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CERTIFICATES OF INSURANCE

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CERTIFICATES OF INSURANCE INCLUDED IN THIS PDF

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ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.
CALL **866-438-4274** WITH ANY QUESTIONS.

SIRIUS AMERICA INSURANCE COMPANY

140 BROADWAY, 32nd Floor
NEW YORK, NY 10005
(212) 312-2500

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE

POLICY EFFECTIVE DATE: October 1, 2020 **POLICY ANNIVERSARY DATE:** October 1, 2021 and each October 1 thereafter

Sirius America Insurance Company certifies that We have issued Group Critical Illness Insurance Policy Number HASA-1000 to United Business Association the Policyholder, to insure Eligible Persons described in this Certificate.

Coverage provided by the Policy will be administered on behalf of the Company by Healthy America.

This Certificate describes the benefits and provisions of the Policy and is in effect for You when You meet the conditions of eligibility described in this Certificate and the Policy under which it is issued. This Certificate takes the place of any other Certificate previously issued to you. It contains all of the terms and conditions applicable to this insurance. Please read it carefully and keep it in a safe place.

This Certificate is not the Policy, nor does it waive or alter any of the Policy's terms and conditions. You may examine the Policy at the office of the Policyholder.

Signed for Sirius America Insurance Company:

Min Huang-Li
Vice President, Financial Reporting
and Chief Financial Officer

Robert P. Kuehn
President

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED PROVIDES LIMITED BENEFITS FOR CERTAIN CRITICAL ILLNESSES SPECIFICALLY DEFINED AND DESCRIBED HEREIN
BENEFITS ARE NOT PAYABLE FOR LOSSES FROM ANY OTHER CAUSE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A MEDICARE SUPPLEMENT POLICY
IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM THE COMPANY

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

THE POLICY IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND THE COMPANY
PLEASE READ YOUR CERTIFICATE CAREFULLY
NON-PARTICIPATING

If you need to contact Us for any reason, We can be reached at:
Sirius America Insurance Company
140 Broadway, 32nd Floor
New York, NY 10005
(212) 312-2500

If We at Sirius America Insurance Company fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all of its provisions carefully.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by the Policy. Please read each section, including the section describing the benefits, for full details.

You are an Eligible Person if You are in:

Class 1	All active members of the Policyholder who have chosen to enroll themselves in the GAP 25000 plan option and who have been insured under this Certificate for less than 12 continuous months following his effective date of coverage and immediately prior to a first diagnosis of a Critical Illness;
Class 2	All active members of the Policyholder who have chosen to enroll themselves in the GAP 25000 plan option and who have been insured under this Certificate or under a prior plan of critical illness insurance sponsored by the Policyholder for at least 12 continuous months following his effective date of coverage and immediately prior to a first diagnosis of a Critical Illness; or
Class 3	a Dependent Spouse of an Eligible Person in either Class 1 or Class 2 above.

Initial Enrollment Period 31 days

Maximum Age: Member and Dependent coverage ends when the Member is age 65.

CRITICAL ILLNESS BENEFITS

The following benefits are payable for Critical Illnesses listed in any of the Categories below that are diagnosed while coverage under the Policy is in force. Unless otherwise indicated below, any benefit amount, benefit limit or benefit maximum applies to each Covered Person.

Amounts of Insurance

Guarantee Issue Amount – Not Subject to Evidence of Insurability

Member	
Class 1	$2,500
Class 2	$25,000
Dependent Spouse	
Class 3	Dependent Spouses of Class 1 Members will receive the Class 1 benefit Dependent Spouses of Class 2 Members will receive the Class 2 benefit

The Amount of Insurance is a lifetime benefit, payable once per Covered Person.

Covered Critical Illness Benefits	**Benefit Amount**
Category 1 – Cardiovascular-Related Critical Illnesses	
Heart Attack (myocardial infarction)	100% of the Amount of Insurance
Stroke	100% of the Amount of Insurance
Category 2 - Cancer-Related Critical Illnesses	
Invasive Cancer	100% of the Amount of Insurance

PREMIUM RATE	$15.45 per month per member $30.90 per month per member and Spouse
MODE OF PREMIUM PAYMENT	Monthly
PREMIUM DUE DATES	The Certificate Effective Date and the first day of each modal period thereafter

GENERAL DEFINITIONS

Please note that certain words used in the Policy and this Certificate have specific meanings. The words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Accident means a sudden, unforeseeable event that:
1. directly and independently of all other causes results in bodily injury to a Covered Person;
2. occurs while coverage is in force for the Covered Person;
3. is not contributed to by Sickness, disease or bodily or mental infirmity; and
4. is not otherwise specifically excluded by name or description under the terms of the Policy and this Certificate.

Age means the Age of a Covered Person on His last birthday as of the Certificate Effective Date. His Age increases by one year on each Certificate anniversary.

If coverage is effective after the Policy Effective Date, Age means the Age of a Covered Person as of His last birthday preceding His request for insurance coverage.

Breslow Method means a method for determining the prognosis for a Covered Person with melanoma by measuring the thickness of such melanoma.

Category means a set of Critical Illnesses shown in the ***Schedule of Benefits*** for which the Policy and this Certificate provide benefits.

Certificate Effective Date means the day on which coverage for the Primary Covered Person and other Covered Persons begins as shown on this Certificate's face page. Coverage will begin on the first day of the month following the date:
1. Our Home Office has approved the Primary Covered Person's Enrollment Form; and
2. the Policyholder has paid the first premium.

Class means a group of persons that We and the Policyholder have agreed to insure.

Clinical Diagnosis means a clinical identification of Invasive Cancer or Carcinoma in Situ based on history, laboratory study and symptoms.

Company or **We, Us, Our** means Sirius America Insurance Company, domiciled in New York, New York.

Covered Person means any of the following:
1. the Primary Covered Person; or
2. any eligible Spouse, as indicated in the ***Schedule of Benefits*** whose coverage has become effective; or
3. any eligible Spouse whose coverage has become effective and who is timely added to the Primary Covered Person's Enrollment Form after the Primary Covered Person's effective date of insurance.

