Not for Consumer Use

TRU GAP COMPREHENSIVE

INPATIENT & OUTPATIENT

AGENT GUIDE

- Review Agent Compliance
- Plan Details &
- State Variations
- and more...

Group Supplemental Medical Insurance
underwritten by SiriusPoint America Insurance Company

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

SIRIUS POINT

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

AGENT GUIDE

This guide is not for consumer use. This is an in-depth agent guide to get you familiar with the TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company to the United Business Association.

In this guide you will find:

AGENT-SPECIFIC REQUIREMENTS

The following need to be included & compliance practices followed when conducting a sales presentation to market the TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company.

SALES PROCESS

When enrolling a new member, make sure to read all the information on the enrollment application to the potential member.

This includes:

- Any Acknowledgments
- Disclosures
- Fraud Notices
- Limitations & Exclusions

The applicant must also be told during the enrollment process that they are joining the United Business Association along with the cost of the $10 membership dues that are separate from any Group Supplemental Medical Insurance premiums and membership plan costs.

The application needs to be reviewed, e-signed and accepted by the applicant. This includes any state specific information, disclosures, and forms, required for that member's state.

OTHER IMPORTANT COMPLIANCE GUIDELINES

- No-Auto Dialers for lead generation.
- Only sell in states you are licensed and appointed with the carrier.
- You should record the sale (if sale is conducted by phone) from start to finish of the sale for your protection and the carrier's protection in case of a complaint.
- Give an accurate and true representation of the TruGap Comprehensive plan (the Group Supplemental Medical Insurance) provided in the plan (including state variations).
- Give the member a copy of the state-specific Certificate **BEFORE** you enroll the potential member so that they can review the group insurance coverage along with all the exclusions, limitations, terms, provisions and conditions.
- Abide by all state and federal laws and regulations with regards to any insurance marketed
- Make sure to explain the cost breakdown to member (Association Dues vs premium) don't lump entire cost or plans together (including additional plans you are selling outside of the UBA plans. Make sure it is clear to the member what they are actually buying and how the cost breaks down for each plan they are purchasing at the same time.) When selling multiple insurance plans, make sure to discuss each type of insurance (i.e. ACA Bronze Plan & Group Supplemental Medical Insurance, etc.) Discuss as separate insurance coverage. Make sure to distinguish the coverage separately so that the member understands all of the insurance in the plans they are enrolling, including any important conditions, limitations and exclusions relative to each coverage.
- Do use the member's correct email address on the enrollment application. This is incredibly important because the email address allows the member to properly review the app, verify, read all state-specific disclaimers, e-sign the enrollment application, receive acceptance email along with link to the member portal which will include the member's ID Card, Certificate and any State Endorsements or Amendatory Riders along with any required State documents, copy of completed and signed application and forms and finally, the United Business Association Member Guide.
- Do not try to circumvent the application by entering a wrong information such as: state that is available instead of the member's residing state, wrong date of birth's so that the member meets the age requirement, a child 18 and over with the siblings as their dependents, another person's agent code to complete the app due to non-appointment or not being licensed in a state, and changing answers on the application from a potential member to bypass any pass/fail application questions.

ELIGIBILITY

Looking for coverage for the member, member & spouse or the entire family? Find out the eligibility requirements for enrollment in the TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company.

MUST BE ENROLLED IN & MAINTAIN A BRONZE ACA PLAN TO ENROLL IN THIS SUPPLEMENTAL PLAN

PRIMARY MEMBER

Ages 18 to under 65 years of age

ELIGIBLE DEPENDENTS

Spouse: Age 18 to under 65 years of age
(depending on state - see definitions for any state variations)

Dependent Children^: Unmarried and under 30
(Coverage ends for dependent children at age 30 in most states - see definitions for any state variations.)

(See the variations for the definitions of Child, Dependent Children, Domestic Partner, Civil Union Partner and Spouse for state-specific variations. Main definitions are located on pages 7-8 & page 12 with a notice if there is a state variation with corresponding page number.)

COVERAGE ENDS WHEN MEMBER TURNS 65

This is a very brief description of the Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company for the TruGap Comprehensive plan. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details.

