UBA ACCIDENT

INCLUDED IN THIS PDF IS:

ATTENTION PLEASE

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

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SIRIUS POINT

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CERTIFICATES OF INSURANCE

UBA ACCIDENT

HASA-BAM-1000_v0823

SIRIUSPOINT AMERICA INSURANCE COMPANY

One World Trade Center
285 Fulton Street, 47th Floor
New York, New York 10007

BLANKET ACCIDENT INSURANCE

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

OUTLINE OF COVERAGE

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

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

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

SCHEDULE OF BENEFITS

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

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

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

Exposure and Disappearance Coverage

24-Hour Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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

SCHEDULE OF COVERED LOSSES

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

ACCIDENT MEDICAL BENEFITS

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

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS

Full Excess Medical Expense

ACCIDENT MEDICAL EXPENSE BENEFIT

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

CONDITIONS OF COVERAGE

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

EXPOSURE AND DISAPPEARANCE COVERAGE

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

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

24-HOUR COVERAGE

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

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

DESCRIPTION OF INDEMNITY BENEFITS

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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

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

Definitions

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

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

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

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

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

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

DESCRIPTION OF EXPENSE-INCURRED MEDICAL BENEFITS

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

ACCIDENT MEDICAL EXPENSE BENEFITS

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

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

SCOPE OF COVERAGE APPLICABLE TO EXPENSE-INCURRED MEDICAL BENEFITS

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

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

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

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

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

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

Definitions

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

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

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

GENERAL DEFINITIONS

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

Aircraft means a vehicle which:

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

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

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration;
3. considered effective for the Covered Injury;
4. not primarily for the convenience of the Covered Person, the Covered Person's Physician or any other Physician; and
5. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of a Covered Injury.

   For the purposes of this definition, Generally Accepted Standards of Medical Practice means:

   a. standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
   b. Physician and health care provider specialty society documents;
   c. The views of Physicians and health care providers practicing in the relevant clinical areas; and
   d. any other relevant factors.

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

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

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

Clean Claim means a claim received for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Covered Person in order to be processed and paid. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Time of Payment of Claims provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

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

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

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

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

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

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

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

Covered Loss means a loss:

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

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

Dependent means:

1. the Covered Person's lawful spouse who is age 18 years and under Age 71;
2. the Covered Person's eligible domestic partner who is a person that:
   a. shares the Covered Person's Home;
   b. has resided with the Covered Person continuously for at least six months and is expected to reside with the Covered Person indefinitely;
   c. is financially interdependent with the Covered Person in each of the following ways:
      i. by holding one or more credit or bank accounts, including a checking account, as joint accountholders;
      ii. by owning or leasing their Home as joint tenants;
      iii. by naming, or being named by, the Covered Person as a beneficiary of life insurance or under a will;
      iv. by each agreeing in writing to assume financial responsibility for the welfare of the other;
   d. has signed a domestic partner declaration with the Covered Person, if he resides in a jurisdiction which provides for a Domestic Partner declaration;
   e. has not signed a domestic partner declaration with any other person within the last 12 months;
   f. is no less than 18 years of age and not more than 70 years of age;
   g. is not legally permitted to marry the Covered Person;
   h. is not legally married to any other person;
   i. is not a blood relative any closer than would prohibit legal marriage.

   In addition to the above requirements, consent of either party due to the domestic partner relationship must not have been obtained by force, duress or fraud.

   A Covered Person may insure a domestic partner if all of the following conditions are met:
      i. the Covered Person has not been married to any person within the past 12 months;
      ii. the domestic partner is the only person meeting the Policy's requirements of a domestic partner with respect to the Covered Person;
      iii. the Covered Person and the domestic partner furnish a notarized affidavit *or* signed statement reflecting these requirements, and an agreement to notify Us that the requirements cease to be met, on a form acceptable to Us.

3. the Covered Person's unmarried child who meets the following requirements:
   a. a child from birth to 25 years old;
   b. a child who is 25 or more years old but less than 30 years old, enrolled in a school as a full-time student and primarily supported by the Covered Person. Coverage will continue during any period between school terms or school years as long as We are provided satisfactory proof that he has enrolled for the next following school term or year;
   c. a child who is 25 or more years old, primarily supported by the Covered Person, and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us 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 the Covered Person's:
      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 the Covered Person;
      iv. child for whom the Covered Person is legal guardian.