Critical Illness means:
1. Heart Attack;
2. Stroke;
3. Invasive Cancer.

Enrollment Form means the form designated by Us that a person in an eligible Class must complete and submit in order to request enrollment in the Policy. Enrollment Forms are available from the Policyholder and must be submitted to the Policyholder to be forwarded to Us or Our authorized representative.

Evidence of Insurability means a form accepted by Us or Our authorized representative showing that an Eligible Member or an Eligible Dependent meets Our requirements to be insured under the Policy.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle resulting from blockage of one or more coronary arteries.

The term Heart Attack does not include the following:
1. an EKG change consistent with transient ischemic change;
2. angina;
3. chance finding of EKG changes suggestive of a previous Heart Attack; or
4. the death of the heart muscle coincidental with death from other causes.

He, His, Him refers to any individual, male or female.

Illness means Sickness or disease of a Covered Person.

Initial Enrollment Period means the period of time during which a Primary Covered Person is first eligible to enroll under the Policy.

Injury means bodily injury sustained which:
1. results directly and independently of all other causes from an Accident;
2. occurs while coverage is in force for the Covered Person;
3. is not caused or contributed to by Sickness; and
4. is not otherwise specifically excluded by name or description under the terms of the Policy and this Certificate.

Invasive Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of local or distant tissue. The term Invasive Cancer also includes Leukemia, Lymphoma and malignant melanoma with a maximum thickness of more than 1.0 mm. as determined by histological examination using the Breslow Method.

The term Invasive Cancer does not include the following:
1. Carcinoma in Situ;
2. All skin cancers, unless there is evidence of metastasis; or
3. Malignant melanoma of less than 1.0 mm. maximum thickness as determined by histological examination using the Breslow Method.

Member means a person who meets all of the conditions of membership and is in good standing with the Policyholder.

Modified Rankin Scale means a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a Stroke. The Modified Rankin Scale runs from 0 to 6 with 0 indicating no symptoms and 6 indicating that the patient has passed away. A score of 5 indicates severe disability causing the Covered Person to be bedridden, incontinent and in need of constant nursing care.

Pathological Diagnosis means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemi (blood) system. A certified pathologist, in keeping with the standards set by the American Board of Pathology, must make a Pathological Diagnosis.

Physician means a medical doctor or other person recognized by law or regulation in the state where His services are rendered. The person must be licensed to practice medicine, prescribe and administer drugs or to perform surgery in the United States.

The term Physician does not include:
1. the Primary Covered Person;
2. a person related to Him by blood or marriage; or
3. a medical doctor or other person practicing outside of the United States.

Policy means the Group Policy issued to the Policyholder.

Policyholder means the entity, in whose name the Policy is issued, as identified on this Certificate's face page.

Policy Effective Date means the date that coverage begins under the Policy.

Primary Covered Person means the person who has completed and signed the Enrollment Form and who has been accepted for coverage by Us. This is the person whose name appears on this Certificate's face page.

Pre-existing Condition means any of the following which a Physician has treated or for which a Physician has advised treatment of the Covered Person within 12 months before the Covered Person's effective date of insurance:
1. Heart Attack;
2. Stroke;
3. Invasive Cancer.

Proof of Loss means information provided to Us, or Our authorized representative, by a claimant that is necessary to properly process and pay a claim.

Schedule of Benefits means the pages so labeled in this Certificate.

Sickness means Illness caused by a Critical Disease:
1. for which benefits are provided by the Policy and this Certificate; and
2. that requires the care of a Physician.

Spouse means the Primary Covered Person's Spouse, provided the Primary Covered Person and His Spouse are not legally separated or divorced.

Stroke, or Cerebrovascular Accident (CVA) means death of brain tissue due to a cerebrovascular event resulting in neurological damage including infarction, hemorrhage or embolization of brain tissue from an extra cranial source for at least 60 days.

The term Stroke does not mean a transient ischemic attack, transient global amnesia, chronic cerebrovascular insufficiency, attacks of vertebrobasilar ischemia or a cerebrovascular event resulting from accidental Injury.

Tentative Diagnosis means a diagnosis of Invasive Cancer or Carcinoma in Situ based upon dated medical records.

You, Your, Member or Primary Covered Person mean the individual who is eligible to enroll for insurance and for whom coverage is provided under the Policy and this Certificate.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Certificate Effective Date
We agree to provide the Critical Illness Insurance Benefits described in this Certificate in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Certificate Effective Date shown on this Certificate's first page.

Individual Coverage - Eligibility
To be eligible for insurance under the Policy as a Primary Covered Person, a person must be a member of an eligible Class as defined in the ***Schedule of Benefits***.

Enrollment
An individual who is a member of an eligible Class may enroll for coverage as a Primary Covered Person during the Initial Enrollment Period as shown in the ***Schedule of Benefits*** that follows the later of:
1. the Policy Effective Date;
2. the date the individual first becomes a member of an eligible Class;
3. the date the individual completes the Waiting Period shown in the ***Schedule of Benefits***, if applicable.

Primary Covered Person Effective Date
Your effective date of coverage under the Policy will be determined follows:
1. If You enroll for coverage when the Policyholder applies for coverage, Your coverage will effective on the Policy Effective Date.
2. If You become eligible after the Policy Effective Date and enroll during a Waiting Period or an Initial Enrollment Period, Your coverage will be effective the first of the month next following the later of the end of any applicable Waiting Period, Initial Enrollment Period and receipt of the Enrollment Form by Us.

Family Coverage - Eligibility
Family members eligible for coverage are:
1. the Primary Covered Person;
2. His Spouse.

A Spouse who is a Member may be covered as a Primary Covered Person or a Covered Dependent, but not both.