HIGHLIGHT[1] OF SCHEDULE OF BENEFITS	TRUGAP COMPREHENSIVE
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 & OUTPATIENT BENEFIT	
Individual Plan Year Benefit Maximum	$7,500
Plan Year Benefit Maximum per Family	2 times the Individual Maximum
ADDITIONAL SCHEDULE OF BENEFITS INFO	
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
Plan Year	Calendar Year (see page 06 for definition)
^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

^This does **NOT** include the **additional $10** required United Business Association (UBA) membership dues. To enroll in this plan, they must be a member of UBA.

Policyholder: United Business Association (UBA)
409 W Vickery Blvd, Fort Worth, TX 76104
Policy# HASA-GAP-1000

[1]This is a very brief description of the Schedule of Benefits for the Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company for the TruGap Comprehensive plan. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details.

The definitions below are for all TruGap Comprehensive, Group Supplemental Medical Insurance states issued by SiriusPoint America Insurance Company to United Business Association (**based on the TX Certificate of Insurance**). Some states may have variations or added definitions. Those variations and added definitions will be located on page 13. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.

DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	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 re-occurrence 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 **(See page 08)**
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	Company, We, Us or Our means SiriusPoint America Insurance Company, domiciled in New York, New York.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	The male pronoun includes the female whenever used.
Complications of Pregnancy	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. **Arizona** has a variation based on the AZ Certificate. **See page 13** for variation of definition language.
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	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.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	The male pronoun includes the female whenever used.
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	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. **Arizona** has a variation based on the AZ Certificate. **See page 13** for variation of definition language.
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. **Arizona DOES <u>NOT</u> have** this definition based on the AZ Certificate.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	The male pronoun includes the female whenever used.
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. **Arizona** has a variation based on the AZ Certificate. **See page 13** for variation of definition language.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	The male pronoun includes the female whenever used.
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	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.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	The male pronoun includes the female whenever used.
Outpatient Therapy Facility	Outpatient Therapy Facility: An office, center or clinic in which a licensed therapist provides physical, kinesiology, occupational, or speech therapy.
Physician	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. **Arizona** has a variation based on the AZ Certificate. **See page 13** for variation of definition language.
Physician's Office	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 & Customer Activities	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.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
GROUP SUPPLEMENTAL MEDICAL INSURANCE	The male pronoun includes the female whenever used.
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. **Arizona** has a variation based on the AZ Certificate. **See page 13** for variation of definition language
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.

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DEFINITION TERM[1]	DEFINITION MEANING[1]
ARIZONA	**STATE VARIATIONS**
Complications of Pregnancy	Any of the following: 1. a condition that, while affected by pregnancy, is still classified by accepted medical standards as a Sickness apart from the normal bodily changes that accompany pregnancy; 2. a non-elective cesarean section; 3. an extra-uterine or ectopic pregnancy; or 4. a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible. Complications of Pregnancy do not include: false labor, premature labor, high risk pregnancy or delivery, occasional spotting, Physician-prescribed rest, morning sickness, pre-eclampsia or placenta previa or similar conditions that occur in a difficult pregnancy.
Eligible Dependent	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 until Age 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, children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a Child where an Eligible Person has the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. 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. On the date the court ordered custody or legal obligation terminates, the Child is no longer considered an Eligible Dependent. 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.
Hospital Emergency Room	Hospital Emergency Room: A portion of a Hospital where emergency diagnosis and treatment of Sickness or Injury due to an Accident is provided.
Physician	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. He may not be the Insured Person or a Family Member.
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 or electronic media, provided it is acceptable to Us and consistent with applicable law.

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LIMITATIONS & 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:

Below Limitations & Exclusions are based on the TX Certificate of Insurance. Any state variations in the Limitations and Exclusions will shown below that Limitation & Exclusion.

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;

[1]This is a very brief description of the Limitations & Exclusions in the TX Certificate of Insurance along with state variations for TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details.

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.

