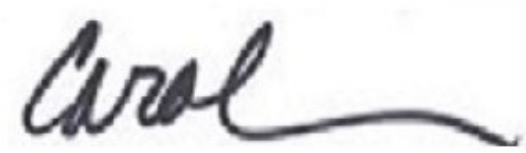
1601 North-Sepulveda Blvd. #606
Manhattan Beach, CA 90266 Floor, New York, New York 10022

GROUP ACCIDENT-ONLY CERTIFICATE OF INSURANCE

Policyholder: SOLARTIS
Policy Number: ADDG 270294
Policy Effective Date: December 1, 2012
Policy Anniversary Date: December 1 of each year beginning in 2013
Certificate Effective Date: December 13, 2020

We have issued the Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of the Policy, which are important to You, are summarized in this Certificate ("Certificate") consisting of this form and any additional forms which have been made a part of this Certificate. This Certificate replaces any other Certificate We may have given to You earlier under the Policy. The Policy alone is the only contract under which payment will be made. The Policy may be inspected at the office of the Policyholder.

Signed for SOLARTIS INSURANCE COMPANY By:



Carol Mowry,
General Counsel and Secretary

Nick Richardson,
President and Chief Executive Officer

THIS IS GROUP ACCIDENT INSURANCE.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.
THIS IS LIMITED COVERAGE.
PLEASE READ THE CERTIFICATE CAREFULLY.

The Policy provides Accident insurance only. It does NOT provide Basic Hospital, Basic Medical or Major Medical insurance as defined by the New York Insurance Department. The anticipated loss ratio for this Policy is 65%. This ratio is the portion of future premiums which the Company expects to return as benefits when averaged over all people with the Policy.

A note on capitalization in this Certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a term defined herein or refers to a specific provision contained herein.

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SECTION 1: SCHEDULE OF INSURANCE

Eligible Persons: Active Members and their Dependents who are citizens or residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal employees.

Class 1 Active Members of the Solartis

Annual Enrollment Period: December 1 through November 30 of each year as determined by the Policyholder.

Policy Age Limit: You: 76 years of age

CONTRIBUTORY COVERAGE:

Accidental Death and Dismemberment Benefit

Principal Sum: $250,000

Principal Sum for each of Your Dependents:
The Principal Sum that applies to each person covered under the Policy as Your Dependent, on the date of accident, is determined by multiplying Your Principal Sum by the percentage determined below.

	Spouse	**Each Dependent Child**
Spouse only	0%	0%
Spouse and Dependent Child(ren)	0%	0%
Dependent Child(ren) only	0%	0%

Additional Benefits:
Seat Belt Benefit

Seat Belt Benefit Percentage:	10% of Principal Sum
Seat Belt Benefit	$25,000

Spouse Education Benefit

Benefit Percentage:	5% of Principal Sum
Maximum Benefit Amount:	$5,000
Minimum Benefit Amount:	$2,500

SECTION 2: DEFINITIONS

Active Member means a member in good standing according to the rules of the Policyholder.

Airworthiness Certificate means:
1) the standard Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Civil or Public Aircraft means a civil or public aircraft which:
1) has a current and valid Airworthiness Certificate;
2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:
1) Your unmarried: children, newborn children, stepchildren, legally adopted children, children in the process of adoption, foster children; or
2) any other children related to You by blood or marriage;

provided such children are primarily dependent upon You for financial support and maintenance and are less than the Limiting Age of 24 years.

The Limiting Age shall not so terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which Dependent coverage would otherwise terminate. Such child must be chiefly dependent upon You for support and maintenance. You must within 31 days of such Dependent's attainment of the termination age submit proof of such Dependent's incapacity as described herein.

Dependent(s) means Your Spouse and Dependent Child(ren). A dependent must be a citizen or legal resident of the United States, its territories or protectorates. Any person who is on active duty in military service cannot be a Dependent.

FAA means:
1) The Federal Aviation Administration of the United States; or
2) the equivalent aviation authority for the country of the aircraft’s registry, if the governmental authority is recognized by the United States.

Hospital means a short-term, acute, general hospital, which: (1) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; (2) has organized departments of medicine and major surgery; (3) has a requirement that every patient must be under the care of a Physician or dentist; (4) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (5) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]); (6) is duly licensed by the agency responsible for licensing such hospitals; is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Injury means bodily injury resulting:

1) directly from an accident; and
2) independent of all other causes;

which occurs while You or Your Dependents are covered under the Policy.

Loss resulting from:

1) sickness or disease, except an infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from injury.

