TRU GAP COMPREHENSIVE

Certificate of Insurance
MICHIGAN

INPATIENT & OUTPATIENT

Group Supplemental Medical Insurance
underwritten by SiriusPoint America Insurance Company

DESIGNED TO SUPPLEMENT
YOUR **BRONZE** **ACA PLAN**

ATTENTION PLEASE

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

SIRIUS POINT

Supplemental Health
Plan for those under 65
and not on Medicaid.

UBA

TruGapCompCert_v0524
HASA-GAP-1000

SIRIUSPOINT AMERICA INSURANCE COMPANY
1 World Trade Center
285 Fulton Street, 47th Floor
New York, NY 10007
212-312-0200

GROUP VOLUNTARY SUPPLEMENTAL MEDICAL INSURANCE CERTIFICATE
INSURING AGREEMENT

SiriusPoint America Insurance Company certifies that We have issued Group Voluntary Supplemental Medical Insurance Policy Number HASA-GAP-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. Interpretation is governed by the Policy. You may examine the Policy at the office of the Policyholder during normal business hours.

IMPORTANT NOTICE: Benefits are payable only for Covered Charges for treatment that is both started and completed while a Covered Person is insured under the Policy., and after any applicable Waiting Periods have been served.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions.

Such an action may be taken without the consent of any Covered Person who Claims rights or Benefits under the Policy.

Signed for SiriusPoint America Insurance Company:

Kevin B. Grzelak
Chief Financial Officer

Patrick Charles
President

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS A LIMITED BENEFIT POLICY
IT IS NOT A MAJOR MEDICAL EXPENSE POLICY
THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED MAY BE SUBJECT TO A PREMIUM INCREASE OR NON-RENEWAL ON ANY POLICY ANNIVERSARY.
PLEASE READ IT CAREFULLY.

The Policy under which this Certificate is issued supplements an underlying Health Benefit Plan (HBP) and is available only while coverage is continuously maintained under an underlying HBP. The Policy under which this Certificate is issued is not intended to cover all medical expenses. The Policy is issued independently from the underlying Health Benefit Plan (HBP). SiriusPoint America Insurance Company, the Company issuing the Policy under which this Certificate is issued, does not provide the primary coverage under the underlying Health Benefit Plan (HBP).

The Policy under which this Certificate is issued is specifically designed to fill gaps in coverage under the underlying Health Benefit Plan (HBP), such as Coinsurance and Deductibles. The Policy does not coordinate its benefits with those provided under any Health Benefit Plan.

The Policy will only be issued if a HBP is in effect. The Policy will terminate upon termination of the HBP.

Coverage under the Policy will not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

Late entrants may be subject to a 30 day waiting period before becoming eligible for coverage.

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

This Policy under which this Certificate is issued is a legal contract between the Policyholder and the Company.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR ASSOCIATION TO DETERMINE WHETHER YOUR ASSOCIATION IS AS SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

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SCHEDULE OF BENEFITS

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy. Interpretation of all provisions and coverages will be governed by the Group Policy on file with the Company at its administrative office and with the Policyholder.

Policyholder:	United Business Association
Policy Effective Date:	January 1, 2024
Policy Number:	HASA-GAP-1000
Policyholder Address:	409 W Vickery Blvd, Fort Worth TX 76104
Eligible Classes:	All active members of the Policyholder who are enrolled in an ACA Bronze plan and have chosen to enroll themselves in the Inpatient and Outpatient TruGap plan.
Waiting Period:	30 days from initial eligibility
Contribution Type:	Voluntary
Initial Monthly Premium for members Under 55:	Member Only: $134.19 Member and Spouse: $256.72 Member and Children: $240.23 Member and Family: $344.75
Initial Monthly Premium for members 55 and older:	Member Only: $201.28 Member and Spouse: $398.54 Member and Children: $259.24 Member and Family: $439.92
Method of Premium Payment:	Remitted by Policyholder to Us or Our Agent
Premium Due Date:	1st of each month
Plan Year:	Calendar Year

Supplemental Medical Benefits

Deductible:

Combined Inpatient Hospital and Outpatient Plan Year Deductible per Covered Person	$1,000
Maximum Deductible per family	2 times the Individual Deductible.

Combined Inpatient Hospital and Outpatient Benefit

Individual Plan Year Benefit Maximum	$7,500 per Covered Person per Plan year
Plan Year Benefit Maximum per Family	2 times the Individual Maximum

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. Additional terms may be defined elsewhere in the Certificate. The male pronoun includes the female whenever used.

Accident: A specific unforeseen event:
1. that is sudden, unexpected, and unintended, over which a Covered Person has no control; and
2. which happens while the Covered Person is covered under this Policy; and
3. which directly, and from no other cause, results in an Injury; and
4. that is independent from Sickness, disease, bodily infirmity, or illness.

Benefit: The dollar amount payable by Us to a Claimant or assignee under the Policy.

Calendar Year: For the first year is the period of time that begins on the Effective Date and ends on December 31. For subsequent years, it is the period of time that begins on January 1 and ends December 31.