AZ does <u>not</u> have #19 Exclusion above listed in the AZ Certificate Limitations & Exclusions

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PROVISION[2]	PROVISION DESCRIPTION[2]
WHEN COVERAGE BEGINS & ENDS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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. **Arizona** has a variation based on the AZ Certificate. **See page 26** for variation of provision language.
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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
WHEN COVERAGE BEGINS & ENDS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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. 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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
WHEN COVERAGE BEGINS & ENDS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
When will your coverage end for 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. 1. The Dependent child became incapacitated prior to the age at which Coverage would otherwise have terminated; and 2. 2. The Dependent child is primarily Dependent on the Eligible Person for support and maintenance; and 3. 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. **Arizona** has a variation based on the AZ Certificate. **See page 27** for variation of provision language.
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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
COVERAGE PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
CLAIMS PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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. **Arizona** has a variation based on the AZ Certificate. **See page 28** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
COMPLAINT & APPEAL PROCEDURES	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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. **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of provision language.
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 **Arizona** has a variation based on the AZ Certificate. **See page 29** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
GENERAL PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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. **Arizona DOES <u>NOT</u> have** this provision based on the AZ Certificate.
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. **Arizona** has a variation based on the AZ Certificate. **See page 30** for variation of provision language.
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. **Arizona** has a variation based on the AZ Certificate. **See page 30** for variation of provision language.

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PROVISION[2]	PROVISION DESCRIPTION[2]
GENERAL PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
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. **Arizona** has a variation based on the AZ Certificate. **See page 30** for variation of provision language.
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. **Arizona** has a variation based on the AZ Certificate. **See page 30** for variation of provision language.
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. **Arizona** has a variation based on the AZ Certificate. **See page 31** for variation of provision language.
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.

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The provisions below are for all TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company to United Business Association (based on the TX Certificate of Insurance). Some states may have variations or added provisions. Those variations and added provisions will be located between pages 26-31. Make sure to review the state variations when marketing to potential members in that state so that you give them correct information for their state.

PROVISION[2]	PROVISION DESCRIPTION[2]
GENERAL PROVISIONS	All provisions below are based on the TX Version of the Claims Provision Section. Any State Variations will list the state & Page # to view
Workers' Compensation Not Affected	The Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state**. **Coverage and benefits may vary or may not be available in all states**. Please review for full details.

STATE VARIATIONS AND ADDITIONS

PROVISION VARIATIONS

In this section of the agent guide (pages 26-31), all of the state variations that are different from the provisions listed between pages 16-24 are detailed. The descriptions are done alphabetically. You will find all variations or additions for that state within each state section. Some states may carry over to multiple pages depending on the amount of variations or additions.

Make sure that BEFORE you discuss the right coverage, terms, definitions, limitations and exclusions with a client that you are reviewing the state-specific version so that you are giving the member the correct information for their home state.

QUICK STATE PAGES REFERENCE

PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
WHEN COVERAGE BEGINS & ENDS PROVISIONS	
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/Children Placed for Adoption: Your newborn or adopted child will be covered for the first 60 days following their birth, adoption, or Placement for Adoption. To continue Coverage beyond that 60-day period, You must notify Us in writing of the Child's date of birth, adoption, or Placement for Adoption enroll the Child 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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
WHEN COVERAGE BEGINS & ENDS PROVISIONS	
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. <u>Handicapped Dependent Children:</u> 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 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 by a Doctor within thirty-one (31) days of the date the child reaches the limiting age. Proof must also be given to Us annually thereafter. 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. <u>Notice Required When Your Coverage Terminates:</u> 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.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details.

PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
CLAIMS 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. Upon receipt by Us of the request for claims forms, 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. When to submit a claim: Proof of Loss must be provided within 90 days from the date of loss to file written Proof 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 filed after 90 days from the date of loss if: 1. it was not reasonably possible to file the Claim within that 90 day 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? After receiving written Proof of Loss and Premium payment, We will pay or deny all Benefits then due for Covered Charges directly to You. We will pay or deny all Claims or any portion of any Claims within 30 days for an electronic claim or 45 days for a written claim , after receipt of the Claim. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 30 days for an electronic claim or 45 days for a written claim after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 21 days. 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.