Interstate Highway means the paved portion (including adjacent shoulders, emergency bays, entrance and exit ramps) of a highway, expressway or toll way designated as an interstate highway and identified by the tri-colored "U.S. Interstate" shield.

Motor Vehicle means a self-propelled, four (4) or more wheeled:

1) private passenger car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck

not being used as a Common Carrier.

On means, when used with reference to any conveyance (land, water or air), in or on, boarding or alighting from the conveyance.

Physician means a licensed practitioner of the healing arts acting within the scope of their license who is not Related to You by blood or marriage.

Related means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Scheduled Aircraft means a Civil or Public aircraft operated by a scheduled airline which:

1) is licensed by the FAA for the transportation of passengers for hire; and
2) publishes its flight schedule and fares for regular passenger service.

Spouse means Your lawful spouse, unless there is a divorce or annulment of the marriage.

Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page of this Certificate.

We, Us, Our means SOLARTIS INSURANCE COMPANY.

You or Your means the insured Active Member to whom this Certificate is issued.

SECTION 3: ELIGIBILITY AND ENROLLMENT

Eligible Persons: All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: You will become eligible for coverage on the latest of:
1) the Policy Effective Date; or
2) the date You become a member of an eligible class.

Eligibility for Dependent Coverage: You will become eligible for Dependent coverage on the later of:
1) the date You become insured for coverage; or
2) the date You acquire Your first Dependent.

You may not elect coverage for Your Dependent if such Dependent is covered as an Member under the Policy. No person can be insured as a Dependent of more than one Member under the Policy.

Enrollment: To enroll for Contributory Coverage, You must:
1) complete and sign a group insurance enrollment form for Your coverage and Your Dependent's coverage; and
2) deliver it to the Policyholder.

If You do not enroll for Your coverage, and/or Your Dependent's coverage within 31 days after becoming eligible under the Policy, You may only enroll for your coverage and Your Dependent's coverage:
1) during an Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date You have a Change in Family Status.

Change in Family Status: A Change in Family Status occurs when:
1) You get married;
2) You and Your spouse divorce;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse is no longer employed, which results in a loss of group insurance ; or
7) You have a change in classification from one class to another.

Newlywed Coverage: If you marry while covered under the Policy, Your spouse shall automatically become covered under the Policy for 31 days from the date of marriage. Benefits and amounts will be those We are providing for Spouse coverage under the Policy at that time.
Coverage of Your Spouse will cease after 31 days of the date of marriage unless You:
1) request in writing that coverage for Your Spouse be continued; and
2) pay any additional required premium.

Newborn/New Child Coverage: If, while covered under the Policy, You:
1) have a newborn child; or

2) adopt or receive a foster or stepchild;

the child will become covered under the Policy for 31 days from the date of birth or the date of financial dependence on You or the beginning of any waiting period prior to finalization of the child's adoption, if earlier. Benefits and amounts will be the same as those We are providing for Dependent Children under the Policy at that time.

Newly born infants adopted by You shall covered from the moment of birth if You take physical custody of the infant upon such infant's release from the Hospital and file a petition pursuant to section 115-c of the domestic relations law within 30 days of birth, unless consent to the adoption has been revoked.

Coverage of the new child will cease after 31 days unless You:

1) request in writing that coverage for Your child be continued; and
2) pay any additional required premium.

SECTION 4: PERIOD OF COVERAGE

Effective Date:

Contributory Coverage will start on the latest to occur of:

1) the date You become eligible, if You enroll on or before that date; or
2) the first day of the month on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll if You do so within 31 days of the date You are eligible.

Dependent Effective Date:

Contributory Coverage will start on the latest to occur of:

1) The date You become eligible for Dependent coverage, if You have enrolled the Dependent on or before that date; or
2) the first day of the month on or next following the last day of the Annual Enrollment Period, if You enroll the Dependent during an Annual Enrollment Period; or
3) the date You enroll the Dependent, if You do so within 31 days from the date they are eligible for Dependent coverage or due to a Change in Family Status.

In no event will Dependent coverage become effective before You become insured.

Change in Coverage:

After your initial enrollment You may increase or decrease coverage for You or Your Dependents or add a new Dependent to Your existing Dependent coverage:

1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage:

Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

1) the date of the change; and
2) the date requirements of the Deferred Effective Date provision are met.

