Excess of Loss, less the Per Covered Person Attachment Point, stated in the DECLARATIONS, for all PLAN BENEFIT AMOUNTS to which this POLICY applies during the POLICY PERIOD per COVERED PERSON.
- c. In addition to the Per Covered Person Attachment Point, stated in the DECLARATIONS, Coverage B, Specific Excess Loss, shall be subject to an Aggregate Specific Attachment Point, stated in the DECLARATIONS. The Aggregate Specific Attachment Point must be satisfied prior to any reimbursement for PLAN BENEFIT AMOUNTS to which this POLICY applies. The Aggregate Specific Attachment Point applies in addition to the ATTACHMENT POINTS for PLAN BENEFIT AMOUNTS to which this Coverage B applies PAID during the POLICY PERIOD.

1. The Drug or Alcohol Abuse Excess of Loss reimbursement applies as follows:

- a. If a Per Covered Person Drug or Alcohol Abuse Excess of Loss Limit is stated in the DECLARATIONS, such Limit shall be the total limit for all PLAN BENEFIT AMOUNTS to which this POLICY applies during the POLICY PERIOD per COVERED PERSON for treatment of drug or alcohol abuse.
 - b. If Terms and Conditions of the Plan is selected on the DECLARATIONS, reimbursement shall be limited to the number of Days Maximum per COVERED PERSON, and Aggregate Drug or Alcohol Abuse Excess of Loss Limit per COVERED PERSON, stated in the DECLARATIONS,
 - c. If included as part of Specific Excess of Loss, paragraph B.1.a. above shall apply.
2. Subject to the Aggregate Run-In Excess of Loss Limit, the Run-In Excess of Loss Limit Per Covered Person, less such COVERED PERSON'S ATTACHMENT POINT, stated in the DECLARATIONS, is the total limit for all PLAN BENEFIT AMOUNTS to which this POLICY applies per COVERED PERSON during the RUN-IN PERIOD, stated in the DECLARATIONS.

- C. All PLAN BENEFIT AMOUNTS reimbursable under this POLICY shall be subject to the Aggregate Attachment Point Percentage shown in the DECLARATIONS. Such Aggregate Attachment Point Percentage is the percentage at which PLAN BENEFIT AMOUNTS, in excess of YOUR ATTACHMENT POINT will be reimbursed by US.
- D. In no event shall more than one Aggregate Excess of Loss Limit of this POLICY or more than one medical stop loss policy issued by US or any of OUR affiliated insurance companies apply to YOUR PLAN.

Section III. Exclusions

This POLICY does not apply to any liability arising out of or related to any claim or suit, damages, fees, medical

expense, act, error or omission. Additionally, the insurance provided by this POLICY is subject to the following exclusions:

A. Administrative Duties

Rendered by any person while acting in the scope and capacity of his or her duties as:

1. A person charged with the duty of claims administration, including any costs arising from YOUR TPA;
2. A person assessing YOUR PLAN eligibility, fiduciary responsibility or actuarial services, including such person's misallocation of funds;
3. A person charged with the duty of effecting, continuing or terminating any COVERED PERSON'S enrollment in YOUR PLAN; or
4. Other administrative duties rendered in the management of YOUR PLAN.

B. Alternative Source of Recovery

Arising out of YOUR right to recovery, offset, benefits, reimbursements, or reduction in charges, including costs, from any source, to which YOU are entitled.

C. Billing Errors and Omissions

Arising out of any improper billing or any other billing-related acts or practices by any person.

D. Breach of Contract

Arising out of any breach of contract.

E. Contractual Liability

Arising out of liability of others assumed by YOU under any contract or agreement other than YOUR PLAN.

F. Disabled Status

Arising out of PLAN BENEFIT AMOUNTS PAID by YOU for DISABLED PERSONS.

However, this exclusion shall not apply following the date that such COVERED PERSON:

1. No longer is considered a DISABLED PERSON;
2. Returns to YOUR employment as defined by YOUR PLAN; and
3. Meets eligibility requirements of YOUR PLAN.

G. Dishonest, Intentional or Criminal Acts

Arising out of any dishonest, fraudulent, criminal or malicious acts or omissions or deliberate or intentional wrongdoing or bad faith committed or alleged to have been committed by YOU.

H. Drug or Alcohol Abuse Treatment

Arising out of treatment programs for drug or alcohol abuse unless such treatment programs are covered by YOUR PLAN.

I. Financial Loss

Arising out of financial loss incurred as a result of YOUR PLAN, other than those agreed to as PLAN BENEFIT AMOUNTS.

WE shall have no duty to pay any costs which arise out of YOUR:

1. Bankruptcy or insolvency;
2. Failure to reimburse benefits within YOUR PLAN, or any other indemnitor's failure to reimburse;
3. Fee-for-service payments; or
4. Infrastructure or maintenance amounts.

J. Inactive Work Status

Arising out of PLAN BENEFIT AMOUNTS PAID by YOU for individuals who, on the latter of the effective date of their coverage under YOUR PLAN or the Effective Date of this POLICY are:

1. Not actively at work, unless the ACTIVE WORK STATUS has been waived in writing as per the DECLARATIONS;
2. DISABLED PERSONS, unless YOU have disclosed such disability and WE have accepted as per the DECLARATIONS;
3. Excluded individuals as per the DECLARATIONS; or
4. Late entrants who are not accepted by US.

K. Legal Defense

WE shall have no duty to defend YOU in any claim, suit, proceeding or deposition whatsoever, nor do WE have any duty to pay any claim expenses related to any such claim, suit, proceeding or deposition.

L. Managed Care Services

Arising out of:

1. Review on behalf of a managed care entity, any healthcare insurer, or third-party administrator of any proposed or actual total or per unit charges, fees or rates for medical, hospital, prescription drug or other healthcare services or products, or of the necessity, quality or utilization of such healthcare services;
2. Submission, handling, investigation, adjudication, denial of payment or adjustment of claims for benefits or coverages under health care or prescription drug plans;
3. Design or implementation of programs which compensate health care providers based on process measures, achievement of documented quality of care metrics, cost efficiencies or patient outcomes or of any other compensation programs for health care services; or
4. Services or activities performed in the administration or management of health care plans.

M. Punitive Damages, Fines, Penalties

Arising from any fine, penalty, extra-contractual or non-contractual damages including punitive or exemplary damages, including any tax-related interest or penalty.

N. Violation of Statutes

Arising out of:

1. A willful, knowing, deliberate or intentional violation of any federal, state or municipal constitution, statute, ordinance, by-law, rule or regulation.
2. Expenses resulting from services or supplies which are rendered or provided in violation of any federal, state, municipal constitution, statute, ordinance, by-law, rule or regulation;
3. Any violation of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 et seq., and any amendments thereto; or
4. Any violation of any statute, ordinance or regulation that requires notice to persons of any actual or potential unauthorized access to or disclosure of any of their personally identifiable non-public information or of any confidential or private information or other breach of privacy or the costs of providing any notice required under any such statute or of any credit monitoring.

