Sun Life Assurance Company of Canada
STOP-LOSS POLICY

Policyholder: **Valdez City School District**

Policy Number: **908195**

Policy Effective Date: **April 1, 2018**

This Policy is delivered in Alaska and is subject to the laws of that jurisdiction.

Sun Life Assurance Company of Canada agrees to pay the benefits provided by this Policy in accordance with the provisions contained herein. This Policy is issued in consideration of the Application submitted by the Policyholder, a copy of which is attached, and continued payment of premium by the Policyholder. The Application, and any Riders, Endorsements, Addenda and Amendments to this Policy are made part of this Policy.

The Policyholder will hereafter be referred to as "You," "Your," and "Yours."

Sun Life Assurance Company of Canada will hereafter be referred to as "We," "Our," and "Us."

When determining any date under this Policy, all days begin at 12:00:00 a.m. and end at 11:59:59 p.m. standard time for Your headquarters.

Signed at Our U.S. headquarters, One Sun Life Executive Park, Wellesley Hills, Massachusetts, by:

Dean A. Connor
President and Chief Executive Officer

Brigitte K. Catellier
Vice President, Associate General Counsel and
Corporate Secretary

PLEASE READ YOUR POLICY CAREFULLY
Non-Participating

This is a reimbursement policy. You, or Your Plan administrator, are responsible for making benefit determinations under Your Plan. We have no duty or authority to administer, settle, adjust or provide advice regarding claims filed under Your Plan.

Sun Life Financial®

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Schedule of Benefits
Specific Benefit

Original Specific Benefit Effective Date	April 1, 2018
Benefit Specifications	
Policy Year	April 1, 2018 through March 31, 2019
Reimbursement Percentage	100% of Eligible Expenses
Covered Benefits	Medical, Including Prescription Drugs
Specific Benefit Deductible	$150,000
Specific Benefit Lifetime Maximum Eligible Expenses	Unlimited
Specific Benefit Claims Basis	**24/12 (12 Month Run-In)** Eligible Expenses include only those expenses Incurred during the Policy Year, or within 12 months prior to the Policy Year (the "Run-In Period"), and Paid during the Policy Year.
Covered Unit(s)	Single Employee, Employee and Family
Retirees	Not Covered
Specific Benefit Premium Rate	$243.00 per Single Employee, Employee and Family per month
Premium Due Date	The Policy Effective Date and the first day of each succeeding month.

Schedule of Benefits
Aggregate Benefit

Original Aggregate Benefit Effective Date	April 1, 2018

Benefit Specifications

Policy Year	April 1, 2018 through March 31, 2019
Reimbursement Percentage	100% of Eligible Expenses
Covered Benefits	Medical Prescription Drug Plan (PDP)
Aggregate Benefit Maximum	$1,000,000
Aggregate Benefit Maximum Eligible Expenses Per Covered Person	$150,000
Aggregate Deductible Factor ("ADF")	The ADF per Benefit Month for each Covered Unit by Covered Benefit is as follows:

Covered Benefit	Covered Units	ADF
Medical	Single Employee and Employee and Family	$2,001.60
PDP	Single Employee and Employee and Family	$325.68

Minimum Aggregate Deductible	The Minimum Aggregate Deductible for the current Policy Year is the greater of: a) $5,956,906**;** or b) 90% of the Monthly Aggregate Deductible for the first month of the Policy Year, then multiplied by 12.
Aggregate Benefit Attachment Point	The Aggregate Benefit Attachment Point is the greater of: a) the sum of the Monthly Aggregate Deductibles for the Policy Year; or b) the Minimum Aggregate Deductible.
Aggregate Benefit Claims Basis	**24/12 (12 Month Run-In)** Eligible Expenses include only those expenses Incurred during the Policy Year, or within 12 months prior to the Policy Year (the "Run-In Period"), and Paid during the Policy Year.
Covered Unit(s)	Single Employee, Employee and Family
Retirees	Not Covered
Aggregate Benefit Premium Rate	$11.76 per Covered Units per month.
Premium Due Date	The Policy Effective Date and the first day of each succeeding month.

Section I
Definitions

Alternative Care: For the purpose of determining Eligible Expenses under this Policy, Alternative Care means a plan of Treatment identified through case management services provided to Your Plan. Expenses arising from Alternative Care for reimbursement may be considered Eligible Expenses if the Treatment is cost-effective and Medically Appropriate and Necessary for the care of a Covered Person. Alternative Care must satisfy the requirements set forth in Section II, Expenses Eligible for Reimbursement.

Benefit Month: Any calendar month during which this Policy is in force.

Catastrophic Diagnosis: Any medical condition that is a special risk on Our Special Risk Questionnaire.

Claims Basis: The period of time, shown on the Schedule(s) of Benefits, during which Eligible Expenses must be Incurred by a Covered Person and Paid by You to be eligible for reimbursement under this Policy.

Covered Benefits: The benefit provisions of Your Plan that are insured for stop-loss coverage under this Policy. The Covered Benefits for this Policy are shown on the Schedule(s) of Benefits.

Covered Person: A person enrolled in Your Plan and entitled to receive benefits under Your Plan while this Policy is in force. Retirees, as defined by Your Plan, may be Covered Persons if they are included on the Schedule(s) of Benefits. Covered Person also includes a person enrolled in Your Plan and entitled to receive benefits under Your Plan during the Run-In Period who dies before the Policy Effective Date.

Covered Unit: A category of participants under Your Plan. The Covered Unit(s) for this Policy are shown on the Schedule(s) of Benefits.