Termination:

Coverage will end on the earliest to occur of:

1) the date the Policy terminates; or
2) the Premium Due Date on or next following the date You:
    a) cease to be an Active Member of the Policyholder;

b) attain the Policy Age Limit shown in the Schedule;

3) the date You are no longer in a class eligible for coverage, or the class is cancelled; or
4) the Premium Due Date that You fail to pay any required premium, subject to the Individual Grace Period, if coverage is Contributory.

Individual Grace Period: If coverage is Contributory, You will be allowed an Individual Grace Period of 31 days from the Premium Due Date for payment of each premium due after the initial premium. Your insurance will be continued during the Individual Grace Period.

The Individual Grace Period will not continue coverage beyond a date shown in the Termination provision that would otherwise terminate coverage.

Dependent Termination: Coverage for Your Dependent ends on the earliest to occur of:

1) the date the Policy terminates; or
2) The Premium Due Date on or next following the date:
   a) with respect to Your Dependent Child, he or she no longer meets the definition of Dependent Child;
   b) with respect to Your Spouse, he or she no longer meets the definition of Spouse or attains the Policy Age Limit shown in the Schedule of Insurance; or
   c) the required premium is not paid, subject to the Individual Grace Period provision, if coverage is Contributory; or
3) the date Your coverage ends.

Reinstatement: If Your coverage terminates after the expiration of the Individual Grace Period, You may reinstate Your coverage by sending a written request for reinstatement to Us within 90 days from the Premium Due Date. We will not provide coverage during the period after the expiration of the Individual Grace Period and prior to the date of receipt of the required premium.

SECTION 5: BENEFITS

Accidental Death and Dismemberment Benefit:

If You or Your Dependents sustain an Injury which results in any of the following Losses within 180 days of the date of accident, We will pay the injured person's amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss, after We receive Proof of Loss in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of the Policy.

We will not pay more than the Principal Sum to any one person, for all Losses due to the same accident. Your amount of Principal sum is shown in the Schedule of Insurance.The amount of Your Dependents' Principal Sum is shown as a percentage of Your Principal Sum in the Schedule of Insurance.

For Loss of:	Benefit Amount:
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum
Either Hand or Foot	One-Half of Principal Sum
Sight of One Eye	One-Half of Principal Sum
Speech or Hearing in Both Ears	One-Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

Loss means with regard to:

1) hands and feet, actual severance through or above wrists or ankle joints;
2) sight, speech, and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints;
4) movement, complete and irreversible paralysis of such limbs.
5) use of brain, permanent, complete and irreversible physical damage to the brain to the extent that the injured person is prevented from performing all the substantial and material functions and activities of a person of like age and gender in good health.

Seat Belt Benefit:

If You or Your Dependents sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt Benefit if the Injury occurred while the Injured person was:

1) a passenger riding in; or
2) the licensed operator of;

a properly registered Motor Vehicle and was wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of the Policy.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which the injured person was wearing a Seat Belt.

Seat Belt means:

1) an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications; or
2) a child restraint device that meets the standards of the National Safety Council and is properly secured and used in accordance with applicable state law and installed according to the recommendations of its manufacturer for children of like age and weight.

The specific amounts for this Benefit are shown in the schedule of Insurance.

Spouse Education Benefit:

If You sustain an Injury that results in a Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Spouse Education Benefit to Your surviving Spouse.

If You are married, Your Spouse must be covered under the Policy in order to receive this Benefit.

This Benefit will be paid:

1) after We receive proof satisfactory to Us that the Spouse has enrolled in an Occupational Training program; and
2) according to the General Provisions of the Policy.

The Spouse Education Benefit is the least of;

1) the Expense Incurred for Occupational Training.
2) the amount resulting from multiplying Your Principal Sum by the Spouse Education Benefit Percentage; or
3) the Maximum amount for this Benefit.

If a Principal Sum is payable because of Your death and there is no surviving Spouse, We will pay the Alternate Amount for this Benefit in accordance with the Claims to be Paid provision.

Your surviving Spouse must enroll in Occupational Training:

1) for the purpose of obtaining an independent source of income; and
2) within one (1) year of Your death.

Occupational Training means any:

1) education;
2) professional; or
3) trade training;

program which prepares the Spouse for an occupation for which he or she was not previously qualified.

Expenses Incurred means:

1) the actual tuition charged, exclusive of room and board; and

2) the actual cost of the materials needed;

for the Occupational Training.