Spouse Effective Date
The effective date of Spouse coverage under the Policy, depends on when You enroll the Spouse. The applicable premium must be paid. The effective dates are as follows:
1. If the Spouse are eligible for coverage when the Policyholder applies for coverage, the coverage for the dependent will become effective on the Policy Effective Date if You enroll the Spouse for coverage at that time;
2. If You first become eligible after the Policy Effective Date and You enroll the Spouse during Your Initial Enrollment Period, the coverage for the dependent will be effective on the same date that Your coverage becomes effective;
3. If Your Spouse is a new Spouse who first becomes eligible after Your effective date of coverage and You timely enroll the new Spouse as described above, coverage will become effective as of the first day of the month next following the date on which We receive Your Enrollment Form;

Termination of a Member's Coverage
A Member's insurance under the Policy will automatically terminate on the earliest of the following dates:
1. the date that the Policy terminates;
2. the date of termination of any section or part of the Policy and this Certificate with respect to insurance under such section or part;
3. the premium due date coinciding with or next following the date that the Member ceases to be a member of an eligible Class;
4. the date the Member reaches the Maximum Age shown in the Schedule of Benefits;
5. any premium due date, if premium remains unpaid by the end of the Grace Period; and
6. the date the Policyholder no longer meets participation requirements.

Termination of coverage will not affect a claim for a loss that occurred while coverage was in force under the Policy. However, in no instance will benefit payments extend beyond the date any benefit amount, benefit limit or benefit maximum shown in the ***Schedule of Benefits*** and applicable to the diagnosis of a Critical Illness is reached.

Spouse Termination

If the Primary Covered Person's Spouse is a Covered Person, His coverage will end:

1. with respect to a covered Spouse, on the date He is divorced from the Primary Covered Person; or
2. on the date the Primary Covered Person dies; or
3. on the date the required premium for the Spouse coverage is not paid.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice must be given to Us or Our authorized representative within 90 days after a Covered Person's loss or as soon as reasonably possible thereafter. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at Our Home Office in New York, New York, such other place as We may designate for the purpose, or to Our authorized representative. Notice should include the Policyholder's name and policy number and the Covered Person's name and address.

Claim Forms
We will send forms to the claimant for filing proof of loss when We receive the notice of claim. If claim forms are not sent within 15 days after We receive notice, the proof requirements will be met by the claimant upon submitting, within the time fixed in this Certificate for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which claim is made.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our Home Office or to Our authorized representative, within 90 days of the loss for which claim is made. Failure to furnish proof within the time required will not invalidate or reduce a claim if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims
We will pay benefits due under this Certificate for any loss immediately upon receipt of due written or authorized electronic proof of such loss. Any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us, unless otherwise stated in this Certificate.

Payment of Claims
All benefits will be paid in United States currency. All proceeds payable under the Policy, unless otherwise stated, will be payable to the Covered Person. If the Covered Person dies before all payments due have been made, all remaining amounts payable will be paid to the Covered Person's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for His property, a payment not exceeding $1,000 may be made at Our option to any relative by blood or connection by marriage of the payee who has submitted reliable documentary evidence and, in Our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs. Any payment We make in good faith fully discharges Our liability to the extent of the payment made.

If the Covered Person provides Us with a written release to do so, we may, at Our option, pay benefits directly to the institution or person rendering treatment or services covered under the Policy.

Physical Examination
We, at Our own expense, have the right and opportunity to examine a Covered Person when and as often as We may reasonably require while a claim is pending.

Legal Actions
No action at law or in equity will be brought to recover benefits under the Policy less than 60 days after satisfactory proof of loss has been furnished as required by the Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

ADMINISTRATIVE PROVISIONS

Grace Period
A Policy Grace Period of 31 days will be granted for payment of required premiums due after the first premium, unless:
1. the Policyholder has given Us advance written notice of intent to discontinue coverage in accordance with the terms of the Policy; or
2. We do not intend to renew the Policy beyond the period for which premium has been accepted; and
3. written notice of Our intention not to renew is delivered to the Policyholder at least 31 days before the premium is due.

The Policy and Certificates under the Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The Policyholder is liable to Us for any unpaid premium for the time the Policy was in force.

Premiums
Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for the Policy will be based on the rates set forth in this Certificate, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Premium Payment
The total premium paid by the Policyholder is the sum of premiums for all Covered Persons including any amounts contributed toward the cost of the coverage by Covered Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the ***Schedule of Benefits***, unless the Policyholder and We agree to another mode of premium payment. Premiums are paid at Our Home Office or to Our authorized representative.

If any premium is not paid when due, the Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in the Grace Period provision.

GENERAL PROVISIONS

Entire Contract; Changes
The Policy, the Policyholder's Application, and any attached Riders or Amendments along with this Certificate make up the entire contract. A copy of the Primary Covered Person's Enrollment Form will also be attached.

No change in the Policy or this Certificate will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to the Policy. No agent may change the Policy or waive any of its provisions.

Misstatement of Age
If premiums for a Covered Person are based on age and the Covered Person's age has been misstated, there will be a fair adjustment of premiums based on His true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on His true age. We may require satisfactory proof of age before paying any claim.

Assignment
The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Incontestability
In the absence of fraud, all statements You have made to obtain insurance under the Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from Your effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or material misrepresentation.

In the event of death or incapacity, Your representative shall be given a copy.

Conformity with State Statutes
Any provision of the Policy and any Certificate, which, on its effective date, is in conflict with the statutes of the state in which the Policy or Certificate is delivered, is hereby amended to conform to the minimum requirements of those statutes.

Clerical Error
Clerical error, whether by the Policyholder or Us, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect or extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

Workers' Compensation Insurance
The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

CRITICAL ILLNESS BENEFITS

We will pay the benefits shown in the ***Schedule of Benefits***, to a Covered Person who is diagnosed by a Physician with a Critical Illness in any of the Categories listed below, subject to all applicable conditions, exclusions and limitations**,** provided that:

1. the Critical Illness occurs and is diagnosed after the Covered Person's effective date of insurance; and
2. coverage for the Covered Person is in force under the Policy and this Certificate.

Benefits payable will equal the Amount of Insurance applicable to the Covered Person and shown in the ***Schedule of Benefits***, multiplied by the percentage of the Benefit Amount applicable to the diagnosis of each Critical Illness shown in the ***Schedule of Benefits***.