Dependent: A person enrolled in Your Plan and entitled to receive benefits under Your Plan as a dependent of a Covered Person. If the law of the state where the Policy is issued requires that domestic partners be covered under Your Plan, then individuals who are domestic partners under the law shall be considered Dependents under the Policy.

Drug or Alcohol Dependence: Dependence on, or abuse of, a chemical substance or alcohol as classified by the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association ("DSM") or a comparable manual if the American Psychiatric Association stops publishing the DSM.

Experimental or Investigational Treatment: For the purpose of determining Eligible Expenses under this Policy, a Treatment (other than covered Off-Label Drug Use) will be considered experimental or investigational if:

1. The Treatment is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the Treatment for the particular condition at the time the Treatment is provided; or
2. The Treatment is provided as part of an ongoing Phase I, II, or III clinical trial as defined by the National Institute of Health, National Cancer Institute or the FDA; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the Treatment.

Experimental or Investigational Treatment shall not include any Treatment provided as part of a clinical trial that would have been provided to the Covered Person if the Covered Person had not participated in the clinical trial.

Incurred: The date on which Treatment is provided.

Section I
Definitions

Independent Review Panel: A panel retained through a third party vendor of medical review services that is comprised of three physicians who are board-certified in the medical specialty or subspecialty that most typically administers the Treatment under review.

Medical Management Vendor: A third party hired to reduce or control the cost of services or supplies provided to Covered Persons under Your Plan.

Medically Necessary and Appropriate: For the purpose of determining Eligible Expenses under this Policy, a medically necessary and appropriate Treatment is one that meets all of the following criteria:

1. It is recommended and provided by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license; and
2. It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
3. It is approved by the FDA, if applicable.

Mental Illness: For the purpose of determining Eligible Expenses under this Policy, Mental Illness includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders and any other mental and nervous condition classified in the DSM. Mental Illness does not include any condition listed in Appendix G of the DSM-IV, titled "ICD-9-CM Codes for Selected General Medical Conditions and Medication Induced Disorders," or any comparable listing if Appendix G is no longer published.

Off-Label Drug Use: The use of a drug for a purpose other than that for which it was approved by the FDA.

Original Aggregate Benefit Effective Date: When We provide You with Aggregate Benefit coverage under this Policy for consecutive Policy Years, the Original Aggregate Benefit Effective Date is the date Aggregate Benefit coverage first became effective in the consecutive year period.

Original Specific Benefit Effective Date: When We provide You with Specific Benefit coverage under this Policy for consecutive Policy Years, the Original Specific Benefit Effective Date is the date Specific Benefit coverage first became effective in the consecutive year period.

Paid: The date Your check or draft for payment of expenses Incurred by a Covered Person is issued and delivered to the payee, provided that the account upon which the payment is drawn contains sufficient funds to permit the check or draft to be honored.

Plan: Your self-funded benefit plan established to provide benefits to Covered Persons as described in Your plan document. For the purpose of determining benefits payable under this Policy, the Plan shall not include any amendments made to the plan document after the Original Aggregate Benefit Effective Date or the Original Specific Benefit Effective Date, whichever is earlier, unless We notify You in writing from Our U.S. Headquarters that We accept the amendment.

Policyholder: You, the legal entity to whom this Policy is issued.

Prescription Drugs: For the purpose of determining Eligible Expenses under this Policy, Prescription Drugs includes all prescription drugs covered under Your Plan, other than prescription drugs administered to a Covered Person while he or she is confined in a hospital or other medical facility.

Prescription Drug Plan: A benefit provision of Your Plan, or a separate employee benefit plan maintained by You, under which prescription drug expenses are paid independently of other medical expenses. Expenses incurred under a Prescription Drug Plan will be included as Eligible Expenses only if the Prescription Drug Plan is included as a Covered Benefit in the Schedule of Benefits. A Prescription Drug Plan does not mean prescription drug expenses paid subject to any deductibles and coinsurance applicable to other medical benefits under Your Plan.

Provider Network: A Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service Plan (POS), self-funded Health Maintenance Organization (HMO), or any managed care network offered under Your Plan.

Reimbursement Percentage: The percent of Eligible Expenses that will be considered for reimbursement under this Policy.

Schedule of Benefits: This Policy's schedule of Specific Benefit coverage or Aggregate Benefit coverage provided under this Policy.

Special Risk Questionnaire: A report used to provide Us with certain information We require to underwrite this Policy.

Third Party Administrator ("TPA"): A third party that You have entered into an agreement with to provide administrative services to Your Plan. Your TPA is not Our agent.

Transplant: The transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by this Policy.

A Transplant must be performed at a Transplant Facility in order to be considered for reimbursement under this Policy.

Transplant Facility: A hospital or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant and:

For organ transplants: is an approved member of the United Network for Organ Sharing for such Transplant or is approved by Medicare as a transplant facility for such Transplant;

For unrelated allogeneic bone marrow or stem cell transplants: is a participant in the National Marrow Donor Program;

For autologous stem cell transplants: is approved to perform such Transplant by: (a) the state where the Transplant is to be performed; or (b) Medicare; or (c) the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient transplant facilities must be similarly approved.

Treatment: Any treatment, procedure, service, device, supply or drug provided to a Covered Person.

Usual and Customary Charge: The usual and customary charge for the locality where the expenses are incurred.

Section I
Definitions

U.S. Headquarters: Our United States headquarters located at One Sun Life Executive Park, Wellesley Hills, Massachusetts.

Section II
Benefit Provisions
Specific Benefit

Definitions

Specific Benefit Deductible: The amount of Eligible Expenses relating to a Covered Person that You must pay before You become eligible for a Specific Benefit.