O. Worker's Compensation

Charges for any injury or illness arising out of, or in the course of, any employment for wage or profit, including self-employment, for which the COVERED PERSON would be entitled to benefits under any Worker's Compensation, Occupational Disease Law, Federal Employees Liability Act, or similar legislation, whether or not such policy is actually in force or a claim has been made.

Section IV. Defined Terms

The capitalized words and phrases used in this POLICY have special meaning as defined in this Section.

- A. ACTIVE WORK STATUS means that an employee is acting within the capacity and scope of their duties for YOU. Such status shall not include time that such employee is not acting within the capacity and scope of their duties for YOU due to confinement to a hospital, other health care facility, or otherwise absent due to illness or accident, or as defined by YOUR PLAN.
- B. ATTACHMENT POINT means the amount or percentage of PLAN BENEFIT AMOUNTS which must be PAID by YOU before coverage under this POLICY applies. ATTACHMENT POINT includes those amounts shown in the DECLARATIONS including but not limited to the:
1. Minimum Annual Aggregate Attachment Point;
 2. Annual Aggregate Attachment Point;
 3. Aggregate Attachment Point Percentage;
 4. Per Covered Person Attachment Point for Individuals or Families, as stated in the DECLARATIONS; or
 5. Aggregate Specific Attachment Point.

ATTACHMENT POINT shall not include:

1. Any amount used to satisfy deductibles, co-insurance or co-payment amounts under the PLAN; and

2. Any expenses incurred by a DISABLED PERSON(S).
- C. COVERED PERSON means an individual covered under YOUR PLAN, including an employee, and such individual's dependents as well as an individual who has elected coverage under YOUR PLAN under the Consolidated Omnibus Budget Reconciliation Act of 1985, et. al. (COBRA) to the extent required by federal law.
- D. DECLARATIONS means the section of this POLICY entitled "Medical Stop Loss Declarations" that sets forth certain important information about the FIRST NAMED INSURED and this POLICY. The DECLARATIONS shall also include, if applicable, the Schedule of Plan Benefits and any other attached schedules.
- E. DISABLED PERSONS, unless otherwise defined in YOUR PLAN, means individuals who are or become unable to perform the same lifestyle functions as a person of similar age and gender who are in good health.
- F. EXPERIMENTAL OR INVESTIGATIONAL, unless otherwise defined in YOUR PLAN, means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The service, supply or treatment will also be considered Experimental or Investigational if:
1. The COVERED PERSON is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety;
 2. The medical treatment is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies;
 3. Such treatment has not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation the Federal Department of Health and Human Services, Food and Drug Administration (FDA), or any other comparable state government agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
 4. A drug, device or biological product does not have FDA approval or it has FDA approval only under an interim step in the FDA process (ie an investigational device exemption or an investigational new drug exemption).

However, if YOUR PLAN BENEFITS include clinical trials, as a condition for coverage on this POLICY, YOU must provide US with the following information:

1. Clinical trial treatment protocol from the facility that conducts the clinical trial including approval from the Institutional Review Board;
2. Signed consent and authorization to participate in the clinical trial by the COVERED PERSON;
3. Evidence that treatment was provided as part of an ongoing Phase I, II, III or IV clinical trial sponsored by the National Cancer Institute, National Institute of Health, or the Federal Drug Administration (FDA);
4. Evidence that the treatment provided by the clinical trial is covered by YOUR PLAN; and
5. Evidence that funding is not available as part of routine costs of the clinical trial from the National Cancer Institute, National Institute of Health, or the FDA.

- G. FIRST NAMED INSURED means the individual or entity listed as such in the DECLARATIONS.
- H. INCURRED means that PLAN BENEFITS have been provided to a COVERED PERSON. PLAN BENEFITS are INCURRED on the date such PLAN BENEFITS are provided to a COVERED PERSON.
- I. OTHER INSURANCE means all other valid and collectible insurance, whether primary, excess, contingent or written on any other basis, including without limitation any captive insurance or self-insurance program or any risk retention group, whether or not subject to a deductible, co-payment or self-insured retention.
- J. PAID means PLAN BENEFIT AMOUNTS adjudicated by YOUR TPA and for which PLAN BENEFIT AMOUNTS have been disbursed in accordance with the PLAN prior to the expiration of this POLICY. Payment of PLAN BENEFIT AMOUNTS is payment to the COVERED PERSON or their healthcare provider in accordance with the PLAN. Payment will be deemed to have been made on the date the:
1. Payor tenders payment by mailing (or other delivery) of a draft or check; and
 2. Account upon which the payment is drawn contains sufficient funds to honor such draft or check.
- K. PLAN means YOUR written and executed self-insured health care plan to provide PLAN BENEFITS as described within YOUR Employee Welfare Benefit Plan, to YOUR employees and their dependents as submitted with YOUR POLICY APPLICATION. Coverage provided by this POLICY shall be no broader than YOUR PLAN.
- L. PLAN BENEFITS mean the healthcare benefits covered by YOUR PLAN, for COVERED PERSONS INCURRED during the POLICY PERIOD as shown in the DECLARATIONS. Additionally, PLAN BENEFITS include those healthcare benefits covered by YOUR PLAN INCURRED during the POLICY PERIOD which are PAID by YOU during any RUN-OUT PERIOD or INCURRED during any RUN-IN PERIOD and PAID by YOU during the POLICY PERIOD.

PLAN BENEFITS also mean healthcare benefits covered by YOUR PLAN for COVERED PERSONS, INCURRED during the POLICY PERIOD, arising out of those amounts YOUR PLAN is legally obligated to pay arising out of statutes and regulations or upon decision of a court of law or an accredited Independent Review Organization.

However, PLAN BENEFITS do not include:

1. Any deductibles described within YOUR PLAN;
2. Co-insurance or co-payment amounts of YOUR PLAN;
3. Expenses or fees not covered by YOUR PLAN unless contrary to the expenses provided within this POLICY; or
4. Amounts recoverable or paid by any other source or OTHER INSURANCE.