Covered Critical Illness Benefits will be paid subject to:

1. any benefit amount, benefit limit or benefit maximum applicable to the diagnosis of a Critical Illness shown in the ***Schedule of Benefits***.

When a Critical Illness for which benefits are provided under the Policy and this Certificate is contributed to or caused by another Critical Illness, We will pay only one benefit. The benefit paid will be the larger of the two. If the benefits are equal, the Covered Person may choose the benefit to be paid.

Covered Critical Illness Benefits

Category 1 – Cardiovascular-Related Critical Illnesses

Heart Attack Benefit

We will pay this benefit when We receive Proof of Loss with a Date of Diagnosis showing that a Covered Person is diagnosed with a Heart Attack that:

1. displays new EKG changes consistent with and supporting the diagnosis of a Heart Attack;
2. exhibits elevation of cardiac biomarkers / enzymes (such as Troponin and Creatine Kinase) above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used); and
3. is confirmed by imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

For the purposes of this benefit, the Date of Diagnosis means the date of ischemic death of an area of the heart muscle, as confirmed by criteria outlined above. The diagnosis must be made based on generally accepted principles of medicine.

We will not pay benefits for a Heart Attack that occurs during or within 48 hours after a cardiac or coronary artery procedure.

Stroke Benefit

We will pay this benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a Stroke based on all of the following criteria:

1. documented neurological impairment or deficits;
2. evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test); and
3. permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Category 2 – Cancer-Related Critical Illnesses

Invasive Cancer Benefit

We will pay this benefit when We receive Proof of Loss, supported by a Pathological Diagnosis made more than 45 days after the Covered Person's effective date of insurance, showing that a Covered Person suffers from Invasive Cancer.

We will accept a Clinical Diagnosis in place of a Pathological Diagnosis and pay this benefit only if:

1. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the Covered Person for cancer.

Proof of Loss must include the Date of Diagnosis. For the purposes of this benefit, Date of Diagnosis means the later of the date of:

a. a Pathological Diagnosis;
b. a Clinical Diagnosis, if acceptable as indicated above; or
c. the day the tissue specimen, culture and/or titer(s) are taken, upon which the Clinical or Pathologic Diagnosis of Invasive Cancer is made.

We will not pay benefits based on a Tentative Diagnosis of Invasive Cancer.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation
We will not pay benefits for a Critical Illness caused or contributed to by, or resulting from, a Pre-existing Condition.

This Limitation will not apply to a Critical Illness that occurs after coverage under this Certificate is in force for the Covered Person for at least 12 months after the Covered Person's most recent effective date of insurance.

If coverage under this Certificate replaces a prior plan of critical illness insurance sponsored by the Policyholder and the Covered Person does not satisfy this Certificate's Pre-existing Condition Limitation, but can satisfy their prior plan's pre-existing condition limitation giving credit for all time insured under both policies, then We will pay the lesser of:
1. benefits under this Certificate without application of the pre-existing conditions limitation; or
2. benefits of the prior plan.

The following conditions must be met:
1. The Primary Covered Person was validly covered under the prior plan on the Policy Effective Date;
2. the applicable premium is paid; and
3. the prior coverage is terminated upon issuance of this coverage.

Exclusions
No benefits will be payable for any of the following unless coverage is specifically provided for and described by name in this Certificate.
1. A Critical Illness diagnosed outside of the United States.
2. Any Critical Illness suffered by a Covered Person that is caused by, contributed to, or that occurs during any of the following:
   a) Any intentionally self-inflicted injury;
   b) Suicide, or attempted suicide, while sane or insane;
   c) Active duty military service;
   d) Participation in the commission or attempted commission of a felony;
   e) Active participation in a riot or insurrection;
   f) Being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless administered on, and taken in accordance with, the instructions of a Physician;
   g) Psychosis; or
   h) Alcoholism or drug addiction.

SIRIUS AMERICA INSURANCE COMPANY
140 BROADWAY, 32nd Floor
NEW YORK, NY 10005

BLANKET ACCIDENT INSURANCE

COVERAGE PROVIDED UNDER POLICY FORM SAM-14-1000TX-A
THE POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

Read This Outline of Coverage Carefully - This outline of coverage provides a brief description of the important features of the coverage. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in greater detail the rights and obligations of both You and Us. However it is important that you READ THIS OUTLINE OF COVERAGE CAREFULLY!

Accident only coverage is designed to provide, to Covered Persons, coverage for certain losses resulting from a covered accident ONLY, subject to any conditions, limitations and exclusions. Benefits are not payable for losses due to sickness. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

COVERAGE PROVIDED UNDER THE POLICY IS NOT MEDICARE SUPPLEMENT INSURANCE.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

SCHEDULE OF BENEFITS

This outline of coverage is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to the benefits provided under the Policy, please read all the provisions included in this outline carefully.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by the Policy. Please read the *Conditions of Coverage* section and each Benefit Description section for full details.

CONDITIONS OF COVERAGE
The benefits provided by the Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages to protect against hazards that may occur during specific activities, situations or events.

Exposure and Disappearance Coverage

24-Hour Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum	$5,000
Loss must occur within	365 days of the Covered Accident

SCHEDULE OF COVERED LOSSES

Covered Loss	**Benefit**
Loss of Life	100% of the Principal Sum
Loss of Both Hands or Both Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in both ears	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum

ACCIDENT MEDICAL BENEFITS

Any benefit limits and benefit percentages for *Accident Medical Benefits* apply, unless otherwise specified, on a per Covered Person – per Covered Accident basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS

Full Excess Medical Expense

ACCIDENT MEDICAL EXPENSE BENEFIT

Total Maximum for all Accident Medical Expense Benefits	$25,000 per year
First Covered Expenses must be Incurred within	90 days after the Covered Accident
Benefit Period	365 days from the date of the Covered Accident
Deductible	$100
applies to	each Covered Accident
Deductible must be Satisfied within	each calendar year

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by the Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the *General Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

EXPOSURE AND DISAPPEARANCE COVERAGE

We will pay benefits provided by the Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Injury which results directly and independently of all other causes from a Covered Accident that results in the Covered Person's unavoidable exposure to the elements following the forced landing, sinking, stranding or wrecking of a vehicle.