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

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

Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care or disability benefits. A Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured or self-funded agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice an individual practice plans;
5. medical benefits provided under automobile "fault" and "no-fault"–type contracts;
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a. a state-sponsored Medicaid plan; or
   b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

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

Hospital means an institution that meets all of the following:

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

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense and there is a legal obligation to pay.

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

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

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

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

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

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to the Covered Person that is appropriate for the condition and locality, and who is not:

1. the Covered Person;
2. an Immediate Family Member of either the Covered Person or the Covered Person's spouse;

3. a person living in the Covered Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

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

Sickness means a physical or mental illness, including pregnancy.

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

GENERAL EXCLUSIONS

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

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

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

General Limitations and Exclusions Applicable to Accident Medical Expense Benefits

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

This provision applies if benefits under any other Health Care Plan are covered under the Policy, and coverage under the Policy and the other Plan are excess.

We pay a pro rata share of the total amount of Covered Expenses. In no case will the total benefits payable exceed 100% of the Covered Expenses.

Our pro rata share equals the total of benefits payable under the Policy multiplied by a fraction, of which the numerator is the benefits

We pay and the denominator is the total of benefits payable by all Health Care Plans for the same Covered Accident.

Excluded Expenses

The following will not be considered Covered Expenses unless coverage is specifically provided.

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

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

CLAIM PROVISIONS

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

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

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

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

Time of Payment of Claims: All benefits payable under the Policy will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the Policy and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after We receive a clean claim containing necessary medical information and other information essential for us to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by Us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Covered Person in order to be processed and paid. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to Us, do not change the clean claim status.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
c. Claims that require information essential for Us to administer preexisting condition, coordination of benefits or subrogation provisions; or
d. Claims submitted by a provider more than thirty 30 days after the date of service; if the provider does not submit the claim on behalf of the Covered Person, then a claim is not clean when submitted more than 30 days after the date of billing by the provider to the Covered Person.

Not later than 25 days after the date We actually receive an electronic claim, We shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date We actually receive a paper claim, We shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us shall be paid within 20 days after receipt.

For purposes of this provision, the term “pay” means that We shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or Covered Person.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, We will pay the provider (where the claim is owed to the provider) or the Covered Person (where the claim is owed to the Covered Person) interest on accrued benefits at the rate of 3 % per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this subparagraph shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

In the event the We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in the previous paragraph and any other damages as may be allowable by law. If it is determined in such action that the We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or Covered Person) shall be entitled to recover damages in an amount up to 3 times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

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

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

If the Covered Person provides Us with written direction that all or a portion of any benefits provided by the Policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then We shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the Covered Person any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the Covered Person that are noncovered benefits.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to an amount not exceeding $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability for that payment.

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

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

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

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

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

Conditional Claim Payment

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

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

Physical Examination

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

Legal Actions

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

Recovery of Overpayment

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

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

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

Subrogation

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

ADMINISTRATIVE PROVISIONS

Grace Period
A Policy Grace Period of 31 days will be granted for payment of required premiums due after the first premium, unless:
1. We do not intend to renew the Policy beyond the period for which premium has been accepted; and
2. written notice of Our intention not to renew is delivered to the Policyholder at least 45 days before the premium is due.

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

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

HIPAA NOTICE OF PRIVACY RIGHTS

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

PLEASE REVIEW IT CAREFULLY.

I. OUR DUTIES

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

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

II. YOUR INDIVIDUAL RIGHTS

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

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

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

3. The right to inspect and copy your Protected Health Information in our records, 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.

NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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

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

The basic protections provided by the Association are:

Life Insurance

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

Health Insurance

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

Annuities

- $250,000 in the 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.

"Health benefit plan" is defined in Miss. Code Ann. § 83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

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 a variable annuity contract. There are also various residency requirements and other limitations under Mississippi law.

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 contract to which it relates.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of 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.