Additionally, unless otherwise included in YOUR PLAN, PLAN BENEFITS do not include expenses incurred due to services arising out of any:

1. EXPERIMENTAL OR INVESTIGATIONAL surgery or treatment, prescription care service, mail order prescription plan, or any prepaid prescription drug plan, dental plan, vision plan, or weekly disability income benefits, unless shown in the DECLARATIONS; or
 2. Non-human organ or tissue transplants, gene therapies, xenographs or cloning.
- M. PLAN BENEFIT AMOUNTS means payments made by YOU for a claim for PLAN BENEFITS that has been adjudicated by YOUR TPA in accordance with YOUR PLAN and PAID by the end of the POLICY PERIOD.
- PLAN BENEFIT AMOUNTS do not include:

1. Payments made by YOU for services or supplies which are not included in YOUR PLAN;
2. Expenses incurred while YOUR PLAN is not in effect with respect to any person who is not deemed a COVERED PERSON under YOUR PLAN;
3. Undiscounted fees and services or supplies due to YOUR TPA's failure to pay providers by the payment deadline. WE will only reimburse for PLAN BENEFIT AMOUNTS that have been discounted had YOUR TPA made payment on a timely basis; or
4. Expenses for services or supplies that are billed above the USUAL AND CUSTOMARY charges which are greater than the PLAN BENEFIT. For the purpose of this POLICY, USUAL AND CUSTOMARY shall mean the common charge for comparable service or supply in the geographic area where such services are provided.

N. POLICY means this insurance contract issued by US to the FIRST NAMED INSURED including the DECLARATIONS, Endorsements, Schedules, and POLICY APPLICATIONS.

O. POLICY APPLICATION means each application, together with YOUR PLAN and all attachments and other documents submitted to US by or on behalf of the FIRST NAMED INSURED in connection with the underwriting or issuance of this POLICY, including any endorsements. If no application was submitted for this POLICY, then POLICY APPLICATION shall mean the most recent application, together with all attachments and other documents submitted to US, in connection with the underwriting or issuance of any previous POLICY issued by US to the FIRST NAMED INSURED for which this POLICY is a renewal or replacement.

P. POLICY PERIOD means the period from the effective date of this POLICY to the expiration date of this POLICY as set forth in the DECLARATIONS or the cancellation date of the POLICY, whichever occurs first.

Q. RUN-IN PERIOD means the period of time shown in the DECLARATIONS immediately preceding the effective date of the POLICY PERIOD during which PLAN BENEFITS are INCURRED by a COVERED PERSON, for which PLAN BENEFIT AMOUNTS are PAID by YOU during the POLICY PERIOD.

R. RUN-OUT PERIOD means the period of time shown in the DECLARATIONS immediately following the expiration date of the POLICY PERIOD, during which PLAN BENEFIT AMOUNTS have been PAID by YOU for PLAN BENEFITS INCURRED by a COVERED PERSON during the POLICY PERIOD.

WE will extend the RUN-OUT PERIOD for a period of twelve (12) months from the expiration of this POLICY for PLAN BENEFITS which are covered by YOUR PLAN for COVERED PERSONS, INCURRED during the POLICY PERIOD, arising out of those amounts YOUR PLAN is legally obligated to pay arising out of statutes and regulations or upon decision of a court of law or an accredited Independent Review Organization.

However, such extension is contingent upon:

1. A final appeal of denial decision has been made by an accredited Independent Review Organization;
2. YOU are notified that the IRO reversed the denial and YOU are required to pay such PLAN BENEFIT AMOUNTS; and
3. Such PLAN BENEFITS are not:
 1. Otherwise excluded under the terms of YOUR PLAN or this POLICY; or
 2. Payable under any OTHER INSURANCE.

If YOUR POLICY is terminated for any reason before the end of this POLICY PERIOD defined in the DECLARATIONS, such extension will not apply.

- S. USUAL AND CUSTOMARY, unless otherwise defined in YOUR PLAN, means the normal charge made to an individual without insurance and which does not exceed the general level of fees and prices normally charged for a given procedure or supply within the same geographical area in which the expense was incurred.

Section V. Conditions

The insurance provided by this POLICY is subject to the following conditions:

- A. **Arbitration.** All controversies arising out of or relating to this POLICY, or any alleged breach thereof, shall be resolved by binding arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.
- B. **Assignment.** Assignment of YOUR interest under this POLICY will not bind US unless OUR consent is endorsed hereon.
- C. **Assistance and Cooperation of the Insured.** YOU must cooperate with US in the administration and settlement of any PLAN BENEFIT AMOUNTS including, any investigation and review of such PLAN BENEFIT AMOUNTS.

In the event WE reasonably identify a discrepancy in the PLAN BENEFIT AMOUNTS, YOU shall respond promptly to any inquires WE make and provide US with records and other information WE request as it relates to YOUR PLAN.

- D. **Authority of the First Named Insured.** The FIRST NAMED INSURED is authorized to accept this POLICY and any endorsements, give notice of loss reports, give or receive of notice of cancellation or non-renewal, invoices for premiums, receive unearned premium or dividends and agree to any changes in this POLICY.
- E. **Bankruptcy or Insolvency.** Bankruptcy or insolvency will not relieve US of any obligations under this POLICY. However, YOUR PLAN must continue to be funded by YOU in order for coverage to apply under this POLICY.
- F. **Benefit Determination.** Determination of benefits under YOUR PLAN is YOUR sole responsibility. WE shall have no duty to settle or adjust benefit amounts under the PLAN with YOU or YOUR TPA.

WE have the right to review each request for PLAN BENEFIT AMOUNTS submitted to US for reimbursement and have sole authority to determine if YOU are eligible for coverage under this POLICY.

- G. **Cancellation or Non-Renewal.** The FIRST NAMED INSURED may cancel this POLICY by returning it to US or by giving US at least sixty (60) days advance written notice of when the cancellation is to take effect.

WE may cancel or non-renew this POLICY by mailing to the FIRST NAMED INSURED at the FIRST NAMED INSURED'S last address as known by US, at least thirty (30) days advance notice of OUR intent to cancel or non-renew unless such cancellation is for non-payment of premium.

In the event YOU fail to pay any premium owed to US, WE may cancel this POLICY by mailing notice to the FIRST NAMED INSURED at least ten (10) days in advance of the effective date of the cancellation. Proof of mailing will constitute proof of notice for purposes of this provision.

In the event that YOU fail to reimburse US any amount YOU owe US under Section V. Conditions, paragraph FF., Right of Recovery, WE may cancel this POLICY by mailing notice to the FIRST NAMED

INSURED at least ten (10) days in advance of the effective date of the cancellation. Proof of mailing will constitute proof of notice for purposes of this provision.

If this POLICY is cancelled, the FIRST NAMED INSURED may be entitled to a premium refund. However, WE are not required to make or offer any refund for any cancellation to be effective. If the FIRST NAMED INSURED cancels, the FIRST NAMED INSURED shall be responsible for payment of any earned premium calculated on a pro rata basis based on the period the POLICY was in effect plus 10% of the unearned premium for the original POLICY PERIOD stated in the DECLARATIONS. If the FIRST NAMED INSURED is due a refund the refund will be equal to any unearned premium calculated on a pro rata basis on the period the POLICY was in effect, less 10% of any unearned premium for the original POLICY PERIOD stated in the DECLARATIONS. If WE cancel WE will refund any unearned premium for the original POLICY PERIOD stated in the DECLARATIONS calculated on a pro rata basis.