Specific Benefit Lifetime Maximum Eligible Expenses: The Specific Benefit Lifetime Maximum Eligible Expenses is the maximum amount of Eligible Expenses We will ever apply towards the Specific Benefit for a Covered Person during his or her lifetime. All Eligible Expenses incurred by a Covered Person during the first Policy Year or any subsequent Renewal Policy Year will apply toward the Specific Benefit Lifetime Maximum Eligible Expenses. The Specific Benefit Lifetime Maximum Eligible Expenses amount is shown in the Schedule of Benefits.

Specific Benefit

The Specific Benefit for any Covered Person for any Policy Year equals:

1. The total amount of Eligible Expenses for the Covered Person; minus
2. The Specific Benefit Deductible.

multiplied by the Reimbursement Percentage shown on the "Schedule of Benefits – Specific Benefit," if that Reimbursement Percentage is less than 100%.

The amount of Eligible Expenses with respect to any Covered Person is subject to the Specific Benefit Lifetime Maximum Eligible Expenses.

Section II
Benefit Provisions
Aggregate Benefit

Definitions

Aggregate Benefit Attachment Point: The amount of Eligible Expenses You must pay during the Aggregate Benefit Claims Basis before We will consider an Aggregate Benefit claim. The Aggregate Benefit Attachment Point is shown on the Schedule of Benefits.

Aggregate Deductible Factor: The deductible factor per Benefit Month per Covered Unit by Covered Benefit. The Aggregate Deductible Factor for each Covered Benefit is shown on the Schedule of Benefits.

Aggregate Benefit Maximum Eligible Expenses per Covered Person: The maximum amount of Eligible Expenses for any one Covered Person that will be used to calculate the Aggregate Benefit. The Aggregate Benefit Maximum Eligible Expenses per Covered Person is shown on the Schedule of Benefits

Minimum Aggregate Deductible: The minimum amount of Eligible Expenses You must pay before You become eligible for an Aggregate Benefit. The Minimum Aggregate Deductible is shown on the Schedule of Benefits.

Monthly Aggregate Deductible: The sum of the deductibles for all Covered Benefits for each Benefit Month. The deductible for each Covered Benefit is calculated by multiplying the number of Covered Units on the first day of the Benefit Month by the Aggregate Deductible Factor for each Covered Benefit. The calculation of the Monthly Aggregate Deductible is subject to the 5% Adjustment Rule.

5% Adjustment Rule: If the Monthly Aggregate Deductible decreases from one month ("Month A") to the next ("Month B"), for any reason, the Monthly Aggregate Deductible for Month B shall not be less than 95% of the Monthly Aggregate Deductible for Month A.

Aggregate Benefit

The Aggregate Benefit equals:

1. The total amount of Eligible Expenses for all Covered Persons, subject to the Aggregate Benefit Maximum Eligible Expenses Per Covered Person, [multiplied by the Related Provider Reimbursement Percentage, if applicable]; minus
2. The Aggregate Benefit Attachment Point; and

multiplied by the Reimbursement Percentage shown on the "Schedule of Benefits – Aggregate Benefit," if that Reimbursement Percentage is less than 100%.

The Aggregate Benefit will be calculated after the end of the Aggregate Benefit Claims Basis.

Aggregate Benefit Maximum

The Aggregate Benefit We will pay will not exceed the Aggregate Benefit Maximum shown on the Schedule of Benefits.

Section II
Benefit Provisions
SunExcel® Centers of Excellence

Introduction

This is a voluntary program. If you utilize it, you must comply with the following terms to receive a benefit under it.

This program provides a number of benefits, which include:

- Providing Covered Persons with access to Centers of Excellence Transplant Facilities;
- Reducing the Specific Benefit Deductible for a Covered Person who uses a Centers of Excellence Transplant Facility for a Transplant;
- Payment of the transplant network access fee;
- Reimbursement for travel and lodging expenses incurred by a Covered Person and the parents/legal guardians of a Covered Person who is a Dependent immediately prior to, and following, a Transplant if such expenses are covered under Your Plan; and
- Reimbursement for certain expenses and deductibles paid by the Policyholder.

Definitions For the purpose of this program, the following term shall be defined as follows:

Centers of Excellence Transplant Facility: A Transplant Facility We have contracted with as part of the SunExcel® Centers of Excellence Transplant Benefit program.

Requirements
To qualify for the Transplant Benefits, You and Your Plan must satisfy all of the following requirements:

1. Your Plan must:
   a) Require pre-certification for Transplant related hospitalizations and outpatient Transplant procedures;
   b) Offer a minimum Transplant benefit of $300,000;
   c) Treat Centers of Excellence Transplant Facilities as in-network providers; and

2. You must:
   a) Require Your TPA and Provider Network(s) to permit Covered Persons to access SunExcel® Centers of Excellence Transplant Facilities;
   b) Advise Your TPA and Medical Management Vendor(s) that Covered Persons may access Centers of Excellence Transplant Facilities.
   c) Agree to waive any exclusion under Your Plan that excludes expenses relating to the acquisition of an organ for a Transplant ("organ acquisition expenses"), when organ acquisition expenses are included in the global fee negotiated with a Centers of Excellence Transplant Facility; and
   d) Advise Your TPA or Medical Management Vendor(s) to contact Our Stop Loss Case Management department at 1-888-467-4267 when You or they receive notice that a Covered Person may require a Transplant so that We can set up the transplant contract with the Center of Excellence Transplant Facility.