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PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
COMPLAINT & APPEAL PROCEDURES	
What if You have questions about your Benefits or Claim payments	If You have any questions about Your Benefits, a specific Claim payment, or denial, You should contact Us or Our Administrator in writing or by telephone within 30 days.
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 Arizona Department of Insurance. Describe the circumstances and Your complaint. Please send to: Arizona Department of Insurance 100 N 15th Ave #261 Phoenix, AZ 85007 (602)-364-3100 https://difi.az.gov/

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details.

PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
GENERAL PROVISIONS	
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 in Writing of the assignment. The assignment will not be effective until we receive the Written notice. We assume no responsibility for the validity of any assignment.
Incontestability	We will not use misrepresentations made by You in a written application to contest the validity of the insurance with respect to which such statement was made, after such insurance has been in force prior to the contest for a period of two years during Your lifetime, unless the misrepresentations are fraudulent. This section does not prevent Us from using at any time a defense based on: 1. non-payment of Premium; or 2. any other provision of the Policy; or 3. any other defense that is allowed by law. 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. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us, or by You, or Your representative or beneficiary, or the Policyholder.
Legal Action	No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 6 years after the time written Proof of Loss is required by the Policy to be given.

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PROVISION[2]	PROVISION DESCRIPTION[2]
ARIZONA	
GENERAL PROVISIONS	
Misrepresentation	Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used 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 Your representative a copy of the written instrument that contains Your misrepresentation.
FLORIDA	
STATE ENDORSEMENT	
Florida State Endorsement	STATE ENDORSEMENT (Applicable only to Insured Persons who are in the State of Florida) This Endorsement is attached to and made part of Master Group Policy Number HASA-GAP-1000 issued to United Business Association (the Policyholder). This Endorsement is attached to and made part of the Policy/Certificate. The provisions of the Endorsement are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated. The Policy/Certificate to which this Endorsement is attached is amended as follows: FACE PAGE 1. The Face Page of the Certificate is revised to include the following disclaimer: The benefits of the Policy providing your coverage are governed primarily by the laws of a state other than Florida. This Endorsement does not change coverage or provisions in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Endorsement, the terms of this Endorsement will govern.

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Please review for full details.

SPECIAL STATE SPECIFIC ADDITIONAL DISCLAIMERS

ARIZONA

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 or notice to any Covered Person who Claims rights or Benefits under the Policy.

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 supplements an underlying Health Benefit Plan (HBP) and is available only while the 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.

FLORIDA

See Endorsement on page 31 for additional disclaimer

[2]This is a very brief description of the provisions in the TX Certificate of Insurance along with state variations for TruGap Comprehensive, Group Supplemental Medical Insurance issued by SiriusPoint America Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states**. Please review for full details.

SPECIAL STATE SPECIFIC ADDITIONAL DISCLAIMERS (continued)

CA, FL, MI & TX

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.

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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DISCLAIMERS FOR GROUP SUPPLEMENTAL MEDICAL INSURANCE

Below are the disclaimers that need to be disclosed to a potential member when doing a Group Supplemental Medical Insurance sale that is underwritten by SiriusPoint America Insurance Company.

MAIN DISCLAIMER

This is a brief description of various group association insurance products and is not an insurance contract, nor part of the Certificate of Insurance and is subject to the terms, conditions, limitations, and exclusions of the Group Policy and Certificate(s) of Insurance. Coverage may vary or may not be available in all states. You'll find complete coverage details in the Certificate(s) of Insurance. Group Supplemental Medical Insurance is underwritten by SiriusPoint America Insurance Company, New York, NY. The insurance described in this document provides limited benefits. Limited benefit plans are insurance products with reduced benefits intended to help supplement comprehensive health insurance plans. The insurance coverage is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, the insurance coverage is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

Optional Supplemental UBA Gap Disclaimer

The optional supplemental UBA Gap plans available to members to add to their membership in the United Business Association allows the member to enhance their overall membership opportunities. These optional supplemental UBA Gap plans are not intended to supplement, not replace, comprehensive health insurance coverage. UBA Gap plans are not major medical insurance and should not be purchased to replace any major medical insurance, Cobra, Medicare, Medicaid, or Medical Disability coverage that you have in place currently. UBA Gap plans do not satisfy the requirement of minimum essential coverage under the Affordable Care Act and does not qualify or generate a 1095-A tax form.