Cancer: The autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body.

Cancer Treatment: The treatment of Cancer at a Cancer Treatment Facility. It does not include supplies or drugs recommended or purchased for use outside of the Cancer Treatment Facility, or routine visits designed to diagnose or prevent the reoccurrence of Cancer.

Cancer Treatment Facility: A facility where the treatment of Cancer is provided on an outpatient basis. This also includes an oncologist's office and a Physician's Office.

Certificate: This document that provides a description of the Coverage available under the Policy.

Child or Children: See definition of Eligible Dependent.

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a Claim for Benefits under the Policy, as an Insured Person or as a Covered Dependent.

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

Complications of Pregnancy: means:
1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and;
2. a non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Coverage: The right of the Covered Person to receive Benefits subject to the terms, Conditions, limitations and exclusions of the Policy and this Certificate.

Covered Charge: Those expenses described in the Policy and this Certificate that are payable under both the Policy and the Covered Person's Health Benefit Plan. Expenses that are excluded under either the Policy or the Covered Person's Health Benefit Plan are not Covered Charges.

Covered Dependent: Your Eligible Dependent who is insured under the Policy.

Covered Person: You and Your Eligible Dependents whom You have enrolled for insurance and paid any Premium due under the Policy.

Deductible: The amount of Covered Charge that must be paid in full by You each Plan Year for each Covered Person (or to the maximum per family limit, when applicable) before any Benefits are payable by Us.

Domestic Partner: An individual in a relationship with You that satisfies the following criteria:
1. For at least 6 consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and

4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
5. You and Your Domestic Partner have filed a Domestic Partner affidavit; and
6. You and Your Domestic Partner are not legally married to anyone else.

Effective Date: The date on which insurance Coverage begins under the Policy.

Eligible Class: A group of people who are eligible for Coverage under the Policy.

Eligible Dependent: Includes:
1. Your Spouse (if not legally separated or divorced from You);
2. Your Child from the moment of birth, until the Child attains Age 30; and
3. Your Child who is a student may be covered after the limiting age of 30 provided such Child is a full-time student and more than 50% dependent on You for support and maintenance and proof of the Child's enrollment as a Full-Time Student is submitted to Us.

Eligible Dependent Children include natural children, stepchildren, adopted children from the earlier of the moment of placement in Your home or when You are a party to a suit in which You seek to adopt, grandchildren, children appointed to Your custody by a court order, or foster children who are dependent upon You for support.

Eligible Dependent Children also include a Your Child for whom You are obligated to provide health care coverage by a court or administrative order. We will enroll such Child under family coverage without regard to any enrollment period restrictions, upon application of the Child's other parent or pursuant to a child support order. Coverage for such Child will not be terminated unless We are provided satisfactory written evidence of either of the following:
   a. The court or administrative order is no longer in effect.
   b. The Child is or will be enrolled under comparable health care coverage provided by another health insurer, which coverage will take effect not later than the effective date of the termination of this coverage.

The term Eligible Dependent does not include any person who:
1. is in full-time active duty in the armed forces of any country or international authority; or
2. is an Insured Person under the Policy.

Eligible Person: A person who belongs to an Eligible Class as described in the Schedule of Benefits, has satisfied the Waiting Period if applicable, and is covered under a Health Benefit Plan.

Emergency Care: Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
(1) placing the patient's health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

Enrollment Form: The document completed by You in electing Coverage under the Policyholder's Policy.

Family Member: A person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or Child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

Freestanding Outpatient Surgery Center: A freestanding facility where surgical and diagnostic services are provided on an ambulatory basis. It does not include a Physician's Office.

Group: A Policyholder or entity who has entered into a contract with Us to provide Coverage under the Policy.

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

Health Benefit Plan: Any major medical or comprehensive medical plan through which a Covered Person has coverage. It may be a self-funded plan or provided through insurance. Health Benefit Plan does not include any limited medical program, Medicare, Medicaid, CHAMPUS, or TRICARE.

Hospital: An institution that meets all the following requirements:
1. it must be operated according to law;
2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. Registered Nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital does not mean a convalescent, nursing, rest or extended care facility or a facility operated exclusively for treatment of the aged, drug addicts or alcoholics, even though such facility is operated as a separate institution by a Hospital.

Hospital Emergency Room: A portion of a Hospital where emergency diagnosis, Emergency Care, and treatment of Sickness or Injury due to an Accident is provided.

Hospital Outpatient Facility: An area contained within a Hospital building that is owned and operated by the Hospital and not otherwise excluded under the terms of the Policy where patients receive diagnostic testing or treatment without being admitted to the Hospital on an Inpatient basis.

Injury: Bodily injury sustained directly and independently of all other causes, which results in loss covered by the Policy. The Injury must occur and the loss must begin while the coverage for the Covered Person is in force under the Policy.

Inpatient: The Covered Person is a registered bed patient in a Hospital for more than 24 continuous hours and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician.

Insured Person, You or **Your**: A person who is an Eligible Person, who has qualified for insurance by completing the Waiting Period, and for whom insurance under the Policy has become effective.