SunExcel® Centers of Excellence Transplant Benefit
If You satisfy the requirements set forth above, and a Covered Person has a Transplant performed at a Centers of Excellence Transplant Facility, We will:

1. Reduce the Specific Benefit Deductible for the Covered Person by $10,000 amount for the Policy Year in which the Transplant occurs; and
2. Pay any fee required for access to the Centers of Excellence Transplant Facility.

In addition, if Your Plan provides the following benefits as Covered Benefits under the Eligible Expenses under the SunExcel® Transplant Benefit, will include:

1. Up to $5,000 for any travel and lodging expenses incurred by the Covered Person and one companion or parents/legal guardians of a Covered Person who is a Dependent immediately prior to, and following, the Transplant; and/or
2. Up to $1,500 for any deductible and co-payments waived by, or paid to, the Covered Person by Your Plan, for the year in which the Transplant occurs.

Section II
Benefit Provisions
Expenses Eligible for Reimbursement

Eligible Expenses
Eligible Expenses include any amount paid by You for Medically Necessary and Appropriate expenses incurred by a Covered Person which:

1. Have been paid in accordance with the terms of Your Plan; and
2. Were Incurred and Paid during the applicable claims basis; and
3. Are paid under a Covered Benefit shown on the Schedule of Benefits; and
4. Are not otherwise excluded under this Policy.

Alternative Care
In addition to satisfying Eligible Expenses criteria 2,3 and 4 above, expenses related to Alternative Care may be considered Eligible Expenses when all of the following additional criteria have been satisfied and submitted to Sun Life Case Management for approval:

1. You demonstrate to Our satisfaction that providing the Alternative Care resulted in a cost savings to the Plan; and
2. The Alternative Care was recommended by case management services provided to Your Plan; and
3. The Alternative Care was Medically Necessary and Appropriate.

Off-Label Drug Use
In addition to satisfying the criteria for Eligible Expenses set forth above, expenses related to Off-Label Drug Use may be considered Eligible Expenses when all of the following additional criteria have been satisfied:

1. The drug is not excluded under Your Plan; and
2. The drug has been approved by the FDA; and
3. You can demonstrate to Our satisfaction that the Off-Label Drug Use is appropriate and generally accepted in the medical community for the condition being treated; and
4. If the drug is used for the treatment of cancer, a nationally recognized compendia recognize it as an appropriate treatment and
5. The drug is not provided as part of a Phase I, II, or III clinical trial as defined by the National Institute of Health, National Cancer Institute, or the FDA.

Reimbursement of Certain Fees
Eligible Expenses will also include the following fees Incurred and Paid by You, when approved by Us at Our U.S. Headquarters:

1. Reasonable hourly fees for case management services provided by a registered nurse case manager retained by You or Your TPA; and
2. Fees for: (a) hospital bill audits; (b) access to non-directed provider networks; and (c) negotiating out of network bills.
3. Such fees shall be considered Eligible Expenses only if You can demonstrate to Us that the work that generated the fees resulted in a cost savings to the Plan. If the Plan can demonstrate such a cost savings, We will reimburse You up to 40% of the amount saved.
4. Fees charged by Your TPA or any subsidiary of Your TPA for any of these services will be considered Eligible Expenses only if prior approval has been obtained in writing from Us at Our U.S. Headquarters.

State Health Care Surcharges
If You pay a state health care surcharge in connection with the payment of Eligible Expenses, the health care surcharge shall be considered an Eligible Expense. Penalties or fines associated with the health care surcharge or the underlying expenses will not be considered Eligible Expenses.

Section II
Benefit Provisions
Limitations and Exclusions

We will NOT reimburse You for:

1. Expenses for medical services rendered to a Covered Person by the Covered Person's family member or relative.
2. Expenses that are payable or reimbursable under any Workers' Compensation Law or similar legislation.
3. Expenses for any cosmetic Treatment as defined in Your Plan. This exclusion does not apply to expenses relating to breast reconstruction after mastectomy.
4. Expenses for any Experimental or Investigational Treatment.
5. Expenses for any transplant not included in the definition of Transplant.
6. Expenses relating to non-human organ or tissue transplants, gene therapies, xenographs or cloning.
7. Expenses for any Treatment administered outside the United States if the Covered Person traveled to the location where the Treatment was received for the purpose of obtaining the Treatment.
8. Expenses for benefits in excess of Your Plan's limits, or expenses that are excluded under Your Plan.
9. Expenses in excess of the Usual and Customary Charge.
10. Any amount paid by You in excess of a negotiated provider discount, or any penalty or late charge incurred, or any discount lost, unless previously approved in writing by Us at Our U.S. Headquarters.
11. Expenses associated with the administration of Your Plan including, but not limited to, claim payment fees, cost containment administrative fees, Pharmacy Benefit Manager administration fees, PPO access fees, premium functions, medical review and consultant fees, unless otherwise covered under this Policy.
12. Expenses paid by You relating to any litigation concerning Your Plan, including, but not limited to, attorneys' fees, extra-contractual damages, compensatory damages and punitive damages.
13. Any portion of an expense which You are not obligated to pay under Your Plan, or which is reimbursable to You under:
    a) Another group health benefit program; or
    b) A government or privately supported medical research program; or
    c) Medicare; or
    d) Any coordination of benefits or non-duplication of benefits provision of Your Plan; or
    e) Worker's compensation; or
    f) Any other source.
14. Expenses incurred by a person who is employed by You at any unit, subsidiary or division of Yours that has not been underwritten by Us.
15. Expenses incurred for any illness or injury due to, or aggravated by, war or an act of war, whether declared or undeclared.
16. Expenses paid by You for any Treatment authorized or approved under any provision of Your Plan which:
    a) Allows the plan administrator to approve alternative care or alternative treatment; or
    b) Allows the plan administrator to alter, modify, or waive Plan provisions or limitations, or
    c) Grants You or Your plan administrator discretion to approve coverage for Treatment not otherwise covered under Your Plan;

    unless the Treatment satisfies the criteria for Alternative Care set forth in Section II.