Group Supplemental Medical Insurance Disclaimer

You hereby request Group Supplemental Medical Insurance underwritten by SiriusPoint America Insurance Company, New York, NY.

You understand the insurance described provides limited benefits and that this insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act. You understand that the information contained herein is a summary of the coverage offered. A Certificate of Insurance along with your UBA membership guide will be made available to you upon enrollment. You will receive a UBA Gap I.D. card and a TruGap Comprehensive I.D. card in the mail along with a welcome letter that includes your effective date for your membership plan.

You attest that you are currently enrolled and will maintain a Bronze ACA plan to stay covered under this supplemental insurance.

You attest that you have read and understood the limitations and exclusions of this coverage:

(You should have emailed them a copy of the Certificate of Insurance for the state in which they reside to review prior to the sale being completed. It is best practices to keep a copy of the email which included a copy of the state-specific Certificate of Insurance that you sent the potential member for your records during the sales process in case of future complaint. It will help prove that you gave the member the information up front and that the member understood what they are purchasing.)

DISCLAIMERS FOR GROUP SUPPLEMENTAL MEDICAL INSURANCE

Below are the disclaimers that need to be disclosed to a potential member when doing a Group Supplemental Medical Insurance sale that is underwritten by SiriusPoint America Insurance Company.

PAYMENT AUTHORIZATION

You authorize H A Partners, Inc. (Healthy America Insurance Agency, Inc. in Florida) to initiate charges to your credit card in the total monthly amount shown for the plans or products you've selected. This authorization will remain in effect until H A Partners, Inc. (Healthy America Insurance Agency, Inc. in Florida) receives notice from you that it should be cancelled.

UBA Membership and all optional supplemental UBA plans are subscription based enrollments. You will continue to be drafted every month until you cancel by submitting a cancellation request via online form or email, or by phone at 866-438-4274.

Your total initial payment, which includes your first monthly payment for these selected supplemental plans as well as any applicable administrative fees or one-time enrollments fees, will be charged immediately when your application is processed. Subsequent monthly payments will be charged on the 5th each month if your effective date is the 1st, or the 15th each month if your effective date is the 15th. If other UBA plans have been purchased along with UBA membership, you will be charged only one monthly payment for the total cost of all purchased supplemental plans. Your credit card statements will show these transactions as paid to "UBA GAP 866-438-4274".

You agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, it may result in forfeiture of your membership, and neither H A Partners, Inc. (Healthy America Insurance Agency, Inc. in Florida) nor your financial institution shall be held liable whatsoever.

You agree that it is your responsibility to check the transactions occurring on your account every month and to cancel with us when desired. Every month we pay for the membership services and the insurance premiums for any applicable group insurance programs on your behalf, whether or not you use the membership services or file a claim with the group insurance programs (if applicable). Please refer to our Refund Policy for details on refunds.

You will receive your I.D. Cards in the mail within 14 days of purchase. Digital copies of your I.D. Cards, as well as all Membership Guides and Certificates of Insurance pertaining to the plans or products you've purchased, will be immediately available for download upon completion of your application. Please take the time to review all Guides and Certificates to ensure you fully understand your plan benefits, including any limitations, exclusions, definitions, or state variations.

You understand that the UBA membership, any optional supplemental UBA plans you selected for this enrollment application are separate from any other health plans or insurance coverage you may have purchased or applied for elsewhere.

SATISFACTION GUARANTEED

We want you to be completely satisfied. If you have any problems, or any questions about your UBA Membership or any plan benefits, please call your Personal Membership Concierge at 1-866-438-4274.

If you are not completely satisfied with your UBA Membership, any supplemental UBA Gap or Benefit Boost plans, you can cancel at any time in the first thirty (30) days for a full refund of paid premiums or membership dues. Cancellation requests can be made by email (info@ubamembers.com), phone (866-438-4274), or through the Member Portal (https://members.ubaapplication.com). Any refunds are processed within 7-10 business days from date of request. **Please be aware that premiums & dues cannot be refunded if a claim has been filed for a group insurance benefit**. We showcase our name UBA GAP and our number 866-438-4274 on all transactions (all together like this UBAGAP8664384274) on your account statement, and **it is your responsibility to check the transactions occurring on your account every month and to cancel with us when desired**. Every month we pay for the membership services and the insurance premiums for any applicable optional supplemental group insurance programs on your behalf, whether you use the membership services or file a claim with the group insurance programs.