Late Entrant: A person who applies for coverage under the Policy more than 31 days after He initially becomes an Eligible Person.

Magnetic Resonance Imaging (MRI) Facility: A freestanding diagnostic imaging facility that provides diagnostic testing using magnetic resonance imaging.

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

Outpatient: The Covered Person is not an Inpatient when covered services are received.

Outpatient Therapy: The following treatments received at an Outpatient Therapy Facility:

1. The treatment of physical dysfunction or Injury by the use of therapeutic exercise and the application of modalities, intended to restore or facilitate normal function or development, including kinesiology;
2. The corrective or rehabilitative treatment of physical and/or cognitive deficits/disorders resulting in difficulty with verbal communication. This includes both speech (articulation, intonation, rate, intensity) and language (phonology, morphology, syntax, semantics, pragmatics, both receptive and expressive language, including reading and writing);
3. Rehabilitative treatment that promotes health and well-being through occupation and is based on the engagement in meaningful activities of daily life to enable and encourage participation in such activities despite impairments or limitations in physical or mental functioning;

For the purposes of Coverage under the Policy this does not include equipment recommended, used or purchased for use outside of the Therapy Facility.

Outpatient Therapy Facility: An office, center or clinic in which a licensed therapist provides physical, kinesiology. occupational, or speech therapy.

Physician: means a person licensed by the state in which He is a resident to practice the healing arts. He must be practicing within the scope of His license for the service or treatment given.

Physician's Office: The location in which a Physician routinely, on an appointment basis, provides health examinations, diagnosis and treatment of Sickness or Injury due to an Accident on an ambulatory basis. It does not include a Hospital, Freestanding Outpatient Surgery Center or Urgent Care Facility.

Plan Year: The period of time shown in the Schedule of Benefits as Calendar Year or Policy Year.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations, and the exclusions regarding Coverage.

Policy Anniversary: The month and day as shown on the Schedule of Benefits in the Policy as the Policy Anniversary.

Policyholder: The organization named in the Schedule of Benefits who has contracted with us to provide benefits to You.

Premium: The periodic fee required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of the Policy.

Regular and Customary Activities: means:
1. for the working Covered Person, He is actively performing all the duties of His regular occupation; and
2. for a non-working dependent, He is regularly performing the normal activities of a person of like age and good health.

Schedule of Benefits: This document shows You the amount of Benefits provided under the Policy.

Sickness: A bodily disorder, disease or illness that begins while the Covered Person's coverage is in force, including Complications of Pregnancy.

Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper, email, or online communication, provided it is acceptable to Us and consistent with applicable law.

Spouse: Your lawful Spouse who is an Eligible Dependent. The term also includes Domestic Partner or civil union partner who is an Eligible Dependent, where allowed by law.

Total Disability/Totally Disabled: Due Injury or Sickness, the Covered Person cannot perform His Regular and Customary Activities. The loss of a professional or occupational license for any reason does not, in itself, constitute Total Disability.

Urgent Care: Necessary medical intervention that is required for a Sickness or Injury that would not result in further disability or death if not treated immediately but requires professional attention and has the potential to develop such a threat if treatment is delayed longer than 24 hours.

Urgent Care Facility: A medical facility or clinic where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate Urgent Care. It does not include a Physician’s Office.

Waiting Period: The period of time that an Eligible Person must wait to reach their eligibility date and begin coverage. The Waiting Period is shown in the Schedule of Benefits. For Late Entrants, refer to the Waiting Period for Late Entrants section of this Certificate for additional limitations.

Written or Writing: A record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

WHEN COVERAGE BEGINS AND ENDS

Who is eligible?

Eligible Person: An individual is eligible for Coverage if He is covered under a Health Benefit Plan, is in an Eligible Class as described in the Schedule of Benefits, and if He satisfies any Waiting Period, if applicable, as described in the Schedule of Benefits.

Eligible Dependent: Your Eligible Dependents are also eligible for Coverage, provided that He is covered under a Health Benefit Plan, You are insured under the Policy and that Dependent Coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Person and His Spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent Child may also only be enrolled by one parent/guardian. If the Spouse carrying dependent Coverage ceases to be eligible, please notify Us immediately. Dependent Coverage then becomes effective under the other Spouse's Coverage.

When do You enroll?

Enrollment is when an Eligible Person completes an Enrollment Form giving the information We require. As the Eligible Person, if You are required to pay all or part of the Premium for Coverage, You must agree to make the required contributions and pay the first premium at time of enrollment. The enrollment for Coverage may be written or electronic on an Enrollment Form furnished or approved by Us.

Eligible Person: An Eligible Person who has met all eligibility requirements of the Policyholder prior to the Policy Effective Date may request enrollment during the initial Enrollment Period that corresponds with the Policy Effective Date. After the Policy Effective Date, an Eligible Person may not enroll until the next Enrollment Period.