The expense must be incurred within two (2) years of the date of Your death.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

SECTION 6: EXCLUSIONS

The Policy does not cover illness, accident, treatment or medical condition arising out of:

1) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto. However, this exclusion does not apply to terrorism;
2) suicide, attempted suicide or intentionally self-inflicted injury;
3) aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline, unless specifically covered in a Benefit provided in Section 5;
4) cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
5) foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
6) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;
7) treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made;
8) dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
9) eyeglasses, hearing aids, and examination for the prescription or fitting thereof;
10) rest cures, custodial care and transportation;

SECTION 7: GENERAL PROVISIONS

Notice of Claim:

You, or the person who has the right to claim benefits, must give Us, or Our authorized representative, written notice of a claim within 30 days after:

1) the date of death; or
2) the date of loss.

However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible. Such notice must include the claimant's name, address and the Policy Number.

Claim Forms:

Within 15 days of receiving a Notice of Claim, We or Our authorized representative will send forms to the claimant to provide Proof of Loss. If such forms are not furnished before the expiration of 15 days after We receive notice of the claim, the claimant shall be deemed to have complied with the Proof of Loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.

Proof of Loss:

Depending on the nature of the Loss, Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) any medical records and information We request that is reasonably required by Us to adjudicate the claim.

Sending Proof of Loss:

Written Proof of Loss must be sent within 180 days after the loss. All Proof of Loss should be sent to Us or Our authorized representative. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.

1)

Physical Examination and Autopsy:

While a claim is pending, We have the right at Our expense:

1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment:

If benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision not more than 60 days after such Proof of Loss is received.

Claims to Be Paid:

Benefits for Loss of Life will be paid in accordance with the Beneficiary Designation.

If no Beneficiary is named, or if no Beneficiary survives You, We may, at Our option, pay:

1) Your estate; or
2) all to Your surviving Spouse; or
3) if Your Spouse does not survive You, in equal shares to Your surviving Child(ren); or
4) if no Child(ren) survive(s) You, in equal shares to Your surviving Parents.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Accidental Death and Dismemberment Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your

surviving Spouse or the executors or administrators of Your estate.

Beneficiary Designation: You may designate or change a Beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a Beneficiary change.

Claim Denial If a claim for benefits is wholly or partly denied, You or Your Beneficiary will be furnished with written notification of the decision.

This written decision will:

1) give the specific reason(s) for the denial;
2) make specific reference to provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Legal Actions: Legal action cannot be taken against Us:

1) sooner than 60 days of the date written Proof of Loss is furnished; or
2) 2 years of the date Proof of Loss is required to be furnished according to the terms of the Policy.

Workers' Compensation: The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Misstatements: In the absence of fraud, if material facts about You or Your Dependents were not stated accurately:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing, signed by You and a copy of such statement must be provided to You or Your beneficiary or representative.

SECTION 8: APPEAL PROVISIONS

Internal Appeal Procedure

If a claim is wholly or partially denied, a written notice or a message on the Explanation of Benefits (EOB) will be sent to You containing the reason for the denial. The notice or message will include a reference to the provision in the Policy and a description of any additional information, which might be necessary for reconsideration of the claim.

If You or Your provider would like additional information or have any complaints concerning the basis upon which payment was made, We may be contacted at 1-866-519-2522. We will address concerns and attempt to resolve them satisfactorily. If We are unable to resolve a concern over the phone, We will request submission of the concern in writing to pursue a formal appeal.

A formal appeal must be submitted, in writing to Us at the following address:

SOLARTIS INSURANCE COMPANY
1601 North-Sepulveda Blvd. #606
Manhattan Beach, CA 90266

A formal appeal should include:
- Your name, security number, and home address;
- Policy number; and
- Any other information, documentation, or evidence to support the appeal.

A formal appeal must be submitted within 60 days of the event that resulted in the complaint. We will acknowledge a formal appeal within 10 working days of its receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to You in writing within 30 days following receipt of the formal appeal. If there are extraordinary circumstances requiring a more extensive review and additional supporting documentation is required, We may take up to an additional 60 days to review the formal appeal before rendering a decision.

External Appeal Procedure

Note: For the purposes of this provision, “the Insured” means to You and your covered Dependents.

I. The Insured’s Right to an External Appeal

Under certain circumstances, the Insured has a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, the Insured or his representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

II. The Insured’s Right to Appeal a Determination that a Service is Not Medically Necessary

If We have denied coverage on the basis that the service is not Medically Necessary, the Insured may appeal to an external appeal agent if the Insured satisfies the following two (2) criteria:
- The service, procedure, or treatment must otherwise be a covered service under the Policy; and
- The Insured must have received a final adverse determination through Our Internal Appeal Procedure described above and We must have upheld the denial or the Insured and Us must agree to waive any Internal Appeal.