SCRIPT FOR GROUP SUPPLEMENTAL MEDICAL INSURANCE

Below is an outline of a script along with the verification / applicant signature script to follow when conducting sales for the Group Supplemental Medical Insurance that is underwritten by SiriusPoint America Insurance Company. As long as the general practice and points of the script is followed, it doesn't have to be word for word since all conversations flow in different ways with different sales. It is good practices that all main points of the script outline are part of a sales recording. This will help protect you for any potential complaints you could have in the future from a disgruntled or unhappy member. We recommend saving the sales recording for any future needs.

BASIC STARTING SCRIPT OUTLINE (an outline of points that need to be addressed in recording)

The **TruGap Comprehensive plan** includes Group Supplemental Medical Insurance underwritten by SiriusPoint America Insurance Company and includes the following:

- Schedule of Benefits information for the **TruGap Comprehensive plan** chosen (page 5 in Agent Guide for reference)
- Send the member a PDF copy of the state-specific Certificate of Insurance by email so that they can review the insurance details along with the Limitations and Exclusions so that you can answer any questions that they might have on the coverage. Make sure that discuss this point that you have sent them a copy of the Certificate to review in your sales presentation.
- Answer any questions based on the STATE in which the member resides. Read all disclaimers. Then complete the application or send your unique link for them to complete the application. Instruct and explain to the potential member that they will receive an email for the verification, application review and e-signature to complete and that the application process will not be completed unless the application is reviewed, accepted and e-signed by them.
- Follow the Application Signature for Recording Script before ending the sales call recording. It is best practices to keep the recording of the entire sales call for any potential future complaint needs for your protection.
- Make sure that you are selling them and confirm they are enrolling or have a Bronze ACA plan in order to qualify for this plan.

APPLICANT SIGNATURE FOR RECORDING

You attest to the best of your knowledge and belief that the answers to the questions on the Enrollment application are true and complete. You understand that the Group Supplemental Medical Insurance provided as part of **TruGap Comprehensive plan** is issued and underwritten by SiriusPoint America Insurance Company.

Sign your application by completing the verification review and e-signature process from the email or text link that you received. Your signature will be saved to your application along with your IP address and the current date & time. You agree that your electronic signature will serve as your original signature, and by signing you agree to all acknowledgments, agreements, authorizations, and certifications that have been presented to you based on the memberships, plans, or products you've selected.

You hereby request to enroll in **TruGap Comprehensive** and the UBA Membership through United Business Association. You have reviewed details regarding both **TruGap Comprehensive** and the UBA Membership. You understand and agree to all terms and conditions, limitations and exclusions and state availability of coverage that may apply to the plans you are purchasing. You authorize H A Partners, Inc. (Healthy America Insurance Agency, Inc. in Florida), the Administrator of these products, to charge all monthly premiums / dues for these products to the credit card or bank account you provided. You attest that you are the owner of, an authorized signer on, or have been granted express authority to use, the credit card or bank account provided for this purchase. You understand that it is your responsibility to check the transactions occurring on your account every month. You understand and agree that membership services and the insurance premiums for any applicable group insurance programs are paid for on your behalf, whether or not you use the membership services or file a claim with any applicable group insurance programs. You agree that this Authorization is to remain in full force until revoked by me in writing to 409 W Vickery Blvd, Fort Worth, TX 76104, by email at info@ubamembers.com, cancellation form at ubamembers.com, the member portal at https://members.ubaapplication.com, or by phone 866-438-4274.

You understand that if the Enrollment is accepted by the Company, coverage will begin on the Requested Effective Date, subject to the payment of the required premium. Coverage will not become effective unless you meet all eligibility requirements on the date of the enrollment and the effective date of coverage.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.