Eligible Dependent: If the Policy provides for Dependent Coverage, an Eligible Person may request enrollment of His or her Dependents at any time throughout the Plan Year. The Enrollment Form must be completed and Signed on or before the desired Effective Date of Dependent Coverage. Eligible Dependents who are not enrolled as indicated above will be considered a Late Entrant. Proof of the Dependent relationship may be required by Us.

Newborn and Adopted Children: Your newborn or adopted child or a child when You are a party to a suit in which You seek to adopt the child will be covered for the first 60 days following their birth, adoption, or when You become a party to a suit in which You seek to adopt. To continue Coverage beyond that 60-day period, You must notify Us of the Child's date of birth, adoption, or when You become a party to a suit in which You seek to adopt at any time during the 60-day period. Any required Premium must be paid when due from the date of birth, adoption, or placement for adoption. Otherwise, Coverage for that Child will terminate as soon as the 60-day period expires.

When will Your Coverage begin?

If the Policyholder requires You to contribute toward the cost of all or part of the insurance, such insurance will not become effective for You before You agree to make the required contributions and the first premium is paid. The form may be obtained from the Policyholder. Insurance will not be effective to You before the first Premium is paid.

Subject to Your enrollment and payment of any premium due, insurance is effective at 12:01 AM at the main office of the Policyholder on:

1. The Policy Effective Date, if You are eligible prior to the Policy Effective Date, You enroll and You pay the Contributory portion for the entire amount requested; or
2. The first of the month following the date an Eligible Person enrolls and pays the Contributory portion due for the entire amount requested, if an Eligible Person enrolls for Coverage after the Policy Effective Date.

When will Coverage begin for Your Dependents?

Subject to the enrollment procedure described above and payment of the Premium due, Your Dependents will become insured on the same date and at the same time as You. If You acquire additional Dependents after Your Effective Date of Coverage and have Dependent Coverage, and provided You enroll Your Eligible Dependents as indicated above, the Effective Date of the newly acquired Dependents will be the date We accept the new enrollment, subject to timely payment of any Premium due.

If You acquire additional Dependents after Your Effective Date of Coverage and do not have Dependent Coverage, and provided You enroll Your newly Eligible Dependents as indicated above, the Effective Date will be:

1. for Your Spouse, the first of the month following the event causing eligibility;

2. for all other Eligible Dependents, the first of the month following the date You enroll such Dependent; subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such child shall take effect on the first of the month following the date of enrollment once the required Premium, if any, has been paid.

When will Your Coverage end?

All of Your insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the earliest of the following dates:

1. The first day of the month following the date in which Your membership terminates. For the purposes of insurance coverage Your membership will terminate when You are no longer an active Member;
2. The date the Policy terminates or Coverage under Your Health Benefit Plan terminates;
3. The first day of the month following the date in which You cease to be an Eligible Person;
4. The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation;
5. The first day of the month following the date in which We receive written notice from You or the Policyholder telling Us to terminate Coverage of a Covered Person or the date requested in that notice, whichever is later;
6. The last day of the period for which premium was paid, if a premium is not paid when due subject to the Grace Period provision;
7. The first day of the month following the date in which the Policy is changed to end the insurance for Your Eligible Class;
8. The first day of the month following the date in which You enter full-time active duty in the armed forces of any country or international authority, We will refund the unearned pro-rata Premium to such person upon request;
9. The date of Your 65th birthday;
10. The date of Your death.

When will Coverage end for Your Dependents?

Your Dependent's insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates or Coverage under Your Health Benefit Plan terminates;
2. The first day of the month following the date in which the Dependent ceases to be an Eligible Dependent;
3. The first day of the month following the date in which You cease to be insured under the Policy;
4. The first day of the month following the date in which You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which premium was paid, if a premium is not paid when due subject to the Grace Period provision;
6. The first day of the month following the date in which We receive written notice from You or the Policyholder telling Us to terminate Coverage on any Dependent or the date requested in that notice, whichever is later;
7. The first day of the month following the date in which the Policy is changed to end the insurance for Your Eligible Class;
8. The first day of the month following the date in which that the Dependent enters full-time active duty in the armed forces of any country or international authority;
9. For Your Dependent Spouse the date of His 65th birthday;
10. The date of Your death.

Handicapped Dependent Children: Insurance will continue for a handicapped Child who has attained the limiting age shown in the definition of Eligible Dependent, if such Child is unwed and mentally or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us within 60 days after the of attainment of the limiting age. Failure to provide such proof within 60 days of Our request will result in the termination of the Dependent child's Coverage under the Policy.

Handicapped Dependent child who is not capable of supporting Himself due to intellectual or physical disability will be continued beyond the age at which Coverage would otherwise have terminated if:

1. The Dependent child became incapacitated prior to the age at which Coverage would otherwise have terminated; and
2. The Dependent child is primarily Dependent on the Eligible Person for support and maintenance; and
3. Proof of such incapacity and dependence is given to Us within thirty-one (31) days after the date the child reaches the limiting age. Proof must also be given to Us subsequently as We may require; except that We will not require proof more frequently than annually after the second anniversary of the date the child attains the limiting age.