If the Covered Person disappears and is not found within one year from the date of wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under the Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

24-HOUR COVERAGE

We will pay benefits provided by the Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Injury resulting directly and independently of all other causes from a Covered Accident that occurs any time while insured by the Policy.

Exclusions This coverage will not be in effect while the Covered Person is participating in any activity, including tryouts, practice or any competitions or games for school and professional sports.

DESCRIPTION OF INDEMNITY BENEFITS

This Section describes the Accident Indemnity Benefits provided by the Policy. Benefit amounts, Benefit Periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the *General Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Losses
We will pay the benefit for any one of the Covered Losses listed in the ***Schedule of Benefits,*** subject to all applicable conditions and exclusions***,*** if the Covered Person suffers a Covered Loss that results, directly and independently of all other causes, from a Covered Accident within the applicable time period specified in the ***Schedule of Benefits***.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, We will pay the Benefit for the Covered Loss for which the largest benefit is payable

Definitions

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent Loss of Sight of one or both eyes. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Severance means complete separation and dismemberment of the part from the body.

DESCRIPTION OF EXPENSE-INCURRED MEDICAL BENEFITS

This Section describes the Scope of Coverage for which Medical Benefits are payable and the *Expense-Incurred Medical Benefits* provided by the Policy. Any applicable benefit percentages, benefit deductibles, benefit periods, benefit limits and maximums are shown in the *Schedule of Benefits.* Please read these and the *General Exclusions* Sections in order to understand all of the terms, conditions and limitations applicable to these benefits.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay the benefits shown in the ***Schedule of Benefits*** for Covered Expenses Incurred by the Covered Person, subject to all applicable conditions and exclusions, for Appropriate Treatment of a Covered Injury that resulted directly and independently of all other causes from a Covered Accident.

Benefits will be paid:
1. when Covered Expenses Incurred exceed any applicable individual Deductible within the number of days from the date of the Covered Accident specified in the ***Schedule of Benefits;*** and
2. as long as the first Covered Expense has been Incurred within the number of days specified in the ***Schedule of Benefits***; and
3. until any applicable Benefit Period shown in the ***Schedule of Benefits*** has expired; and
4. until Benefits paid for all Covered Persons insured under the Policy equal the Total Maximum for Accident Medical Expense Benefits shown in the ***Schedule of Benefits***.

SCOPE OF COVERAGE APPLICABLE TO EXPENSE-INCURRED MEDICAL BENEFITS

Covered Expenses and any applicable Deductibles are shown in the ***Schedule of Benefits.***

Other Health Care Plan Benefits
When another Health Care Plan provides benefits in the form of services rather than cash payments, We will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by the Policy will be reduced.

Full Excess Medical Expense
We will pay Covered Expenses:
1. after the Covered Person satisfies any Deductible; and
2. only when they are in excess of amounts payable by any other Health Care Plan whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the amount the Health Care Plan would have paid had its services or facilities been utilized if:
1. the Covered Person has coverage under another Health Care Plan; and
2. the other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses payable will not be reduced for emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement.

Definitions For purposes of the Accident Medical Benefits provided by the Policy:

HMO Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider of service.

PPO Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform these services at rates lower than Non-Preferred Providers.

GENERAL DEFINITIONS

Please note that certain words used in this outline of coverage have specific meanings. The words defined below and capitalized within the text of this outline have the meanings set forth below.

Aircraft means a vehicle which:

1. has a valid Certificate of Airworthiness; and
2. is being flown by a properly qualified pilot with a valid license to operate the Aircraft.

Appropriate Treatment means care, services or supplies provided to a Covered Person, solely by or at the direction of a treating Physician exercising prudent medical judgment and acting independently of the Company, for the purpose of evaluating, diagnosing or treating a Covered Injury sustained as the direct result of a Covered Accident, that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration;
3. considered effective for the Covered Injury;
4. not primarily for the convenience of the Covered Person, the Covered Person's Physician or any other Physician; and
5. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of a Covered Injury.
   For the purposes of this definition, Generally Accepted Standards of Medical Practice means:
   a. standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
   b. Physician and health care provider specialty society documents;
   c. The views of Physicians and health care providers practicing in the relevant clinical areas; and

d. any other relevant factors.

Benefit Percentage means the percentage of Covered Expenses We pay that are Incurred by the Covered Person after he satisfies any applicable Deductible. Benefit Percentages are shown in the ***Schedule of Benefits***.

Benefit Period means a period, shown in the ***Schedule of Benefits*** and commencing with the date of the first Covered Expense Incurred for treatment of a Covered Injury sustained as the direct result of a Covered Accident, during which Benefits are payable.

Certificate of Airworthiness means the standard airworthiness certificate issued by the Federal Aviation Administration of the United States or its foreign equivalent.

Company or **We, Us, Our** means Sirius America Insurance Company, domiciled in New York, New York.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Accident means a sudden, unforeseeable event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under the Policy;
2 occurs under one of the Conditions of Coverage specified in the ***Schedule of Benefits;***
3. is not contributed to by disease, Sickness, or mental or bodily infirmity;
4. is not otherwise excluded under the terms of the Policy.

Covered Expenses means the Usual and Customary charges for services or supplies listed in the ***Schedule of Benefits,*** and described in the ***Accident Medical Benefits*** section, that the Covered Person Incurs during the Benefit Period for Appropriate Treatment of a Covered Injury. A Physician must recommend and approve these services or supplies.

Covered Injury means any bodily harm that results, directly and independently of all other causes, from a Covered Accident. A Covered Injury does not include aggravation of an injury sustained before the Covered Accident.

Covered Person means an Eligible Person, as defined in the ***Schedule of Benefits***, for whom an enrollment form has been accepted by Us and required premium has been paid when due, and for whom coverage under the Policy remains in force.