17. Expenses covered under a Prescription Drug Plan, unless Prescription Drug Plan coverage is a Covered Benefit on the Schedule of Benefits.
18. Expenses for any Transplant if You have a separate insurance policy that covers Transplants for Covered Persons regardless of whether the Covered Person is covered by that policy.

19. Notwithstanding any other Policy provision, We will not reimburse any expense incurred by any employee, or by the employee's dependents, where the employee is a member of: (a) a division, unit, group, subsidiary, affiliate, or class of employee of the Policyholder; or (b) an association, trust, cooperative or similar organization connected with the Policyholder, that is not covered by the Plan as of the Policy Renewal Effective Date.

Section III
Claim Provisions

Proof of Claim
Proof of claim must be provided to Us at Our U.S. Headquarters. Expenses for claims submitted to Us that are not submitted in accordance with the Proof of Claim provisions of this Policy are not reimbursable and shall not be considered Eligible Expenses under the Policy.

Specific Benefit

Written proof of claim, in a form and content satisfactory to Us, must be provided to Us as soon as reasonably possible after the Specific Benefit Deductible for a Covered Person has been satisfied. Proof of claim must be provided to Us no later than 12 months after the end of the Specific Benefit Claims Basis during which the claim arose.

Proof of claim for a Specific Benefit claim shall include the following:

1. A fully completed claim form;
2. A copy of the Covered Person's original enrollment record and records of any change in the Covered Person's coverage under Your Plan;
3. Copies of all bills over $25,000 and invoices for expenses submitted for reimbursement under this Policy;
4. Proof of payment of any expenses submitted to Us for reimbursement under this Policy or a claims paid detailed report, which includes: Dates of Service, Provider Name, Provider TIN, Amount billed, Discount amount, Eligible Amount, Amount paid, Date paid, Reimbursement amount requested, Previously paid amount, ICD 9 codes and CPT Codes; and
5. Any additional information We may require to fulfill Our obligations under this Policy.

Aggregate Benefit

Written proof of claim, in a form and content satisfactory to Us, must be provided to Us as soon as reasonably possible after the end of the Aggregate Benefit Claims Basis for the Policy Year. Proof of claim must be provided to Us no later than twelve (12) months after the end of the Aggregate Benefit Claims Basis.

Proof of claim for an Aggregate Benefit claim shall include the following:

1. A complete aggregate calculation report;
2. A detailed claims history report for all Eligible Expenses Incurred and Paid during the Aggregate Benefit Claims Basis;
3. A report listing all Covered Units eligible for benefits under Your Plan at any time during the Aggregate Benefit Claims Basis;
4. A copy of Your Plan in effect during the Policy Year and any amendments thereto;
5. If Prescription Drug Plan coverage is included as a Covered Benefit on the Schedule of Benefits, a copy of all prescription drug invoices and an itemization thereof, including the amounts of any rebates received by You; and
6. Any additional information We may require to fulfill Our obligations under this Policy.

Appeal of a Claim Determination
You may appeal the initial claim determination made by Us under this Policy by submitting a written appeal to Us at Our U.S. Headquarters within ninety (90) days from the date of Our determination. Your appeal should state the basis of Your disagreement with Our initial claim determination and should include all documentation and information supporting Your appeal that has not been previously provided to Us. Once you receive a determination from Us regarding Your appeal, You will have exhausted Your administrative remedies under this Policy.

Section III
Claim Provisions

Deferred Payments by You
You must obtain prior written approval from Us at Our U.S. Headquarters during the Policy Year in order for any Eligible Expenses Incurred in the Policy Year, but that will be Paid after the end of the applicable claims basis to be considered eligible for reimbursement under this Policy.

Payment of Claims
All benefits due under this Policy will be paid to You. During the Policy Year, reimbursements will be disbursed when the amount payable exceeds $500.00. Any reimbursable amount remaining unpaid at the end of a Policy Year will be paid after the end of the Policy Year.

Section IV
Your Rights and Responsibilities

Authorizations to Release Information
You are responsible for authorizing Your TPA, Plan Administrator, case manager or other third party service provider to release to Us information We request to underwrite, review potential claims, make claim determinations, calculate potential reimbursements, or perform other obligations under this Policy. If We do not receive requested information, it may result in the delay, reduction or denial of a claim.

Disclosure Requirements
This Policy has been underwritten based upon the information You provided to Us concerning all persons eligible for benefits under Your Plan on the Original Specific Benefit Effective Date and/or the Original Aggregate Benefit Effective Date (or on the effective date of any class of Covered Persons added thereafter). This includes, but is not limited to, those persons who are a special risk as defined in the Special Risk Questionnaire.

Your signature on the Application for this Policy warrants and represents to Us that:

1. You or Your authorized representative have consulted with your precertification, utilization review and Medical Management Vendors and Your TPA, or former TPA, to determine who must be disclosed as a special risk on the Special Risk Questionnaire; and
2. You have identified any person who is or may be a special risk by either listing them on the Special Risk Questionnaire or by indicating any such person on the reports listed on the Special Risk Questionnaire.

