

# INDIANA GAP 5000+ Certificates of Insurance



# UBA

*These Certificates of Insurance are for the Gap 5000+ Product. You can call your personal member concierge at 866.438.4274 for any questions with your certificates.*

*Note: The Certificates of Insurance are only for the Group Insurance included in the product and not any non-insurance services that may or may not be included in your membership product. Please refer to the Member Guide for details on any non-insurance services that may or may not be included in your product.*



**READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.**

\*Blanket Group Accident Insurance and Group Critical Illness are underwritten by Sirius America Insurance Company.

Gap5000+\_CertificatesofInsurance\_v0222 [HA-1000]  
United Business Association  
409 W Vickery Blvd, Fort Worth, TX 76104  
866.438.4274 | ubamembers.com

# Member Driven Value.

PGS 03-18	Group Critical Illness Insurance Certificate of Insurance
PGS 19-42	Blanket Group Accident Insurance Outline of Coverage

ASSOCIATION BENEFITS  
PROVIDED BY:



BLANKET GROUP ACCIDENT INSURANCE  
& GROUP CRITICAL ILLNESS INSURANCE  
COVERAGE UNDERWRITTEN BY:

Sirius America Insurance Company



BILLING\*, FULFILLMENT,  
& CUSTOMER SERVICE  
PROVIDED BY:



\*Billing is administered through the Third Party Administrator of H A Partners, Inc. or HealthyAmerica (depending on state).

# SIRIUS AMERICA INSURANCE COMPANY

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

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## 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:



Robert P. Kuehn  
President



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

**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**

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## **SCHEDULE OF BENEFITS**

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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 5000 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 5000 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**

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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	\$1,000
Class 2	\$5,000
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
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### **PREMIUM RATE**

\$3.26 per month per member  
\$6.51 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

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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. is not contributed to by Sickness, disease or bodily or mental infirmity; and
3. 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. 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 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 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; or
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. is not caused or contributed to by Sickness; and
3. 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.

**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; or
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 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**

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### **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 an eligible 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 is eligible for coverage when the Policyholder applies for coverage, the coverage 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 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's coverage is not paid.

## **CLAIM PROVISIONS**

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### **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 not more than 45 days if the claim is filed on paper, or 30 days if the claim is filed electronically, after 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**

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### **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 change 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**

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### **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**

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 non-payment of the required premiums.

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 Covered Person resides on such date, 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**

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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

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### 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.

**Questions regarding the Certificate or coverage should be directed to:  
Sirius America Insurance Company**

If you (a) need assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, Indiana 46204

Consumer Hotline (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi).

# SIRIUS AMERICA INSURANCE COMPANY

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

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**POLICYHOLDER:** United Business Association  
**POLICY NUMBER:** HASA-BAM-1000  
**POLICY EFFECTIVE DATE:** October 1, 2020  
**POLICY TERM:** October 1, 2020 through September 30, 2021  
**STATE OF ISSUE:** Indiana

This Certificate describes the terms and conditions of insurance provided to the Policyholder named above. The Policy under which it is issued goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Certificate Effective Date described herein. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This Certificate terminates at 12:00 A.M. on the day following the last day of the Policy Term unless the You cease to meet the definition of an Eligible Person shown in the Schedule of Benefits. The laws of the State of Issue govern this Certificate.

We and the Policyholder have agreed to the terms of the Policy under which this Certificate is issued.

**BLANKET ACCIDENT INSURANCE CERTIFICATE  
IT PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY  
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS**

**PLEASE READ YOUR CERTIFICATE CAREFULLY**

**NON-PARTICIPATING**



Robert P. Kuehn  
President



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

**Questions regarding your Policy or coverage should be directed to:**

**Sirius America Insurance Company: (844)312-4357**

If a Covered Person (a) need the assistance of the governmental agency that regulates insurance; or (b) has a complaint they have been unable to resolve with us, the Covered Person may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, Indiana 46204  
Consumer Hotline: (800) 622-4461; (317)232-2395  
Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi).