The effective date and hour of cancellation stated in the notice or the time of surrender of the POLICY will become the end of the POLICY PERIOD.

Bankruptcy or insolvency will not preclude US from asserting OUR right to cancel or non-renew this POLICY.

- H. **Changes.** Notice to or knowledge of any agent or other person acting on OUR behalf will not effect a waiver or change to any terms or conditions of this POLICY or estop US from asserting any right under the terms and conditions of this POLICY. The terms and conditions of this POLICY can be waived or changed only by written endorsement signed by US.
- I. **Changes to Your Plan.** Any changes to any terms and conditions related to YOUR PLAN, including paragraphs 1. through 5. below, must be reported to US in writing and approved by US in writing.

WE may change YOUR premium and attachment point due to material changes in YOUR exposure including:

1. Any subsidiary or affiliated company created, acquired or dissolved by the FIRST NAMED INSURED covered by YOUR PLAN;
2. Implemented PLAN changes;
3. Geographic location changes;
4. Changes to YOUR business activities; or
5. An increase or decrease of YOUR COVERED PERSONS.

WE must be notified of any changes to YOUR PLAN in writing at least thirty (30) days prior to the requested effective date of the change. The terms and conditions of this POLICY can be waived or changed only by written endorsement signed by US. If WE do not receive written notice from YOU in advance of the change, or WE decline coverage under this POLICY for any such PLAN changes, this POLICY shall only apply to PLAN BENEFITS prior to the change.

- J. **Compliance with Your Plan.** YOU shall comply with YOUR PLAN terms and conditions.
- K. **Declarations and Applications.** By accepting this POLICY, the FIRST NAMED INSURED represents and agrees on behalf of all INSUREDS that:
1. The statements in the DECLARATIONS and POLICY APPLICATION are accurate and complete;
 2. The statements in the POLICY APPLICATION are YOUR representations, such statements are material to the risk assumed by US and OUR decision to issue this POLICY, this POLICY is issued in reliance upon the truth and completeness of such statements and, such statements are deemed to be incorporated into this POLICY;

3. This POLICY embodies all agreements between YOU and US or any of OUR agents relating to this POLICY; and
4. Misrepresentations made in the POLICY APPLICATION shall invalidate this POLICY.

L. Duties of Your Third Party Administrator.

1. WE recognize YOUR TPA as an administrator of YOUR PLAN. YOUR TPA shall:
 - a. Audit, calculate and pay all benefits as described within YOUR PLAN;
 - b. Provide reports as required by US and any data WE request due to PLAN BENEFIT AMOUNTS; and
 - c. Comply with the terms and conditions of this POLICY.
2. If YOU give YOUR TPA Power of Attorney, or revoke such Power of Attorney, WE shall not recognize such change until YOU provide US with written notification.
3. YOU will pay for YOUR TPA for all administrative functions performed to comply with this POLICY.
4. YOUR TPA is YOUR agent, YOU authorize YOUR TPA to:
 - a. Submit notice and proof of PLAN BENEFIT AMOUNTS;
 - b. Certify PLAN BENEFIT AMOUNTS;
 - c. Transmit reports and payment of premiums to US; and
 - d. Receive reimbursements from US.
5. Reimbursements paid by US to YOUR TPA are reimbursements to YOU.
6. Notice to YOUR TPA is notice to YOU and notice to YOU is notice to YOUR TPA.

M. Government Access to Records. In accordance with the requirements of Section 952 of the Omnibus Reconciliation Act of 1980, upon written request, WE will allow the Secretary of Health and Human Services and the Comptroller General of the United States access to this POLICY and necessary books, documents and records to verify the cost of this POLICY, to the extent required by law. Access will also be allowed to subcontracts between US and any related organization of OURS and to its books, documents and records. Such access will be provided for up to four (4) years after the services furnished under this POLICY end.

N. Inspection and Audit. At OUR option WE may inspect YOUR operations and examine and audit YOUR records and procedures at any time, including those of YOUR TPA and any other agent or independent contractor that YOU utilize that relate to PLAN BENEFITS covered by this POLICY. These inspections are for OUR benefit only. By OUR right to inspect, or by OUR making any inspection, WE make no representation that YOUR operations are safe, not harmful to health or comply with any law, rule or regulation.

O. Indemnification, Defense and Hold Harmless. YOU agree to indemnify, defend and hold US harmless from:

1. Any liability related to any negligence, error, omission or defalcation by YOU or YOUR TPA;
2. Any liability or responsibility related to:
 - a. Any dispute involving a COVERED PERSON unless it is a result of OUR sole negligence or intentional acts; and
 - b. Any State premium taxes WE are assessed with respect to funds paid by or to YOU under YOUR PLAN, or taxes assessed against YOU for PLAN BENEFIT AMOUNTS reimbursed

to YOU in accordance with this POLICY. Taxes on amounts paid to US as premiums for this POLICY are excluded.

WE will notify YOU if YOU have obligations under this condition. WE may participate in the defense at OUR expense. If YOU do not act promptly, WE may defend or settle the claim or other matter on YOUR behalf, for YOUR account. However, YOU are obligated to reimburse US for all costs WE incur to defend or settle any such dispute.

- P. **Interpretations Made Under This Policy.** In determining PLAN BENEFITS due under this POLICY, WE will exercise discretion in a manner consistent with typical industry standards and reasonable interpretations of the provisions of this POLICY.

In determining whether PLAN BENEFITS were properly payable under YOUR PLAN, WE defer that YOUR discretion was made appropriately as defined by typical industry standards and a reasonable interpretation of YOUR PLAN.

In the event YOU disagree with any discretion WE have exercised, YOU shall have the right to advise US in accordance with the terms and conditions of this POLICY.

- Q. **Legal Action Against Us.** No legal action may be brought against US until there has been full compliance with all of the terms of this POLICY.

Any disputes between the FIRST NAMED INSURED and US as to whether there is coverage under this POLICY must be filed in the courts of the United States of America.

- R. **Maintenance of Third Party Claims Administrator.** The FIRST NAMED INSURED must maintain a Third Party Claims Administrator (TPA) approved by US. WE have no duty to settle or adjust claims filed under YOUR PLAN. WE will not reimburse YOU for any PLAN BENEFIT AMOUNTS unless the TPA:

1. Has PAID PLAN BENEFIT AMOUNTS in accordance with YOUR PLAN;
2. Supervises the administration and adjustment of all claims and verifies the accuracy and computation of all claims in accordance with YOUR PLAN;
3. Maintains records of all claim payments;
4. Maintains a record of all expenses not covered by YOUR PLAN; and
5. Provides US every fifteenth (15) of the month during the POLICY PERIOD the number of COVERED PERSONS, Covered Units and total benefits PAID.