Failure to provide such proof within thirty-one (31) days of Our request will result in the termination of the Dependent child's Coverage under the Policy.

Coverage will continue as long as the Dependent continues to be so incapacitated and Dependent, unless otherwise terminated in accordance with the terms of the Policy.

Notice Required When Your Coverage Terminates: We must be informed within 30 days of the date Your Coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of 2 Policy months. If We are not notified that Your Coverage is terminated and We pay any Benefits for Your Covered Expenses incurred after the date Your Coverage terminated, You will be responsible for payment of all Premiums due through the Policy month in which Benefits were paid.

What happens if You return to eligible status?

After release from active duty: If Your insurance or Your Eligible Dependent’s insurance ends due to Your being called or ordered to full-time active duty in the armed forces of any country or international authority, such insurance will be reinstated without any Waiting Period when You return.

After loss of eligibility: If You meet the definition of Eligible Person within 30 days of the date Your Coverage terminated, You may re-enroll for insurance under this Policy.

COVERAGE PROVISIONS

What Benefits are provided to Covered Persons?

The following benefits are payable if the Covered Person is covered by a Health Benefit Plan when the Covered Charges are incurred. Each benefit is subject to the terms, conditions, limitations, exclusions and Plan Year Maximums as described herein.

Inpatient Hospital Benefit. We will pay the Benefit shown in the Schedule of Benefits for Covered Charges incurred by a Covered Person if:

1. the Covered Charges are incurred while the Covered Person is an Inpatient; and
2. after satisfaction of any Deductible shown on the Schedule of Benefits; and
3. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Covered Person's Health Benefit Plan; and
2. any coinsurance and/or copayment amount applied to the expenses covered by the Covered Person's Health Benefit Plan.

Outpatient Benefit. We will pay the Benefit shown in the Schedule of Benefits for Covered Charges incurred by a Covered Person:

1. after satisfaction of any Deductible shown on the Schedule of Benefits.

Benefits payable under the Policy are limited to any out-of-pocket deductible, copayment, and coinsurance amounts the Covered Person incurs under His Health Benefit Plan for:

1. Outpatient treatment in a Hospital Emergency Room without subsequently being considered an Inpatient; and
2. Outpatient treatment in an Urgent Care Facility; and
3. Cancer Treatment performed in a Cancer Treatment Facility; and
4. Outpatient Therapy performed in an Outpatient Therapy Facility; and
5. Outpatient surgery performed in a Hospital Outpatient Facility a Freestanding Outpatient Surgery Center; and
6. Outpatient diagnostic testing performed in a Hospital Outpatient Facility, a Magnetic Resonance Imaging (MRI) Facility, or an independent lab facility; and
7. Outpatient treatment performed in a Hospital Outpatient Facility; and
8. Ground or Air Ambulance services; and
9. Chiropractic services.

Combined Inpatient Hospital and Outpatient Benefit. After satisfaction of any Deductible, We will pay a combined benefit for Covered Charges incurred by a Covered Person. The total Benefits payable for each Covered Person during a Plan Year will not exceed the Individual Plan Year Benefit Maximum under the Combined Inpatient Hospital and Outpatient Benefit shown in the Schedule of Benefits.

Is there a Plan Year Maximum Benefit?

The Plan Year Benefit Maximum is the maximum benefit payable by the Policy for a Benefit in a Plan Year. This maximum will apply even if a Covered Person's Coverage is interrupted or if a Covered Person has been covered both as an Insured Person and as a Covered Dependent during a Plan Year. The Plan Year Benefit Maximum is listed in the Schedule of Benefits.

CLAIM PROVISIONS

Submitting Claims and Receiving Reimbursement

How to submit a claim: Written notice of claim must be given to Us within 20 days after the date of loss. We will send Claim forms to the Claimant or You. If such forms are not sent to You or the Claimant within 15 days, You or the Claimant will meet the Proof of Loss requirements below if We are given written proof of the nature and extent of the loss. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give notice within that time and notice was given as soon as was reasonably possible.

When to submit a claim: Proof of Loss must be provided to Us within 90 days from the date of loss. Proof of loss includes a copy of the Health Benefit Plan's explanation of benefits. We will not deny or reduce any Claim if:

1. it was not reasonably possible to file the Claim within that time period.
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us within 1 year after it is due, unless You are legally incapable of doing so.

What if additional information is required? If the Proof of Loss provided does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the Claimant along with a request for the missing information.

When will the Claim be paid or denied? Benefits will be paid as soon as reasonably possible; but not later than 60 days after We receive proper written Proof of Loss.

All benefits will be paid to the You or Your assignee. If any benefits are payable to the estate of an individual or to an individual who is a minor or is otherwise not competent to give a valid release, We may pay the benefits, up to $1000, to any individual related by consanguinity or affinity to the individual who is considered by Us to be equitably entitled to the benefits. All payments made to or by Us will be made in United States dollars.