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## **SCHEDULE OF BENEFITS**

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*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 it carefully.*

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

**Eligible Persons:** An Eligible Person is an individual who meets all of the requirements of one of the Covered Classes shown below:  
Class 1 All active members of the Policyholder, age 18-79, who have chosen to enroll themselves in the GAP 5000 plan option and their enrolled Spouse up to age 70 as well as their enrolled dependent Children.

### **CONDITIONS OF COVERAGE**

The benefits provided by this Certificate 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

**Benefits Applicable to Class 1**

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

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Principal Sum	\$2,500
Loss must occur within	365 days of the Covered Accident

**SCHEDULE OF COVERED LOSSES**

<b>Covered Loss</b>	<b>Benefit</b>
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**

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**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	\$5,000 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 applies to	\$100 each Covered Accident
Deductible must be Satisfied within	each calendar year

**RATE TABLE**

Premium Rate	\$4.17 per month per member \$8.37 per month per member and Spouse \$15.76 per month per member, Spouse, and Dependent Children
Mode of Premium Payment	Monthly
Premium Due Dates	Individual Effective Date and the first day of each modal period thereafter
Contributions	The cost of the coverage is paid by the Covered Person

## GENERAL DEFINITIONS

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Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy 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 You, 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 Your convenience, or the convenience of Your 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 You incur after You satisfy 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.

**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 You are insured under this 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 this Policy.

**Covered Activity** means any recurring activity or event that is shown in the *Schedule of Benefits* and:

1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits*; and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

The activity must be under sole direct supervision of qualified Policyholder authorities and may, if specified in the Policy, include Policyholder sponsored and supervised travel to and from such an activity.

**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 You incur 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, You** 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 this Policy remains in force.

**Covered Loss** means a loss:

1. which is the result of a Covered Injury to You;
2. for which benefits are payable under this Certificate; and
3. which is not otherwise excluded under the terms of this Certificate.

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

**Dependent** means:

1. Your lawful spouse of the same or opposite sex who is age 18 years and under Age 71;
2. Your child who is:
  - a. a child from birth to 26 years old; or
  - b. a child who is 26 or more years old but less than 30 years old, enrolled in a school as a full-time student and primarily supported by You. 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; or
  - c. a child who is 26 or more years old, primarily supported by You, 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 within 31 days 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 Your:

- i. natural child;
- ii. adopted or foster child, from moment of birth if placement of adopted or foster child occurs within 30 days of the child's birth, from the date of placement if placement of adopted or foster child occurs 30 days or more after the child's birth;
- iii. stepchild who resides with You;
- iv. child for whom You is legal guardian.

**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 You permanently reside.

**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 You incur 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 You in any of the following ways: spouse, 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 You.

**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.

**Physical Therapy** means any form of physical therapy, whether by machine or hand, by use of exercise, manipulation, massage, adjustment, heat or cold, air, light, water, electricity or sound.

**Physician** means a United States- licensed health care provider practicing in the United States within the scope of his license and rendering care and treatment to You that is appropriate for the condition and locality, and who is not:

1. You;
2. You or Your Spouse's Immediate Family Member;
3. a person living Your household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

**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.

**War** means a state or period of declared or undeclared war whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states or parties.

## **ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS**

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### **Policy Effective Date**

We agree to provide Accident Insurance Benefits described in this Certificate in consideration of the Policyholder's application, Your enrollment form and payment of the Premium when due.

### **Eligibility**

You are eligible for insurance under this Policy when You meet the definition of an Eligible Person shown in the *Schedule of Benefits*. You may be insured under only one Covered Class, even though You may be eligible under more than one Covered Class.