Covered Loss means a loss:
1. which is the result of a Covered Injury to a Covered Person;
2. for which benefits are payable under the Policy; and
3. which is not otherwise excluded under the terms of the Policy.

Deductible means the amount of Covered Expenses that each Covered Person must Incur, as applicable, before benefits are paid under the Policy. The Deductible may apply to each Covered Accident or each Policy Term, as shown in the ***Schedule of Benefits***.

Dependent means:
1. the Covered Person's lawful spouse of the same or opposite sex who is age 18 years and under Age 70;

   The term spouse, where referenced in the Policy, shall also mean and include the Covered Person's civil union partner as defined by state law.

2. the Covered Person's unmarried child who meets the following requirements:
   a. a child from birth to 25 years old;
   b. a child who is 25 or more years old but less than 30 years old, enrolled in a school as a full-time student and primarily supported by the Covered Person. Coverage will continue during any period between school terms or school years as long as We are provided satisfactory proof that he has enrolled for the next following school term or year;
   c. a child who is 25 or more years old, primarily supported by the Covered Person, and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

      A dependent child, for purposes of this definition, includes the Covered Person's:
      i. natural child;

ii. adopted or foster child, from moment of birth if petition of adopted or foster child and enrollment occurs within 60 days of the child's birth, from the date of placement if petition of adopted or foster child and enrollment occurs 60 days or more after the child's birth;
iii. stepchild who resides with the Covered Person;
iv. child for whom the Covered Person is legal guardian.

If the Covered Person who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with him for at least six consecutive months and intend to reside with him for an indefinite period of time.

He, His, Him refers to any individual, male or female.

Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care or disability benefits. A Health Care Plan includes group, blanket, franchise, family or individual:
1. insurance policies;
2. subscriber contracts;
3. uninsured or self-funded agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice an individual practice plans;
5. medical benefits provided under automobile "fault" and "no-fault"–type contracts;
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a. a state-sponsored Medicaid plan; or
   b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

Home means the structure or land on which the Covered Person permanently resides.

Hospital means an institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense and there is a legal obligation to pay.

Hospital Stay means a confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least 90 days.

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: spouse or domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, including stepparent, brother or sister, including stepbrother or stepsister, or child, including legally adopted child or stepchild.

Incurred or Incurs means an obligation to pay for a Covered Expense for treatment, service or purchase of supplies, deemed to be the date it is provided to the Covered Person.

In-Patient means a Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Out-Patient means a Covered Person who receives Appropriate Treatment, services and supplies while not an Inpatient in a Hospital.

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Covered Person that is appropriate for the condition and locality, and who is not:
1. the Covered Person;
2. an Immediate Family Member of either the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Private Passenger Automobile means a validly registered, four-wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other Public Conveyance will not be considered a Private Passenger Automobile.

Sickness means a physical or mental illness, including pregnancy.

Usual and Customary Charge means the normal charge, in the absence of insurance, made by the provider of any Appropriate Treatment, but not more than the prevailing charge in the area:
1. for a like service by a provider with similar training or experience; or
2. for a supply that is identical or substantially equivalent.

GENERAL EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Policy:

1. Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
5 declared or undeclared War or act of War;
6. flight in, boarding or alighting from an Aircraft, except as:
   a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
   b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
   c. a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent;
7. travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an Accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Covered Person holds a valid learners permit and (b) the Covered Person is receiving instruction from a Driver's Education Instructor;
10. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
11. medical or surgical treatment, diagnostic procedure, or administration of anesthesia unless it occurs during treatment of injuries sustained in a Covered Accident;
12. the Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
13. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
14. injuries compensable under Workers' Compensation law or any similar law;
15. occupational injuries for which benefits are not paid under the Workers' Compensation Law or any similar law;
16. a Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
17. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while

taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:
1. retained by the Policyholder;
2. living in the Covered Person's household;
3. an Immediate Family Member of either the Covered Person or the Covered Person's spouse;
4. the Covered Person or Covered Person's Spouse;
5. a person providing homeopathic, aroma therapeutic, or herbal therapeutic services.

General Limitations and Exclusions Applicable to Accident Medical Expense Benefits

Non-Duplication of Benefits When The Policy and Other Plans Are Excess	This provision applies if benefits under any other Health Care Plan are covered under the Policy, and coverage under the Policy and the other Plan are excess. We pay a pro rata share of the total amount of Covered Expenses. In no case will the total benefits payable exceed 100% of the Covered Expenses. Our pro rata share equals the total of benefits payable under the Policy multiplied by a fraction, of which the numerator is the benefits We pay and the denominator is the total of benefits payable by all Health Care Plans for the same Covered Accident.

Excluded Expenses

The following will not be considered Covered Expenses unless coverage is specifically provided.
1. Any service, treatment or supply that is not considered Appropriate Treatment as defined in the Policy.
2. Expenses Incurred after the end of the Benefit Period, even if Incurred for continuing services or treatment of a Covered Injury.
3. Whole blood, concentrated red blood cells or blood storage except expenses by a Hospital for processing or administration of blood.
4. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
   a cosmetic surgery resulting from a Covered Accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Covered Accident;
   b reconstruction incidental to or following surgery resulting from a Covered Accident;
   c. any unplanned and unintended adverse consequences that may result during the treatment of a Covered Accident.
5. Any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States.
6. Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices.
7. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
8. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
9. Rest cures or custodial care.
10. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
11. Personal services such as television and telephone or transportation.
12. Expenses payable by any automobile insurance policy without regard to fault.
13. Treatment or service provided by a private duty nurse.
14. Repair or replacement of existing artificial limbs, eyes and larynx.
15. Treatment of hernia of any kind.

Other Exclusions that apply to this benefit are in the ***General Exclusions*** Section.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice must be given to Us or Our agent within 31 days after a Covered Accident occurs or the loss begins or as soon as reasonably possible, but in no case any longer than 15 months after the date of loss. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at Our Home Office in New York, New York, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name and address.