What if there is an overpayment of Benefits? We will not retroactively deny, adjust, or seek recoupment or refund of a paid claim for any reason, other than fraud or duplicate payments for the same service, after the expiration of one year from the date that the initial claim was paid. If We retroactively deny, adjust, or seek recoupment or refund of a paid claim, the health care provider will have an additional period of six months from the date that the notice of our intent to recoup was received within which to file either a revised claim or a request for reconsideration with additional medical records or information, and We will then process the revised claim or request for reconsideration in accordance with the requirements of When will the Claim be paid or denied above or in accordance with U.S. Department of Labor regulations governing the resolution of claims disputes and time for appeals, if applicable.

We will pay benefits to the Texas Health and Human Services Commission on behalf of an insured Dependent Child upon written notice if:

1. You are required to pay child support by a court order issued in Texas or is not entitled to possession or access to the insured Dependent Child and is required by court order to pay child support
2. the Texas Health and Human Services Commission is paying benefits on behalf of the insured Dependent Child on behalf of the insured Dependent Child under Chapter 31 and 32 of the Texas Human Resources Code; and;
3. notification is given to Us in writing with a submitted claim that such benefits should be paid directly to the Texas Health and Human Services Commission.

Benefits for a Dependent Child may also be paid to a possessory or managing conservator of the Dependent Child if the appointment for that Dependent Child was issued by a court in this or another state. A possessory or managing conservator is entitled to be paid benefits under this section if We are provided with the following:

1. Written notice that the person is a possessory or managing conservator for the Dependent Child on whose behalf the claim is made; and
2. a certified copy of the court order designating the person as possessory or managing conservator for the Dependent Child or other evidence designated by rule of the Commissioner that the person is eligible for the benefits.

COMPLAINT AND APPEAL PROCEDURES

What if You have questions about your Benefits or Claim payments?

Please contact Us If You have any questions about Your Benefits. For a specific Claim payment, or denial, You should contact Us or Our Administrator in writing or by telephone within 30 days of such payment or denial.

What if You don't agree with a Claim denial?

If We send You a written statement denying Your Claim in whole or in part, You may submit a written appeal to Us that outlines Your concerns and Your efforts to resolve the matter. The appeal must be filed within 30 days of the receipt of denial. A written decision with respect to the appeal shall be sent to You within 30 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

Please send to:
Health Special Risk, Inc.
HSR Plaza II, 8400 Belleview Drive Ste 150
Plano TX 75024

If You are not satisfied by the appeal response or for any reason, You may write to the State of Texas Department of Insurance. Describe the circumstances and Your complaint.

Please send to:
Texas Department of Insurance
1601 Congress Avenue
Austin, TX 78701
MC-CO-CP, PO Box 12030
Austin, TX 78711-2030
1-800-252-3439, 1-800-578-4677
www.tdi.texas.gov/consumer/complfrm.html

LIMITATIONS AND EXCLUSIONS

Limitations

Waiting Period for Late Entrants. For this provision, "Waiting Period" means the first 30 days following the Late Entrant's Effective Date. After the expiration of the Waiting Period, Late Entrants will be eligible for all benefits listed in the Schedule of Benefits for any Covered Charge that is incurred after such Waiting Period.

Exclusions

No Benefits are payable under the Policy for the following. In addition, the Charges listed below will not be recognized toward the satisfaction of any Deductible, copayment or coinsurance amount:

1. any expenses incurred during any period the Covered Person does not have coverage under a Health Benefit Plan;
2. suicide or any attempt thereat, while sane, except that this exclusion does not apply to any self-inflicted Injury or Sickness that is the result of a medical condition;
3. any intentionally self-inflicted Injury or Sickness, while sane except that this exclusion does not apply to any self-inflicted Injury or Sickness that is the result of a medical condition;
4. home health care, rest care or rehabilitative care and treatment;
5. voluntary abortion except;
   a. where the Insured's or the Dependent's life would be endangered if the fetus were carried to term; or
   b. where medical complications have arisen from abortion;
6. any Injury or Sickness as a result of Participation in a Riot, civil commotion, civil disobedience or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law;
7. a Covered Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause of loss occurred. A violation of law includes both misdemeanor and felony violations;
8. participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity for exhibition purposes;
9. Injury or Sickness as a result of air travel, except;
   a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
   b. as a passenger for transportation only and not as a pilot or crew member;
10. any Injury that occurs while a Covered Person has been determined to be intoxicated:
    a. by judicial or administrative judgment or order;
    b. by evidence of an alcohol concentration in the Covered Person's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or
    c. by other evidence demonstrating the Covered Person was under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage; and the use of such substance was a proximate cause of the Injury;
11. alcoholism or drug use, unless administered on the advice of a Physician and was taken according to the prescribed dosage;
12. procedures associated with sex changes;
13. any treatment, drugs or surgery considered experimental by the American Medical Association, the Health Care Finance Administration or the Federal Drug Administration;
14. any loss while the Covered Person is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Covered Person pro rata any premium paid, less any benefits paid, for any period during which the Covered Person is in such service;
15. Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law or similar legislation;
16. dental or vision services, including, but not limited to, treatment, surgery, extractions or x-rays, except surgical extractions that are covered under the Insured Person's Health Benefit Plan, and unless:
    a. resulting from an Injury occurring while the Covered Person's Coverage under the Policy is in force and if performed within 12 months of the date of such Accident; or
    b. due to congenital disease or anomaly of a Dependent newborn child;
17. routine examinations, such as health exams, periodic check-ups or routine physicals;
18. any expense for which benefits are excluded under the Covered Person's Health Benefit Plan, unless covered under the Additional Preventive Care Benefit.