### **Effective Date for Individuals**

Insurance becomes effective for the Eligible Person who enrolls and agrees to make the required contributions within 31 days of eligibility on the latest of the following dates:

1. the Policy Effective Date;
2. the date the person becomes eligible;
3. the date We receive the Eligible Person's completed enrollment form and the required premium payment.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

### **Effective Date of Changes**

Any increase or decrease in the amount of insurance for You resulting from:

1. a change in benefits provided by this Certificate; or
2. a change in Your Covered Class

will take effect on the date of such change.

### **Termination of Insurance**

Your Insurance will end on the earliest of:

1. the date You are no longer in an Eligible Class; and
2. the date You enter full time active duty in any Armed Forces. We will refund any premium paid for any period of active duty when We receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; and
3. the end of the period for which the last premium was paid; and
4. The date coverage for the Eligible Class of which You are a member ends and;
5. the date the Policy under which this Certificate is issued ends;

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period.

## **GENERAL EXCLUSIONS**

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In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury, Covered Loss or Covered Expense 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 this Policy:

1. Intentionally self-inflicted injury, suicide or any attempt thereof 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 a 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 You are the operator of a motor vehicle and do not possess a valid motor vehicle operator's license, unless: (a) You hold a valid learners permit and (b) You are 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, administration of anesthesia unless it occurs during treatment of injuries sustained in a Covered Accident;
12. Your 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 You have 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. employed or retained by You;
2. living in Your household;
3. Your or Your Spouse's Immediate Family Member.

## **CLAIM PROVISIONS**

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### **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 this 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: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. 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 or deny a clean claim for benefits due under this Policy for any loss, other than a loss for which this 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 this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefit descriptions. If We fail to pay or deny a clean claim for written proof of loss within 45 days and for electronic proof of loss in 30 days, then We shall pay the provider that submitted the claim interest on the allowable amount of the claim. 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 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 this Policy, unless otherwise stated, will be payable to You or to Your 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 You 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 You, unless You request 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**

SAM-14-1000INC

The beneficiary is the person or persons You name or change on a form You execute and which is 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 this Policy.

A beneficiary designation or change will become effective on the date You execute 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 You have specified otherwise. The share of any beneficiary who does not survive You will pass equally to any surviving beneficiaries unless otherwise specified.

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

1. Spouse;
2. Child or Children;
3. parents;
4. siblings;
5. Your estate.

### **Conditional Claim Payment**

If You incur 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. You first agree 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 this Policy, We will pay the difference.

### **Physical Examination and Autopsy**

We, at Our own expense, have the right and opportunity to examine You 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 this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this 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 this Policy.

If there is an overpayment due when You die, We may recover the overpayment from Your 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 You from anyone liable for the Covered Loss. If You recover from anyone liable for the Covered Loss, We will be reimbursed first from such recovery to the extent of Our payments to You. You agree 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**

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### **Premiums**

Premium rates are expressed in, and premiums are payable in, United States currency. Any premiums You are required to contribute will be based on the rates set forth in the *Premium Rate Table*, the plan and amounts of insurance in effect You and the premium mode shown in the *Schedule of Benefits*.

### **Premium Payment**

Your initial premium is due on Your Effective Date. Any periodic premiums will be due on premium due dates established between Us and the Policyholder.

## **GENERAL PROVISIONS**

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### **Entire Contract; Changes**

This Certificate, including Your signed enrollment form, if required, and any endorsements, amendments and attached papers, constitutes the entire contract of insurance. No change in this Certificate will be valid until approved by one of Our executive officers and endorsed on or attached to it. No agent has authority to change this Certificate or the Policy under which it is issued, or to waive any of its provisions.

### **Misstatement of Fact**

If the You or Policyholder has misstated any fact, all amounts payable under this Certificate will be such as the premium paid would have purchased had such fact been correctly stated.

### **Assignment**

We will be bound by an assignment of Your insurance only when the original assignment or a certified copy of the assignment, signed by You and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under Your Certificate remains in force.

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

### **Incontestability Of Your Insurance**

All statements You made 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 lack of eligibility for insurance.