If You fail to disclose an individual as a special risk, who should have been disclosed as a special risk in accordance with the Special Risk Questionnaire, We will have the right to revise the premium rates, deductibles, deductible factors and terms and conditions of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten, retroactive to the Original Specific Benefit Effective Date and/or the Original Aggregate Benefit Effective Date.

Reporting Requirements
You are required to provide periodic reports to Us as described below. If You, or Your TPA, do not provide the reports, or do not provide them on a timely basis, We reserve the right, once we receive them, to take whatever action We could have taken if the reports had been provided when required. Such action may include, but is not limited to, the right to revise premium rates, deductibles, and deductible factors, and to do so retroactive to the Original Specific Benefit Effective Date and/or the Original Aggregate Benefit Effective Date.

Specific Benefit Reporting

You, or Your TPA, are required to provide Us with notice of any potential Specific Benefit claim within thirty-one (31) days of the date:

1. A Covered Person's Eligible Expenses exceed 50% of the Specific Benefit Deductible; or
2. You, Your TPA, or Your medical management, utilization review or precertification vendors, or any other party acting on Your behalf, are notified that a Covered Person has been diagnosed with, or treated for, a Catastrophic Diagnosis.

Aggregate Benefit Reporting

You, or Your TPA, are required to provide Us upon request a report (the "Aggregate Benefit Report") that lists:

1. The total amount of Eligible Expenses Incurred by any Covered Person and Paid by You, or Paid on Your behalf, during the Benefit Month; and
2. The number of each type of Covered Unit on the first day of the Benefit Month.

If you have purchased the Monthly Aggregate Accommodation Benefit, You must provide Us with an Aggregate Benefit Report within thirty-one (31) days after the end of each Benefit Month.

Renewal Reporting

If You intend to renew this Policy, then three months prior to the end of the Policy Year, You, or Your TPA, are required to provide Us with a report that includes the following information:

1. Monthly Paid claims and enrollment data, organized by Covered Benefit;
2. Large claim information, including amount, diagnosis and prognosis, and any Covered Person who has been diagnosed with a Catastrophic Diagnosis;
3. A census of all Covered Persons;
4. A summary of the number of Covered Persons by workplace zip code, if this Policy covers Employees at multiple locations;
5. A summary report of precertification, utilization review and case management services;
6. A summary report of Your Provider Network(s) or per diem arrangements, setting forth the average hospital discount or per diem charge per day;
7. A copy of changes adopted by or proposed for Your Plan.

Plan Changes

You must notify Us in writing at Our U. S. Headquarters at least thirty-one (31) days before the effective date of any change in, or to:

1. Your Plan;
2. Your TPA;
3. Your Provider Networks; or
4. Your Medical Management Vendors.

Our prior written agreement is required before the coverage under this Policy will apply to any such change. Otherwise, benefits under this Policy will be paid based upon the terms of Your Plan, as it existed prior to any such change. We reserve the right to terminate this Policy as of the effective date of any change in or to Your Plan, Your TPA, Your Provider Network, or Your Medical Management Vendor.

Notice of Legal Action

You agree to give Us prompt notice of: (a) any event that might result in a lawsuit relating to this Policy; or (b) any lawsuit involving this Policy; and to promptly provide Us with copies of any correspondence and pleadings relating to any such event or lawsuit.

Hold Harmless

You agree to defend, indemnify and hold Us harmless from and against any and all claims, demands and causes of action of every kind, relating to any litigation, that We, without Our fault, become involved with that relates to this Policy. You shall pay any and all attorneys' fees, costs, expenses, and damages (including compensatory, exemplary or punitive damages) incurred by Us, or payable by Us, in connection with any such litigation.

This Hold Harmless provision shall not apply to litigation solely between You and Us relating to this Policy.

Refund of Overpayment

If We, You, or Your TPA determine that We have overpaid You under this Policy, You will promptly refund such overpayment to Us within 60 days of such a determination. If We are required to take legal action to collect such overpayment, You agree to indemnify Us for any costs of collection, including, but not limited to, attorneys fees and court costs.

Section IV
Your Rights and Responsibilities

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

Right of Recovery
You must pursue all valid claims including, but not necessarily limited to, claims for restitution, constructive trust, equitable lien, breach of contract, injunction, and any other state or federal law claims You or Your Plan may have against any third party responsible, in whole or in part, for any Eligible Expenses Paid by You. You must immediately advise Us of any amount You recover from them. We reserve the right to pursue any and all such claims not pursued by You, and You agree to assign such claims to Us upon Our request.

Section V
Our Rights and Responsibilities

Audit
We have the right to inspect and audit any and all of Your records and procedures, and those of Your TPA and any other party, that relate to any claim made by You under this Policy. We have the right to require documentation from You that demonstrates You paid an Eligible Expense and that the payment was made in accordance with the terms of Your Plan. We reserve the right to employ a third party, at Our expense, to assist Us with any audit function.

Determination of Eligible Expenses
For the purpose of determining Eligible Expenses under this Policy, We have the right to determine whether an expense was Paid by You in accordance with the terms of Your Plan.

Cost Containment
We have the right to retain the services of a Medical Management Vendor, or other service providers at Our expense, to (a) assist Us with cost containment with respect to claims under Your Plan; or (b) provide services to You, Your Plan, or Your Plan Participants to reduce cost, risk or expenses under Your Plan. We may also cause a Medical Management Vendor or other service provider, with whom we may have negotiated a set or discounted rate, to contact You if, the Medical Management Vendor or other service provider provides a service that may allow You or Your Plan to reduce Your risk, costs and expenses.