Claim Forms
We send forms for filing proof of loss when We receive the notice of claim. If claim forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims
We will pay benefits due under the Policy for any loss, other than a loss for which the Policy provides any periodic payment, immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid monthly unless otherwise specified in the benefit descriptions. Any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us, unless otherwise stated in the Policy.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under the Policy, unless otherwise stated, will be payable to the Covered Person or to his estate. If any payee of benefits is a minor or otherwise legally incompetent, we will pay benefits to the person designated as his legal guardian or conservator.

If the amount of any benefit payable is determined based on benefits payable under another Health Care Plan, We have the right to require the Covered Person to provide information about that Plan and benefits paid or payable for the same claim before We pay benefits. We may, at Our option, pay any accident medical benefits directly to a health care provider that renders services to the Covered Person, unless the Covered Person requests in writing when submitting the claim that such payment not be made to the provider.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability for that payment.

Beneficiary
The beneficiary is the person or persons the Covered Person names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by the Policy.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:

1. Spouse or domestic partner;
2. Child or Children;
3. parents;
4. siblings;
5. estate of the Covered Person.

Conditional Claim Payment

If the Covered Person incurs expenses for Covered Injuries received in a Covered Accident and it is likely a third party may be liable, We will pay benefits if:

1. the Covered Person first agrees in writing to refund the lesser of:
   a. the amount We actually paid for such expenses; and
   b. the amount actually received from the third party regardless of whether the amount is for such expenses; and
2. the third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the third party's liability is satisfied in an amount less than the benefits paid under the Policy, We will pay the difference.

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity will be brought to recover benefits under the Policy less than 60 days after satisfactory proof of loss has been furnished as required by the Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

Subrogation

We have the right to recover all payments including future payments, which We have made, or will be obligated to pay in the future, to the Covered Person from anyone liable for the Covered Loss. If the Covered Person recovers from anyone liable for the Covered Loss, We will be reimbursed first from such recovery to the extent of Our payments to the Covered Person. The Covered Person agrees to assist Us in preserving Our rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by Us.

ADMINISTRATIVE PROVISIONS

Grace Period

A Policy Grace Period of 31 days will be granted for payment of required premiums due after the first premium, unless:

1. We do not intend to renew the Policy beyond the period for which premium has been accepted; and
2. written notice of Our intention not to renew is delivered to the Policyholder at least 45 days before the premium is due.

The Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The Policyholder is liable to Us for any unpaid premium for the time the Policy was in force.

Premiums

Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for the Policy will be based on the rates set forth in the ***Premium Rate Table***, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the ***Schedule of Benefits.***

HIPAA NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. OUR DUTIES

We are required, by Federal law, to maintain the privacy of Protected Health Information. Furthermore, we are required to provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. "Protected Health Information" includes any identifiable information that we obtain from you or others relating to your physical or mental health, the health care you have received, or payment for your health care.

We are required to abide by the terms of this Notice of Privacy Rights currently in effect. We reserve the right to change the terms of this Notice of Privacy Rights and to make the new notice provisions effective for all Protected Health Information we maintain. In the event we change this Notice of Privacy Rights we will notify you and post the new notice to the Sirius America website.

II. YOUR INDIVIDUAL RIGHTS

With respect to Protected Health Information, you have the following rights:

1. The right to request restrictions on certain uses and disclosures of Protected Health Information, including the uses and disclosures listed in this Notice of Privacy Rights and permitted disclosures. However, we are not required to agree to a requested restriction.

2. The right to reasonably request to receive confidential communication of Protected Health Information by alternative means or at alternative locations.

3. The right to inspect and copy your Protected Health Information in our records, <u>except</u> for:

   - Psychotherapy notes;

   - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

   - Protected Health Information that is subject to a law prohibiting access to that information; <u>or</u>

   - If the Protected Health Information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

4. We may also deny your request to inspect and copy your Protected Health Information if:

   - A licensed health care professional has determined that the access requested is reasonably likely to endanger your life or physical safety, or the life or physical safety of another person;

   - The Protected Health Information makes reference to another person and a health care professional has determined that the access requested is reasonably likely to cause substantial harm to such other person; or

   - A licensed health care professional has determined that the access requested by your personal representative is reasonably likely to cause substantial harm to you or another person.

In the event we deny access on one of the above four grounds, you have the right to have the denial reviewed in accordance with applicable law.

5. The right to amend your Protected Health Information contained in our records. However, we are not required to amend the information if the information: (i) was not created by us; (ii) is not part of your medical or billing records; (iii) is not available for inspection; or (iv) the information is accurate and complete.

6. The right to receive an accounting of disclosures of Protected Health Information made by us in the six (6) years prior to the date on which the accounting is requested, except for disclosures:

   - To carry out payment and health care operations as provided below;

   - For notification purposes, as provided by law;

   - For national security or intelligence purposes, as provided by law;

   - To correctional institutions or law enforcement officials, as provided by law; or

   - That occurred prior to September 1st, 2014 (Effective Date of Notice)

7. The right to obtain a paper copy of this notice upon request if you are viewing this notice electronically.

III. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Under Federal law, we are permitted to use and disclose Protected Health Information, without your authorization, for the purposes of treatment, payment, and health operations.

- Treatment: We do not provide treatment.

- Payment: Payment refers to activities involving collection of premium and payment of claims. Examples of uses and disclosures for the purposes of payment include: (i) sharing Protected Health Information with other insurers to determine coordination of benefits, the administration of claims, determining coverage, and providing benefits; and (ii) sharing Protected Health Information with third party administrators for the processing of claims.

- Operations: Operations refers to the business functions necessary for us to operate, such as quality assurance activities, audits, and complaint responses. Examples of uses and disclosures for operations purposes include: (i) using Protected Health Information for the purpose of underwriting and calculating premium rates; (ii) using Protected Health Information to perform legal, actuarial, and auditing services; (iii) disclosing Protected Health Information when responding to complaints; and (iv) use of Protected Health Information for general data analyses and long-term management and planning.

We may also use and disclose your Protected Health Information for other purposes permitted or required by law, including the following:

- To you, as the covered individual.