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

### **30 Day Right To Examine Certificate**

If You do not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid, and the Certificate will be void as if never issued.

### **Examination of the Policy**

The Policy under which this Certificate is issued will be available for inspection at the Policyholder's office during regular business hours.

### **Conformity with Statutes**

Any provision in this Certificate that is in conflict with the requirements of any state or federal law that apply to it are automatically changed to satisfy the minimum requirements of such laws.

### **Workers' Compensation Insurance**

This insurance is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.



## CONDITIONS OF COVERAGE

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This Section describes the Conditions of Coverage under which benefits of this Certificate 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 this Policy, subject to all applicable conditions and exclusions, if You suffer a Covered Injury which results directly and independently of all other causes from a Covered Accident that results in Your unavoidable exposure to the elements following the forced landing, sinking, stranding or wrecking of a vehicle.

If You disappear and are not found within one year from the date of wrecking, sinking or disappearance of the conveyance in which You were riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that Your death resulted directly and independently of all other causes from a Covered Accident.

### 24-HOUR COVERAGE

---

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if You suffer a Covered Injury resulting directly and independently of all other causes from a Covered Accident that occurs any time while Your coverage is in effect.

**Exclusions** This coverage will not be in effect while You are participating in any activity, including tryouts, practice or any competitions or games for school and professional sports.

Other exclusions that apply to this Condition of Coverage are in the *General Exclusions* Section.

## DESCRIPTION OF INDEMNITY BENEFITS

---

This Section describes the Accident Indemnity Benefits provided by this 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 You suffer 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 You sustain 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**

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This Section describes the Scope of Coverage for which Medical Benefits are payable and the *Expense-Incurred Medical Benefits* provided by this 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.

### **SCOPE OF COVERAGE APPLICABLE TO EXPENSE-INCURRED MEDICAL BENEFITS**

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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 this Policy will be reduced.

#### **Full Excess Medical Expense**

We will pay Covered Expenses:

1. after You satisfy 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. You have coverage under another Health Care Plan; and
2. the other Health Care Plan is an HMO, PPO or similar arrangement; and
3. You do 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 this 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.

## ACCIDENT MEDICAL EXPENSE BENEFITS

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We will pay the benefits shown in the *Schedule of Benefits* for Covered Expenses You Incur, 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 the total of Covered Expenses paid equals any applicable Benefit Limit or Maximum Benefit shown in the *Schedule of Benefits*.

### General Limitations and Exclusions Applicable to Accident Medical Expense Benefits

#### Non-Duplication of Benefits When This Policy and Other Plans Are Excess

This provision applies if benefits under any other Health Care Plan are covered under this Policy, and coverage under this 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 this 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 this 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 Your initial treatment 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.

# 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, except 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; or
  - 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 1<sup>st</sup>, 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  
Sirius America Insurance Company  
140 Broadway, 32<sup>nd</sup> Floor  
New York, NY 10005

#### **VI. EFFECTIVE DATE**

The effective date of this Notice of Privacy Rights is September 1<sup>st</sup>, 2014.



**NOTICE OF PROTECTION PROVIDED BY THE  
INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

**Basic Protections Currently Provided by ILHIGA**

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

**Life Insurance**

- \$300,000 in death benefits
- \$100,000 in net cash surrender or net cash withdrawal values

**Health Insurance**

- \$500,000 for health plan benefits (see definition below)
- \$300,000 in disability income and long-term care insurance benefits
- \$100,000 in other types of health insurance benefits

**Annuities**

- \$250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity or health insurance policy or contract. The statutory limits on ILHIGA coverage

have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at [www.inlifega.org](http://www.inlifega.org) or contact:

Indiana Life & Health Insurance  
Guaranty Association  
3502 Woodview Trace, Suite 100  
Indianapolis, IN 46268  
(317) 636-8204

Indiana Department of Insurance  
311 W. Washington Street, Suite 103  
Indianapolis, IN 46204  
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**