- S. **Maintenance of Your Plan.** Coverage under this POLICY is contingent upon the maintenance of YOUR PLAN as provided with YOUR POLICY APPLICATION. If YOUR PLAN is terminated, cancelled, modified or amended, YOU shall notify US within ten (10) business days of such termination, cancellation, modification, amendment or any other change. WE shall have the right to cancel, or adjust YOUR premium and/or Limit of Insurance due to such material change in exposure by written endorsement signed by US.

If YOU fail to provide US with such notification, this POLICY shall apply to the terms of the lesser of the new PLAN or YOUR PLAN prior to the change.

If YOUR PLAN is terminated or cancelled, this POLICY shall not apply to any PLAN BENEFITS that are INCURRED, or to any PLAN BENEFIT AMOUNTS PAID, after such termination or cancellation.

- T. **Medicare Benefits.** PLAN BENEFIT AMOUNTS reimbursable under this POLICY shall apply in excess of any amounts recoverable by Medicare benefits or any similar program. When this POLICY applies in excess over Medicare benefits or any similar program, reimbursement for such PLAN BENEFIT AMOUNTS shall not exceed 100% of such COVERED PERSONS actual expenses otherwise reimbursable under this POLICY.

- U. **Notice of Appealed Benefits.** In the event of an objection, notice of legal action or complaint received on a benefit processed by YOU or YOUR TPA under YOUR PLAN which may result in PLAN BENEFIT AMOUNTS potentially covered by this POLICY, YOU must notify US in writing as soon as practicable.
- V. **Notice of Claim for Specific Excess of Loss for Covered Persons.** YOU must provide US with written notice within thirty (30) days from when YOU become aware that YOU have reached 50% of the Specific Excess of Loss Per Person Covered Attachment Point.

Written proof of PLAN BENEFIT AMOUNTS covered by this POLICY shall include:

1. Completed claim form;
2. Enrollment and change documents of such COVERED PERSON under YOUR PLAN;
3. Copies of bills and invoices for expenses submitted for reimbursement under this POLICY;
4. Evidence of reimbursement by YOU or YOUR TPA including:
 - a. Provider name;
 - b. Provider Tax Identification Number;
 - c. ICD and CPT codes;
 - d. Date of benefit provided;
 - e. Amount billed;
 - f. Discount amount;
 - g. Eligible amount;
 - h. Amount paid;
 - i. Date paid;
 - j. Reimbursement amount requested from US; and
 - k. Previously paid amount.
5. Any additional information WE require to assess reimbursement under this POLICY.

However, if YOU have a Large Claim, or Potentially Catastrophic Loss, YOU must follow the provision outlined in paragraph X. below.

- W. **Notice of Claim for Excess Loss for Aggregate Excess Loss.** YOU must provide US with written notice within thirty (30) days from when YOU become aware that YOU have reached YOUR Annual Aggregate Attachment Point.

Written proof of PLAN BENEFIT AMOUNTS covered by this POLICY shall include:

1. Aggregate calculation report;
2. Claim history report including all PLAN BENEFITS that were INCURRED and all PLAN BENEFIT AMOUNTS PAID during the POLICY PERIOD;
3. Report of all COVERED PERSONS covered by YOUR PLAN during the POLICY PERIOD;
4. YOUR PLAN document, and all amendments thereto, in effect during the POLICY PERIOD;
5. YOUR PLAN document with respect to any prescription drug plan, if covered by this POLICY, including invoices and rebates received by YOU; and

6. Any additional information WE require to assess reimbursement under this POLICY.

- X. **Notice of Large Claim or Potentially Catastrophic Loss.** In the event of a pending claim that may result in PLAN BENEFIT AMOUNTS equal to or greater than 50% of the ATTACHMENT POINTS for Coverage A and B, potentially covered by this POLICY, YOU must notify US in writing as soon as practicable.

Such notice shall contain:

1. The identity of the COVERED PERSON;
2. Description of illness and/or injury; and
3. Date that such claim was INCURRED.

If YOU fail to provide notification to US, this POLICY shall not apply to any PLAN BENEFIT AMOUNTS associated with such claim.

Large Claim means PAID or pending PLAN BENEFIT AMOUNTS reaching or with the potential to reach 50% of the ATTACHMENT POINT.

Potentially Catastrophic Loss means PAID or pending PLAN BENEFIT AMOUNTS with the potential to be catastrophic. Such losses include, but are not limited to, those within the Schedule of Catastrophic Losses attached to this POLICY.

- Y. **Notice of Plan Benefit Amounts.** In the event of a pending claim that may result in PLAN BENEFIT AMOUNTS equal to or greater than 50% of the Coverage A ATTACHMENT POINT for a COVERED PERSON, potentially covered by this POLICY, YOU must notify US in writing as soon as practicable.

Additionally, YOU must notify US in writing as soon as practicable of PLAN BENEFIT AMOUNTS that have reached the Aggregate Attachment Point.

Such notice shall contain:

1. The identity of the COVERED PERSON;
2. Description of illness and/or injury; and
3. Date that such claim was INCURRED.

- Z. **Offset Accounting.** WE may offset reimbursements due to YOU under this POLICY against reimbursement overpayments and premium payments due to US.

- AA. **Other Insurance.** This POLICY is excess over, and shall not contribute with, any OTHER INSURANCE, including applicable Medicare benefits. This condition will not apply to insurance specifically written as excess over the specific limits of this POLICY and that specifically refers to this POLICY.

When this POLICY is excess over any OTHER INSURANCE, WE shall not reimburse YOU for any PLAN BENEFIT AMOUNTS which exceeds YOUR actual expenses that are otherwise reimbursable under this POLICY and applicable OTHER INSURANCE.

- BB. **Payment of Plan Benefit Amounts.** PLAN BENEFIT AMOUNTS reimbursable under this POLICY shall be paid upon OUR receipt and acceptance of all required notification including bordereaux reports, evidence of payment by YOUR TPA and any requested documentation from YOU with respect to such PLAN BENEFITS. WE have the sole authority to reimburse or deny PLAN BENEFIT AMOUNTS under this POLICY.

- CC. **Policy Headings.** The headings used in this POLICY are for convenience only and shall not limit or otherwise affect the terms and conditions of the POLICY.