Confidentiality
We will protect the privacy and confidentiality of all personally identifiable and/or medical information provided to Us in the course of underwriting or administering this Policy in accordance with Our policies and applicable state and federal laws.

Recoupment
We have the right to recoup from any benefit payable to You under this Policy any premium You owe to Us that has not been paid. Our right of recoupment does not impair Our right to terminate this Policy for non-payment of premium under the Termination Provisions of this Policy.

Right to Recalculate
We have the right to recalculate any Specific Benefit Premium Rate, Specific Benefit Deductible, Aggregating Specific Deductible, Aggregate Benefit Premium Rate, Aggregate Deductible Factor or Minimum Aggregate Deductible with respect to this Policy Year whenever any one or more of the following events occur:

1. Your Plan changes;
2. You change Your TPA, Your Provider Network(s), or Medical Management Vendor(s);
3. This Policy is amended;
4. The number of Covered Units on the first day of a Benefit Month increases or decreases by more than 15% from the number of Covered Units on the first day of the Policy Year;
5. The number of Covered Units on the first day of a Benefit Month increases or decreases by more than 10% from the first day of the prior Benefit Month;
6. A unit, division, subsidiary, or affiliated company of Yours is added to, or deleted from, this Policy;
7. The amount of Eligible Expenses paid in any one of the three (3) months immediately preceding the Policy Effective Date (the "three month period") exceeds 125% of the monthly average of Eligible Expenses Incurred during the nine (9) months immediately preceding the three month period; or
8. There are changes in Your, or Your TPA's, claim paying system or payment practices that causes a variation of fifteen (15) days or more in the most recent twelve (12) month average of claim processing time.

Any right to recalculate exercised under this section may be made retroactive to the Policy Effective Date at Our election. Any recalculation will be made in accordance with Our underwriting practices in effect at the time the Policy was underwritten. The right to recalculate shall survive the termination of this Policy.

Section V
Our Rights and Responsibilities

Right of Reimbursement

Any portion of an Eligible 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 deductible or 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.

Section VI
General Provisions

Assignment
Your interest in this Policy cannot be assigned.

Bankruptcy or Insolvency
The bankruptcy, insolvency, dissolution, receivership or liquidation of You, Your Plan or Your TPA will not impose upon Us any obligations other than those set forth in this Policy.

Clerical Error
In the event of a clerical error in this Policy, the Policy will be revised to correct the error. Your failure to:
1. Report the existence of a Covered Person; or
2. File proof of claim in a timely manner; or
3. Comply with the reporting requirements of this Policy;

shall not constitute clerical error.

Entire Contract
This Policy, along with any Attachments, Riders, Endorsements, Addenda or Amendments, and the Application completed by You constitutes the entire contract of insurance between us.

Legal Action
You may not bring a legal action against Us to recover on this Policy earlier than sixty (60) days after You have furnished Us with proof of claim in accordance with the Proof of Claim provisions of this Policy. You may not bring any legal action against Us to recover on this Policy after two (2) years from the time proof of claim is required under this Policy.

Statements
In the absence of fraud, all statements made in any application are considered representations and not warranties.

Misrepresentation
If:
1. You make any misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation You, Your TPA 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 expenses or claims that were incurred or paid, but not reported to Us, during the underwriting of this Policy;

We have the right, at Our election, to rescind this Policy or to revise the premium rates, deductibles, and terms and conditions 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 Policy Effective Date.

No ERISA Liability
Under no circumstance will We accept responsibility as a "Plan Administrator" or be deemed a "plan fiduciary" with respect to your Plan under the Employee Retirement Income Security Act of 1974, as amended.

Non-Participating Policy
This Policy is non-participating and does not share in Our surplus earnings.

Section VI
General Provisions

Policy Amendment
No change in this Policy, or waiver of any of its provisions, will be valid unless such change or waiver is in writing and agreed to by Us at Our U.S. Headquarters and made a part of this Policy. No agent, broker, TPA, or managing general underwriter has authority to change this Policy or waive any of its provisions.

Policy Renewal
This Policy may be renewed unless it has been terminated or is subject to termination in accordance with the Termination Provisions of this Policy. Policy changes for any renewal policy will appear on a revised Schedule of Benefits and/or a Policy amendment. Your payment of the renewal premium after receipt of the revised Schedule of Benefits and/or Policy amendment constitutes acceptance of the renewal policy by You.

No New Special Conditions Rider at Renewal
We guarantee that if You renew Your Policy with Us, Your renewal stop loss policy will not contain a new or revised Special Conditions Rider, provided that:

1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy;

2. Your renewal stop loss policy contains no material changes from Your present Policy; and

3. A new unit, division, subsidiary, affiliated company or class of covered people is not added to this Policy.

We reserve the right to carry over to the renewal stop loss policy any Special Conditions Rider that is part of Your current Policy.

If any change referenced in sections 1 through 3 above is material, this provision shall be of no force and effect.

Renewal Rate Increase Cap
If You renew Your Policy with Us, We guarantee that the Specific Benefit Premium Rate on Your renewal stop loss policy will not be increased more than 50% over the Specific Benefit Premium Rate shown on the Schedule of Benefits, provided that:

1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy;

2. Your renewal stop loss policy contains no material changes from Your present Policy; including, but not limited to, changes to: a) the length of the Policy Year; (b) Covered Benefits; (c) coverage for Retirees; (d) the Specific Benefit Deductible; (e) the Claims Basis; (f) the Specific Benefit Lifetime Maximum or Annual Maximum Eligible Expenses; (g) the Specific Benefit Reimbursement Percentage; (h) the commission payable; (i) Your TPA; or (j) Provider Networks;

3. There are no material changes in the demographic distribution of the group covered by Your current Policy versus the group covered by the renewal stop loss policy; and

4. A new unit, division, subsidiary, affiliated company or class of covered people is not added to this Policy.

5. There is no change in any assessment levied against Us by the state in which this Policy was issued.

If any change referenced in sections 1 through 3 above is material, we shall adjust the Renewal Rate Increase Cap accordingly.