19. Services or treatment rendered by a Physician who is a Covered Person or his spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother or other relative.

GENERAL PROVISIONS

Policyholder Grace Period

A Grace Period of 31 days (without interest charge) is granted for the payment of any Premium Due Date after the first. The Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under the Policy is to be ended on the first day before the Grace Period would otherwise start. If the Premium is not paid by the end of the Grace Period all insurance under the Policy will end on the last day of the Grace Period, and the Policyholder will owe Us all Premiums then due and unpaid including the Premium for the Grace Period.

If the Policyholder gives Us written notice that insurance under the Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later. The Policyholder will owe Us the pro-rata Premium for the time the insurance was in effect during the Grace Period.

Assignment

You may assign the Benefits of the Policy to the Provider rendering health care services. You may not assign the Policy in any other way or to any other person. We must be notified of the assignment. The assignment will not be effective until we receive the notice. We assume no responsibility for the validity of any assignment.

Changes to Policy

The Policy may be amended at any time by written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any amendment to the Policy must be in Writing and be attached to it. The amendment must bear the signature or a reproduction of the signature of Our President, a Vice President, or Secretary.

Incontestability

The validity of the Policy will not be contested after the Policy has been in force for two years after its date of issue. In the absence of fraud, a statement made by any Covered Person relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for two years during the Covered Person's lifetime and unless the statement is contained in a written instrument signed by the Covered Person making the statement. This section does not prevent Us from using at any time a defense based on:

1. non-payment of Premium; *or*
2. eligibility for coverage; *or*
3. over-insurance.

If You apply to add additional Covered Persons, the incontestable period with respect to newly added Covered Persons is for two years from such Covered Person's effective date. If You apply for increased Benefits under the Policy, We will not use misrepresentations made by You in a written application for such increase to contest the validity of the increased insurance with respect to which such statement was made, after such increase has been in force prior to the contest for a period of two years from the effective date of the increase.

Errors

You must be properly insured under the Policy. An error or omission by the Policyholder or by Us will not cause You to become Insured. An error or omission by the Policyholder or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect. After an error is found, We will take appropriate action, which may include adjusting, collecting, or refunding premium.

Legal Actions

No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required written Proof of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given.

Misrepresentation

Any statement You or the Policyholder make in an application to become insured is a representation and not a warranty. No representation made by You or the Policyholder in an application to become insured will be used in any contest or to reduce or deny Your Claim or contest the validity of Your insurance unless:

1. Your insurance would not have been approved except for Your misrepresentation; *and*
2. Your misrepresentation is contained in a written instrument Signed by You; *and*
3. We give You or in the event of Your death or incapacitation, Your beneficiary or personal representative a copy of the written instrument that contains Your misrepresentation.

Misstatement of Age or Fact

If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether he or she is insured and if so, for what amount and duration. We will adjust Premium rates to the Covered Person's correct age. We may make this change back to the date Coverage became effective based on the misstated information.

Notice to Policyholder

Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy, including termination of the Policy and termination of individual Coverage under the Policy.

Workers' Compensation Not Affected

The Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

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.

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 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.

SUMMARY OF COVERAGE AND LIMITATIONS AND EXCLUSIONS UNDER THE MICHIGAN LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION

Introduction

Welcome to the Michigan Life & Health Insurance Guaranty Association (MLHIGA) web site. Michigan residents who purchase life insurance, annuities or health insurance should know that most insurance companies licensed in Michigan to write these types of insurance are members of the Michigan Life & Health Insurance Guaranty Association (MLHIGA). The purpose of this association is to assure that policyholders may be protected, **within limits**, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, MLHIGA will assess its other member insurance companies for the money to pay the covered claims of insured persons who live in Michigan and, in some cases, to keep coverage in force. If coverage is provided, it may be subject to limitations or exclusions and may require residency in Michigan. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Guaranty Association Act

The Michigan Life & Health Insurance Guaranty Association Act, Chapter 77 of the Insurance Code of 1956, MCL 500.7701 to 500.7780, details the specific coverage, exemptions and limitations provided to certain policyholders. The general information provided by this summary or the MLHIGA web site does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of MLHIGA. For a definitive statement of the law governing MLHIGA, you must refer to the MLHIGA Act itself. If there is any inconsistency between this summary or the MLHIGA web site and any applicable law, then such law will control.