- DD. **Premiums.** All premiums for this POLICY will be computed in accordance with OUR rules, rates and rating plans in effect with respect to the period for which the premiums are due.
- The premium is due on the first day of the POLICY PERIOD or as invoiced by US. The POLICY shall not be effective unless the first installment payment is received on or before the due date stated on the invoice for the initial policy premium. If any subsequent premium is not paid when due, this POLICY, if not previously cancelled, will be terminated in accordance with the provisions of paragraph G. above.
- YOUR premium will be adjusted positively or negatively based on the actual number of enrolled COVERED PERSONS within YOUR PLAN as well as any other material changes YOU implement to YOUR PLAN. YOU must provide US with notification of such changes as stated under Section V. Conditions, paragraph I. Changes to Your Plan.
- EE. **Regulatory Investigation.** If YOU are the subject of any state or federal regulatory investigation involving YOUR quality of care, billing practices, financial status or licensure, YOU must notify US in writing immediately.
- FF. **Right of Recovery.** If it is determined that WE reimbursed YOU for PLAN BENEFIT AMOUNTS which exceeded the amount owed to YOU, it is YOUR duty to reimburse US within thirty (30) days, or as invoiced by US, for such overpayment.
- If YOU fail to reimburse US, this POLICY, if not previously cancelled, will be terminated in accordance with the provisions of paragraph G. Cancellation or Non-Renewal above.
- GG. **Severability.** Provisions in this POLICY deemed void, voidable, invalid or otherwise unenforceable, whether or not such provision is contrary to public policy, will not invalidate any remaining provisions in this POLICY.
- HH. **Subrogation.** YOU are required to investigate and prosecute all valid claims that YOU may have against person or entity arising out of any benefits covered by YOUR PLAN. As a condition of this POLICY, YOU shall account to US for all amounts YOU recover.
- In the event YOU fail to pursue any action against any person or entity, WE will be subrogated to all of YOUR rights of recovery therefore against any person or entity, including without limitation any person or entity that provides OTHER INSURANCE applicable to PLAN BENEFIT AMOUNTS that have been reimbursed by US, and YOU shall execute and deliver instruments and papers and do whatever else is reasonably necessary to secure such rights. YOU will do nothing to prejudice such rights and will not enter into any oral or written contracts or agreements that in any way impair or waive OUR right of subrogation.
- Any amounts recovered by YOU, YOUR TPA or any COVERED PERSON, shall be first reimbursed to US for any PLAN BENEFIT AMOUNT WE have paid on behalf of any COVERED PERSON. Any amounts recovered by US shall be first reimbursed to US for any PLAN BENEFIT AMOUNT WE have paid on behalf of any COVERED PERSON and any expenses WE incurred to recover that amount from such person or entity.
- II. **Terms Conformed to Statute.** If any term of this POLICY is in conflict with the statutes and regulations of the state where the POLICY is issued, that term shall be deemed to be amended to conform to such statutes and regulations.
- JJ. **Time Limit on Certain Defenses.** In the absence of fraud, all statements made by YOU or YOUR TPA shall be deemed representations and not warranties. If these statements appear as part of YOUR POLICY APPLICATION WE may use them to contest this POLICY. If WE do, WE will furnish YOU or YOUR TPA with a copy of the POLICY APPLICATION in question. After two (2) years from the effective date of this POLICY, only fraudulent misstatements may be used to contest coverage under this POLICY.



ProSelect Insurance Company

dba Coverys Insurance Company

In witness whereof, WE have caused this POLICY to be executed and attested.



Joseph G. Murphy
President & CEO

Elizabeth B. Brodeur
Secretary

ADVANCE REIMBURSEMENT ENDORSEMENT

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

Subject to all other terms and conditions of the POLICY, it is agreed and understood that with respect to Coverage B – Specific Excess Loss:

- A. Upon OUR receipt and approval of a completed Stop Loss Advance Reimbursement Request Form from YOU or YOUR TPA, WE will advance reimbursement to YOU or YOUR TPA to pay PLAN BENEFIT AMOUNTS incurred by a COVERED PERSON contingent upon the following conditions:
 - 1. YOU have satisfied the Per Covered Person Attachment Point and the Specific Excess Loss Annual Maximum, if any;
 - 2. Such PLAN BENEFIT AMOUNTS incurred by the COVERED PERSON:
 - a. Were for medically necessary and appropriate treatment;
 - b. Are covered under YOUR PLAN;
 - c. were incurred within Coverage B – Specific Excess Loss; and
 - d. Are covered as a PLAN BENEFIT on this POLICY; and
 - e. Are not otherwise excluded by this POLICY;
 - 3. YOU approved such benefits for the COVERED PERSON to be covered by YOUR PLAN;
 - 4. YOUR request for advance reimbursement is equal to or greater than \$5000;
 - 5. This POLICY is in force at the time YOUR request for advance reimbursement is made; and
 - 6. WE receive YOUR request at least thirty (30) days before the end of this POLICY PERIOD.
- B. Upon receipt of any advance reimbursement from US, YOU or YOUR TPA must:
 - 1. Pay the benefit amounts giving rise to the advance reimbursement request within ten (10) days after YOUR receipt from US. If YOU do not pay such benefit amounts in accordance with this paragraph, YOU or YOUR TPA must immediately refund such advance reimbursement payment to US; and
 - 2. Provide US with proof of payment of benefit amounts incurred by the COVERED PERSON within ten (10) days of the date YOU or YOUR TPA make the payment; and
 - 3. Immediately refund to US any reimbursement that is not used to pay benefit amounts incurred by the COVERED PERSON.
- C. If YOU do not comply with all of these requirements, in addition to any other remedy available to US, WE

may elect not to make any future advance reimbursement to YOU.

- D. If WE subsequently determine that the expenses incurred by the COVERED PERSON are not eligible for reimbursement under this POLICY, YOU will immediately return to US the amount of the advance reimbursement.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other than as expressly stated above.



Joseph G. Murphy
President & CEO

Elizabeth B. Brodeur
Secretary

CASE MANAGEMENT FEES ENDORSEMENT

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

Subject to all other terms and conditions of the POLICY, it is agreed and understood that Section IV. Defined Terms, Paragraph J. has been amended to include the following:

PLAN BENEFIT AMOUNTS also mean those fees INCURRED and PAID by YOU and approved by US in writing in advance for:

- A. Reasonable and customary hourly fees for case management services provided by a registered nurse case manager retained by YOU and YOUR TPA; and
- B. Reasonable and customary fees for:
 - 1. Healthcare facility bill audits;
 - 2. Access to non-directed provider networks; and
 - 3. Negotiating out of network bills,

but only if YOU demonstrate to US that such amounts resulted in savings to PLAN BENEFIT AMOUNTS. For any such savings to PLAN BENEFIT AMOUNTS, WE will reimburse YOU up to Twenty Five percent (25%) of the amount of PLAN BENEFIT AMOUNT savings and up to a maximum of \$25,000 for each healthcare facility in-patient stay per COVERED PERSON.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other than as expressly stated above.