- To a personal representative designated by you to receive Protected Health Information or a personal representative designated by law such as the parent or legal guardian of a child, or the surviving family members or representative of the estate of a deceased individual.

- To the Secretary of Health and Human Services, or any employee thereof, as part of an investigation to determine our compliance with HIPAA and the HIPAA Privacy Rules.

- To a business associate as part of a contracted agreement to assist us with our business activities. We require these business associates to appropriately safeguard the privacy of your information.

- For any purpose required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

- To an appropriate government authority as required by law if we suspect child abuse or neglect, or if we believe you to be the victim of abuse, neglect, or domestic violence.

- To a health oversight agency for oversight activities authorized by law.

- In connection with judicial and administrative proceedings, including disclosures in response to a court order, subpoena or discovery request.

- As required for law enforcement purposes.
- To a coroner or medical examiner consistent with law.
- To cadaveric organ, eye or tissue donation programs.
- For specialized government functions (*e.g.*, military and veterans activities, national security and intelligence).
- As required to comply with Workers' Compensation or other similar programs established by law.

The examples of permitted uses and disclosures listed above are not provided as an all inclusive list of the ways in which Protected Health Information may be used. They are provided to describe in general the types of uses and disclosures that may be made.

Other uses and disclosures of your Protected Health Information may be made only with your written authorization unless otherwise permitted or required by law. You may revoke such authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used and disclosed your Protected Health Information in good faith with the authorization.

IV. COMPLAINTS REGARDING YOUR PRIVACY RIGHTS

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services (the "Secretary"). The Secretary can be contacted at the following address: Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. If you would like to file a complaint with us, address your complaint to the Privacy Officer at the location listed in the section below entitled "Contact Us." You will not be retaliated against for filing a complaint.

V. CONTACT US

You may exercise the rights described in this Notice of Privacy Rights by contacting the office identified below. The contact is:

Privacy Officer
SiriusPoint America Insurance Company
One World Trade Center, 285 Fulton St, 47th Floor
New York, NY 10007

VI. EFFECTIVE DATE

The effective date of this Notice of Privacy Rights is September 1st, 2014.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for a consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol Avenue
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, ***et seq.*** Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights, and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under the Federal Pension Benefit Corporation ("FPBC"), regardless of whether the FPBC is yet liable;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;

- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims; or
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from assets of the impaired or insolvent insurer.

SIRIUSPOINT AMERICA INSURANCE COMPANY

ONE WORLD TRADE CENTER, 285 FULTON ST, 47th Floor
NEW YORK, NY 10007

IMPORTANT NOTICE REGARDING THE OFFICE OF FOREIGN ASSETS CONTROL

Your rights as a policyholder and payments to you, any insured or claimant, for loss under the policy may be affected by the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL ("OFAC").

WHAT IS OFAC?

OFAC is an office of the Department of the Treasury and acts under the presidential national emergency powers, as well as authority granted by specific legislation, to impose controls on transactions and freeze foreign assets under U.S. jurisdiction. OFAC administers and enforces economic embargoes and trade sanctions primarily against:

- Targeted foreign countries and their agents
- Terrorism sponsoring agencies and organizations
- International narcotics traffickers

PROHIBITED ACTIVITY

- OFAC enforces certain embargoes and sanctions against certain designated countries. No U.S. business or persons may enter into certain transactions in or connected to such designated "sanctioned" countries.
- OFAC maintains a directory known as the "Specially Designated Nationals and Blocked Persons" ("SDNBP") list. No U.S. business or person may transact business with any person or entity named on the SDNBP list.

Additional and more in-depth information on OFAC is available at the following website: https://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

OBLIGATIONS PLACED ON US BY OFAC

If we determine that you, any insured or claimant are on the SDNBP list or are connected to a sanctioned country as described in the regulations enforced by OFAC, we must block or "freeze" property and payment of any funds transfers or transactions and report all blocks to OFAC within ten (10) business days.

POTENTIAL ACTIONS BY US

1. We may immediately cancel your coverage effective on the day that we determine that we have transacted business with an individual or entity associated with your policy on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.
2. If we cancel your coverage, you will not receive a return premium unless approved by OFAC. All funds will be placed in an interest bearing blocked account established on the books of a U.S. financial institution.
3. We will not pay a claim, accept premium or exchange monies or assets of any kind to or with individuals, entities or companies (including a bank) on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC. And, we will not defend or provide any other benefits under your policy to individuals, entities or companies on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.

YOUR RIGHTS AS A POLICYHOLDER

If funds are blocked or frozen by us in conjunction with the OFFICE OF FOREIGN ASSETS CONTROL, you may complete an "APPLICATION FOR THE RELEASE OF BLOCKED FUNDS" and apply for a specific license to request their release. Forms are available for download at the OFAC website. See https://www.treasury.gov/resource-center/sanctions/Documents/license.pdf.

SIRIUSPOINT AMERICA INSURANCE COMPANY
One World Trade Center
285 Fulton Street, 47th Floor
New York, NY 10007

INSURANCE COMPANY NAME CHANGE ENDORSEMENT

This Endorsement is made part of the Policy/Certificate to which it is attached. It is subject to all provisions, terms, conditions, and definitions of the Policy/Certificate unless otherwise stated in this Endorsement and should be kept with your Policy/Certificate.

The Endorsement is effective on the date issued unless otherwise stated.

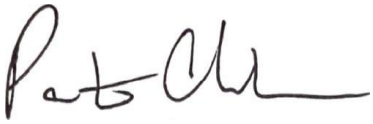
The name of SIRIUS AMERICA INSURANCE COMPANY was changed to SIRIUSPOINT AMERICA INSURANCE COMPANY effective on July 8, 2021, in its state of domicile of New York.

The following changes are made to your Policy, Certificate, Application, Enrollment Form, and any applicable Riders:

- All references to “Sirius America Insurance Company” are changed to “SiriusPoint America Insurance Company”.

All other terms, conditions or benefits remain unchanged.

Signed for SiriusPoint America Insurance Company:



Patrick Charles
President