Premium Provisions

Premium Payments

Premium is due on or before the Premium Due Date.

Grace Period

A grace period of forty five (45) days will be allowed for the payment of each premium due after the first premium has been paid. This Policy will continue in force during the grace period. If a premium is not paid by the end of the Grace Period, this Policy will terminate, without notice to You, as of the last date for which premium was paid.

Premium Data

You must provide a report to Us with each premium payment, in a form satisfactory to Us, that lists:

1. The number of each type of Covered Unit, for each Covered Benefit, under Your Plan on the first day of the Benefit Month; and
2. The amount of premium paid.

We use such premium data reports solely to process premium. They do not replace any report required, or which may be required, under Section IV of this Policy.

Severability

In the event that a court of competent jurisdiction invalidates any provision of this Policy, all remaining provisions of the Policy shall continue in full force and effect.

Termination Provisions

1. If You fail to pay the premium, this Policy will terminate in accordance with the Premium Provision of this Policy.
2. If Your Plan is terminated, this Policy will terminate on the date the Plan terminated.
3. If You fail to maintain a minimum of 35 participants in Your Plan at any time during the Policy Year, We may elect to terminate this Policy at the end of the first month during which there are less than 35 participants.
4. This Policy will terminate at the end of the Policy Year unless agreed by You and Us to renew.
5. If You, or Your TPA, fail to satisfy any of Your obligations under this Policy We may terminate this Policy at the end of the Policy Year by providing You forty five (45) days advanced written notice.
6. We may terminate this Policy at the end of the Policy Year by providing You 45 days advanced written notice.
7. You may terminate this Policy at any time by providing Us with 31 days advance written notice at Our U.S. Headquarters.

The parties to this Policy may agree in writing to terminate it at any time.

Reinstatement

If this Policy is terminated for non-payment of premium, We may, at Our sole discretion, agree to reinstate it as of the date it terminated upon payment of all outstanding premiums. We may require You to provide certain information to Us before We will consider reinstating the Policy.

Section VI
General Provisions

Time Limitations
If any time limitation in this Policy is less than that permitted by the law of the state in which the Application was taken, the limitation is hereby extended to the minimum period permitted by the law.

SUN LIFE ASSURANCE COMPANY OF CANADA

ADVANCE FUNDING ENDORSEMENT

This endorsement is part of the Policy to which it attaches and is effective on April 1, 2018. It is subject to the terms and conditions of the Policy. If the terms of the endorsement and the Policy conflict, then the terms of the endorsement will control.

DEFINITIONS

Business Day: Any day the New York Stock Exchange (NYSE) is open for regular trading.

BENEFIT

Upon receiving a written request from You or Your TPA, We will advance funds to You or Your TPA to pay expenses incurred by a Covered Person if all of the following conditions are met:

1. You have satisfied the Specific Benefit Deductible for the Covered Person and the Aggregating Specific Deductible, if any.

2. The expenses incurred by the Covered Person: (a) were for Medically Necessary and Appropriate Treatment; (b) are covered under the terms of Your Plan; (c) were incurred within the Specific Benefit Claims Basis; (d) are covered under a Covered Benefit shown on the Schedule of Benefits; and (e) are not otherwise excluded under the Policy;

3. You have approved the expenses incurred by the Covered Person for payment under Your Plan;

4. You have completed and submitted the Stop Loss Advance Funding Request Form;

5. The advance funding request is for an amount equal to or greater than $5,000;

6. The Policy is in force at the time the request for advance funding is made; and

7. We receive the advance funding request at least 30 days before the end of the Specific Benefit Claims Basis. Any advance funding request received after that date is not eligible for advance funding.

Upon receipt of the advance funding payment from Us, You or Your TPA must:

(a) Pay the expenses giving rise to the advance funding request within 10 Business Days after receiving the advance funding payment. If the expenses are paid within this time period, We will consider them to be Paid within the Specific Benefit Claims Basis even if the payment occurs after it. If the expenses are not paid within this time period, You or Your TPA must immediately refund the advance funding payment to Us.

(b) Provide Us with Proof of Claim which demonstrates payment of the expenses incurred by the Covered Person within 10 Business Days of the date You or Your TPA make the payment; and

(c) Refund to Us immediately any funds that are not used to pay the expenses incurred by the Covered Person.

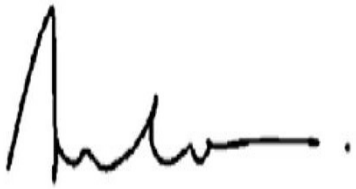
If You do not comply with these requirements, in addition to any other remedy available to Us, we may choose to not advance any other funds under this endorsement.

If We subsequently determine that the expenses incurred by the Covered Person are not eligible for reimbursement under the Policy, You agree to return to Us immediately the amount of the advance funding payment.

GENERAL

Termination

This endorsement will terminate on the date the Policy terminates. If this endorsement terminates and You owe Us any money under it, the total amount owed by You will become immediately due and payable and shall survive the termination of the endorsement.



Dean A. Connor
President and Chief Executive Officer