Joseph G. Murphy
 President & CEO

Elizabeth B. Brodeur
 Secretary

SCHEDULE OF POTENTIALLY CATASTROPHIC LOSSES

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

Subject to all other terms and conditions of the POLICY, it is agreed and understood that Section VI. Conditions, paragraph W., Notification of Large Claim or Potentially Catastrophic Loss is amended to include the following which qualify as reportable claims:

- A. High Risk Pregnancy and Pre-Term/Neonatal
 - 1. Premature births – weighing under four pounds and/or less than 36 weeks gestation;
 - 2. Multiple births (three or more infants) or expected multiple births;
 - 3. Abnormal respiration/respiratory failure (APNEA);
 - 4. Congenital heart defects:
 - a. Spina – Bifida;
 - b. Encephalocele;
 - c. Cephalohematoma; or
 - d. Hyaline Membrane Disease
 - 5. Birth injuries or major birth traumas;
 - 6. Congenital Anomalies of Digestive System;
 - 7. Lack of Expected Normal Physiological Development;
 - 8. Maternal causes of Prenatal Morbidity and Mortality; or
 - 9. Other conditions originating in the Perinatal Period.
- B. Catastrophic Diseases and Illnesses
 - 1. Renal dysfunction/failure, including dialysis treatment;
 - 2. Cerebral vascular accident (stroke); or
 - 3. Diabetes with complications.
- C. Trauma
 - 1. Spinal cord injuries;
 - 2. Coma;

3. Massive internal injuries;
 4. Traumatic brain injury;
 5. Brain lesion or tumors;
 6. Multiple or serious fractures;
 7. Severe burns (10% or more of the body with 3rd degree burns, or 30% of the body with 2nd degree burns)
 8. Trauma to the elderly or chronically ill; or
 9. Paralysis of any kind.
- D. Disease of the Heart and Pericardium
1. Myocardial infarction;
 2. Myocarditis;
 3. Coronary Artery Disease;
 4. Multiple Bypass; or
 5. Cardiomyopathy.
- E. Cancer.
- F. HIV Positive or AIDS (Acquired Immune Deficiency Syndrome) Related Illnesses including:
1. Kaposi's sarcoma;
 2. Cytomegalovirus; or
 3. Pneumocystis carinii pneumonia.
- G. Organ Tissue, Bone Marrow, or Stem Cell Transplant Evaluation, Procedure or Surgery.
- H. Extended Illness or Injury
1. Chronic Liver Disease;
 2. Multiple Sclerosis or Muscular Dystrophy or Cystic Fibrosis or Cerebral Palsy or Degenerative Muscular Disease; or
 3. Any illness or injury which requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators).
- I. Continuous hospitalization of 2 weeks or more.
- J. Amputations.
- K. Any serious condition which the Employer or the TPA thinks may require Large Claim management.
- L. Home health care greater than 20 days.
- M. Hospitalization of \$40,000 or more.
- N. Interim/Cycle hospital billings.
- O. Hospitalization during pregnancy, prior to delivery, or for high-risk pregnancy.
- P. Mental disorders requiring hospital confinement.

- Q. Hepatitis C.
- R. Multiple hospitalizations of three or more per year.
- S. Inpatient admission greater than 10 days.
- T. Hereditary Angioedema.
- U. Pulmonary Hypertension.
- V. Hemophilia.
- W. Spinal Muscular Atrophy.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other than as expressly stated above.



Joseph G. Murphy
President & CEO

Elizabeth B. Brodeur
Secretary

STATE HEALTHCARE SURCHARGE ENDORSEMENT

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

Subject to all other terms and conditions of the POLICY, it is agreed and understood that the following is added to Section IV. Defined Terms, Paragraph L. Plan Benefit Amounts:

If YOU pay a state healthcare surcharge imposed by any state in connection with PLAN BENEFITS, such healthcare surcharges shall be included in PLAN BENEFIT AMOUNTS. However, subject to the Limit stated in the DECLARATIONS, WE will only reimburse such health care surcharges imposed by any state up to 9.63% of the amount upon which the surcharge was levied.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other than as expressly stated above.



Joseph G. Murphy
 President & CEO

Elizabeth B. Brodeur
 Secretary

EXPERIMENTAL OR INVESTIGATIONAL EXCLUSION

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

Subject to all other terms and conditions of the POLICY, it is agreed and understood that:

A. Section IV. Definitions, paragraph F. Experimental or Investigational is hereby replaced in its entirety as follows:

EXPERIMENTAL OR INVESTIGATIONAL means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The service, supply or treatment will also be considered Experimental or Investigational if:

1. The COVERED PERSON is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety;
2. The medical treatment is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies;
3. Such treatment has not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation the Federal Department of Health and Human Services, Food and Drug Administration (FDA), or any other comparable state government agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
4. A drug, device or biological product does not have FDA approval or it has FDA approval only under an interim step in the FDA process (i.e. an investigational device exemption or an investigational new drug exemption).

B. Section IV. Definitions, paragraph L. Plan Benefits is hereby replaced in its entirety as follows:

PLAN BENEFITS mean the healthcare benefits covered by YOUR PLAN, for COVERED PERSONS INCURRED during the POLICY PERIOD as shown in the DECLARATIONS. Additionally, PLAN BENEFITS include those healthcare benefits covered by YOUR PLAN INCURRED during the POLICY PERIOD which are PAID by YOU during any RUN-OUT PERIOD or INCURRED during any RUN-IN PERIOD and PAID by YOU during the POLICY PERIOD.

PLAN BENEFITS also mean healthcare benefits covered by YOUR PLAN for COVERED PERSONS, INCURRED during the POLICY PERIOD, arising out of those amounts YOUR PLAN is legally obligated to

pay arising out of statutes and regulations or upon decision of a court of law or an accredited Independent Review Organization.

However, PLAN BENEFITS do not include:

1. Any deductibles described within YOUR PLAN;
2. Co-insurance or co-payment amounts of YOUR PLAN;
3. Expenses or fees not covered by YOUR PLAN unless contrary to the expenses provided within this POLICY;
4. Amounts recoverable or paid by any other source or OTHER INSURANCE; or
5. EXPERIMENTAL OR INVESTIGATIONAL surgery or treatment.

Additionally, unless otherwise included in YOUR PLAN, PLAN BENEFITS do not include expenses incurred due to services arising out of any:

1. Prescription care service, mail order prescription plan, or any prepaid prescription drug plan, dental plan, vision plan, or weekly disability income benefits, unless shown in the DECLARATIONS; or
2. Non-human organ or tissue transplants, gene therapies, xenographs or cloning.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other than as expressly stated above.



Joseph G. Murphy
President & CEO

Elizabeth B. Brodeur
Secretary

NO NEW LASER AND RATE CAP AT RENEWAL ENDORSEMENT

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

This endorsement is subject to all the terms, conditions, definitions, and exclusions of the POLICY, except as they are specifically modified herein. In the event the POLICY and this endorsement conflict, the terms of this endorsement shall govern.