Coverage

Generally, individuals will be protected by MLHIGA if they reside in Michigan and own a life, health or annuity contract issued by a member insurer licensed in Michigan or if they reside in Michigan and are insured under a group life or health insurance contract issued by a member insurer licensed in Michigan. For owners of unallocated annuity contracts, coverage will be provided if the contract is issued in connection with a specific plan whose sponsor has its principal place of business in Michigan or if the individual is a resident of Michigan and the contract is issued in connection with a government lottery. For payees (or beneficiaries of deceased payees) of structured settlement annuities, coverage will be provided only if the payee is a resident of Michigan. In limited situations, coverage might also be available to certain non-residents.

You may find out if your insurance company is licensed in Michigan by contacting the Department of Insurance and Financial Services at P.O. Box 30220, Lansing, Michigan 48909-7720, telephone number (517) 284-8800 or 877-999-6442. Please be aware, although licensed in Michigan, policies issued by the following entities are not covered by MLHIGA: a nonprofit health care corporation, a health maintenance organization, a fraternal benefit society, a nonprofit dental care corporation (e.g. Delta Dental), a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an organization limited to the issuance of charitable gift annuities.

Protection can be provided in one of several different ways. For example, MLHIGA may provide coverage directly or a financially sound insurer may take over the troubled company's assets and policies and assume responsibilities for continuing coverage and paying covered claims. MLHIGA may also work with other state guaranty associations to develop an overall plan to provide protection for the failed insurer's policyholders. In any case, delays could be necessary to sort out the affairs of the financially troubled insurer.

Limits on Amount of Coverage

The MLHIGA Act limits the amount MLHIGA is obligated to cover for each insolvent company as follows:

(1) MLHIGA cannot cover more than what the insurance company would owe under a policy or contract;
(2) for any one life, regardless of the number of policies or contracts held with the same company, MLHIGA will cover a maximum of:
   (a) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
   (b) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
   (c) for health insurance:
      (i) $300,000 in disability income insurance benefits or long-term care benefits;
      (ii) $500,000 in basic hospital, medical, and surgical insurance benefits;
      (iii) $100,000 in all other health insurance benefits.
   (d) In no event is the association obligated to cover more than an aggregate of $300,000 in all benefits (other than basic hospital, medical, and surgical benefits) for any one life.

The limits mentioned above are applied per any “one life” per insolvent company.

As an example of this “one life” limitation, if you own three annuities with the same annuitant from the same insurance company, each worth $100,000 and that company is declared insolvent and ordered liquidated, only $250,000, **in total**, may be protected because that is the maximum amount protected under the MLHIGA Act for all annuities from a single insurer.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund **governmental retirement plans only** under sections 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits per participating individual; for covered unallocated annuities that fund other plans, benefits are not available on an individual basis and a special limit of $5,000,000 applies to the contract holder, regardless of the number of contracts held with the same company or number of persons covered by the plan. Coverage is dependent on plan sponsor having its principal place of business in Michigan. In all cases, of course, the contract limits also apply.

Exclusions from Coverage

Persons holding policies otherwise covered are **not** protected by MLHIGA 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); or
- the insurer was not authorized to do business in Michigan.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate set by formula in the MLHIGA Act;
- dividends;
- obligations not arising from the express written terms of the policy or contract;
- insurer’s obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets owned by benefit plan;
- interest determined by external reference that has not been credited to the policy or is subject to forfeiture;
- employers' plans that are self-funded (that is, not fully insured by an insurance company, even if an insurance company administers them);

- unallocated annuity contracts, unless they fund a government lottery or a benefit plan of an employer, association or union, however, unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered. An unallocated annuity contract is an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. The term shall also include, but not be limited to, guaranteed investment contracts and deposit administration contracts;
- policies issued by the following entities, even though licensed in Michigan: a nonprofit health care corporation, a health maintenance organization, a fraternal benefit society, a nonprofit dental care corporation (e.g. Delta Dental), a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an organization limited to the issuance of charitable gift annuities;
- a portion of a policy or contract to the extent that the assessments required by section 7709 of the MLHIGA Act for the policy or contract are preempted by federal or state law;
- a policy or contract providing any hospital, medical, prescription drug , or other health care benefits under Part C or Part D of Title XVIII of the Social Security Act, 42 USC 1395W-21 to 1395W-29 and 42 USC 1395W-101 to 1395W-152, or under regulations issued under Part C or Part D of Title XVIII of the Social Security Act, 42 USC 1395W-21 to 1395W-29 and 42 USC 1395W-101 to 1395W-152.
- MLHIGA **will not** provide duplicate coverage to **any** individual that is also covered by the laws of another state or another state's guaranty association.

Contact

The intent of this summary and the MLHIGA web site is to briefly explain how MLHIGA provides protection to Michigan policyholders in the event their insurance company becomes insolvent. If you have any questions that are not answered here, you should contact MLHIGA or consult with your attorney.

Disclaimer

The information provided by this summary and the MLHIGA web site is subject to change without notice. The statements made herein are for information purposes only. MLHIGA has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the insurer is declared insolvent. For these reasons, no final determination of coverage can be made until an insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind MLHIGA in any way. Finally, this summary and the MLHIGA web site are for general information purposes and should not be relied upon as legal advice.