It is agreed and understood that with respect to Coverage B – Specific Excess Loss:

- A. Upon renewal of this POLICY for the subsequent POLICY PERIOD, no person covered under YOUR PLAN will be newly added to the Exclusion of Designated Persons Schedule, Exclusion of Specified Conditions for Designated Persons Schedule, or Specific Attachment Point for Designated Persons Schedule. However, WE reserve the right to carry over to such renewal and subsequent POLICY PERIOD any Designated Persons who are currently listed on such Schedules.
- B. Upon renewal of this POLICY for the subsequent POLICY PERIOD, YOUR renewal premium for Coverage B – Specific Excess Loss rates are subject to a maximum 50% increase, provided the renewal POLICY contains no material changes from the current POLICY. Material changes include but are not limited to:
 - 1. A change to the Specific Excess Loss Coverage Benefit Period as shown in the renewal APPLICATION.
 - 2. A change to the Per Covered Person ATTACHMENT POINT as shown in the DECLARATIONS.
 - 3. A change to the commission level.
 - 4. A more than 10% increase or decrease in the number of COVERED PERSONS.
 - 5. A change to the Covered Party Eligibility as shown in the DECLARATIONS.
 - 6. A significant change in the benefits provided under YOUR PLAN or a significant change in the PLAN terms.
- C. We reserve the right to cancel this endorsement should YOUR PLAN or renewal POLICY materially change, as described above.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other



ProSelect Insurance Company

dba Coverys Insurance Company

than as expressly stated above.

Handwritten signatures of Joseph G. Murphy and Elizabeth B. Brodeur in black ink.

Joseph G. Murphy
President & CEO

Elizabeth B. Brodeur
Secretary

MIRRORING ENDORSEMENT

Attached to and forming part of Policy Number:	First Named Insured:	Policy Period:
002CA00001585M	San Joaquin Valley Insurance Authority	January 1, 2026 to January 1, 2027 At 12:01 AM Standard Time at the address of the First Named Insured as stated herein.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

Medical Stop Loss Policy

Subject to all other terms and conditions of the POLICY, it is agreed and understood that Section V. Conditions is amended to include the following:

A. Mirroring.

In the event of a conflict as to what is considered PLAN BENEFITS between the POLICY and YOUR PLAN, YOUR PLAN will govern, except that PLAN BENEFITS do not include:

1. Any deductibles described within YOUR PLAN;
2. Co-insurance or co-payment amounts of YOUR PLAN;
3. Expenses or fees not covered by YOUR PLAN unless contrary to the expenses provided within this POLICY;
4. Amounts recoverable or paid by any other source or OTHER INSURANCE;
5. Prescription care service, mail order prescription plan, or any prepaid prescription drug plan, dental plan, vision plan, or weekly disability income benefits, unless shown in the DECLARATIONS; and
6. EXPERIMENTAL OR INVESTIGATIONAL surgery or treatment, if excluded by YOUR PLAN or excluded by the POLICY via endorsement.

Additionally, unless otherwise included in YOUR PLAN, PLAN BENEFITS do not include expenses incurred due to services arising out of any:

Non-human organ or tissue transplants, gene therapies, xenografts, or cloning.

Medical or other expenses PAID by YOU for a claim for PLAN BENEFITS in accordance with YOUR PLAN shall be deemed PLAN BENEFIT AMOUNTS, subject to all other terms and conditions of the POLICY, except that PLAN BENEFIT AMOUNTS do not include:

1. Payments made by YOU for services or supplies which are excluded by YOUR PLAN;
2. Expenses incurred while YOUR PLAN is not in effect with respect to any person who is not a COVERED PERSON under YOUR PLAN;

3. Undiscounted fees and services or supplies due to YOUR TPA's failure to pay providers by the payment deadline. WE will only reimburse for PLAN BENEFIT AMOUNTS that have been discounted had YOUR TPA made payment on a timely basis; or
4. Expenses for services or supplies that are billed above the USUAL AND CUSTOMARY charges, as defined in the POLICY, unless otherwise defined in YOUR PLAN.

Nothing in this endorsement shall vary, alter, waive or extend any of the terms and conditions of the POLICY, other than as expressly stated above.



Joseph G. Murphy
President & CEO

Elizabeth B. Brodeur
Secretary



ProSelect Insurance Company

dba Coverys Insurance Company

PRODUCER INFORMATION		
Broker/Agent of Record Keenan & Associates	Primary Contact Name Bordan Darm	Phone Number (310) 212-3344
Address 2355 Crenshaw Blvd	City/State Torrance, CA	Zip 90501

APPLICANT INFORMATION		
Applicant Full Legal Name (including DBA, etc.) San Joaquin Valley Insurance Authority		Website (if applicable)
Primary Contact and Job Title Lupa Garza, SJVIA Assistant Manager	Contact Phone Number (559) 636-4900	Contact Email lugarza@tularecounty.ca.gov
Principal Office Address (Street Address, City, State, Zip) 2220 Tulare Street, 14th Floor, Fresno, CA 93721		(Check Applicable) <input checked="" type="checkbox"/> Mailing <input type="checkbox"/> Billing

BUSINESS INFORMATION		
Nature of Business: General Government, NEC		
If including Employee Welfare Benefit Plans of subsidiary or affiliated companies (those that under common control through stock ownership or otherwise) please list the legal names and address of such companies and the nature of their business. (Attach a separate sheet, if necessary.)		

Legal Name	Address	Nature of Business

Please list the full name of your Employee Welfare Benefit Plan: San Joaquin Valley Insurance Authority Health Plan(s)

Please include a copy of your ERISA Employee Welfare Benefit Plan Document as well as those of any subsidiary or affiliated companies that you wish to be included. These must be attached to and will become part of this application.

If your Employee Welfare Benefit Plan is for a Multiple Employer Welfare Agreement (MEWA) or a Multiple Employer Trust (MET), your application will need to provide a clear and concise statement from the U.S. Department of Labor that it is exempt from ERISA requirements, or it will not be accepted.

Please list your Designated Third-Party Administrator (TPA) who administers claims under your Employee Welfare Benefit Plan below.

Name	Address	City/State	Zip	Telephone Number
Anthem				

COVERAGE INFORMATION				
Requested Effective Date:	<u>January 1, 2026</u>			
Aggregate Excess Loss Coverage				
<input type="checkbox"/> Include	<input checked="" type="checkbox"/> Do Not Include			
Coverages To Be Included:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Other _____
<input type="checkbox"/> Weekly Disability Income – Maximum per covered employee or policy period: N/A	<input type="checkbox"/> Other _____			