III. The Insured's Right to Appeal a Determination that a Service is Experimental or Investigational

If the Insured has been denied coverage on the basis that the service is an experimental or investigational treatment, the Insured must satisfy the following two (2) criteria:

- The service must otherwise be a covered service under the Policy; and
- The Insured must have received a final adverse determination through Our Internal Appeal Procedure described above and We must have upheld the denial or the Insured and Us must agree in writing to waive any Internal Appeal.

In addition, the Insured's attending Physician must certify that the Insured has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the Insured's attending Physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders the Insured unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The Insured's attending Physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Policy **or** one for which there exists a clinical trial (as defined by law).

In addition, the Insured's attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the Insured than any standard covered service (only certain documents will be considered in support of this recommendation – the attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which the Insured is eligible (only certain clinical trials can be considered).

For purposes of this section, the Insured's attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat the life-threatening or disabling condition or disease.

IV. The External Appeal Process

If, through Our Internal Appeal Procedure, the Insured has received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, the Insured has 45 days from receipt of such notice to file a written request for an External Appeal. If the Insured and Us have agreed in writing to waive any internal appeal, the Insured has 45 days from receipt of such waiver to file a written request for an External Appeal. We will provide an External Appeal application with the final adverse determination issued through Our Internal Appeal Procedure or Our written waiver of an Internal Appeal.

The Insured may also request an External Appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If the Insured satisfies the criteria for an External Appeal, the State will forward the request to a certified External Appeal Agent.

The Insured will have an opportunity to submit additional documentation with his request. If the External Appeal Agent determines that the information the Insured submits represents a material change from the information on which We based Our denial, the External Appeal Agent will share

this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an Expedited Appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Insured's completed application. The External Appeal Agent may request additional information from the Insured, his Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the Insured in writing of its decision within two (2) business days.

If the Insured's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Insured's health, the Insured may request an Expedited External Appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the Insured's completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the Insured and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify the Insured in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only cover the costs of services required to provide treatment to the Insured according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Insured and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge the Insured a fee of $50 for an External Appeal. The External Appeal Application will instruct the Insured on the manner in which he must submit the fee. We will also waive the fee if We determine that paying the fee would pose a hardship to the Insured. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to the Insured.

V. The Insured's Responsibilities

It is the Insured's RESPONSIBILITY to initiate the External Appeal process. The Insured may initiate the External Appeal process by filing a completed application with the New York State Insurance Department. The Insured may appoint a representative to assist him with his External Appeal request, however, the Insurance Department may contact the Insured and request that he confirm in writing that he has appointed such representative.

Under New York State law, the Insured's completed request for appeal must be filed within 45 days of either the date upon which the Insured receives written notification from Us that We have upheld a denial of coverage or the date upon which the Insured receives a written waiver of any Internal Appeal. We have no authority to grant an extension of this deadline.

1601 North-Sepulveda Blvd. #606
Manhattan Beach, CA 90266

PASSENGER, PILOT OR CREW MEMBER BENEFIT RIDER

POLICYHOLDER:	SOLARTIS
GROUP POLICY NUMBER:	ADDG 270294
GROUP POLICY EFFECTIVE DATE:	December 1, 2012
GROUP POLICY ANNIVERSARY DATE:	December 1, 2013
STATE OF ISSUE:	New York
EFFECTIVE DATE OF THIS RIDER:	December 13, 2020

This Passenger, Pilot or Crew Member Benefit Rider is a part of the Policy and Certificate to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

RIDER SCHEDULE OF BENEFITS

Policy Age Limit:	Under age 76
Accidental Death & Dismemberment Principal Sum:	**$250,000**

PASSENGER, PILOT OR CREW MEMBER BENEFIT

If You suffer a Loss as a result of flying or riding as a Passenger, Pilot (with a valid license) or Crew Member on:

(a) an aircraft (which has a valid and current airworthiness certificate issued by the FAA); or
(b) a regularly scheduled flight on an airline.

We will pay the Principal Sum after We receive Proof of Loss, in accordance with the Proof of Loss provision.

For Loss of:	Benefit Amount:
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum

Either Hand or Foot ..... One-Half of Principal Sum
Sight of One Eye ..... One-Half of Principal Sum
Speech or Hearing in Both Ears ..... One-Half of Principal Sum
Movement of One Limb (Uniplegia) ..... One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand ..... One-Quarter of Principal Sum

Loss means with regard to:

1) hands and feet, actual severance through or above wrists or ankle joints;
2) sight, speech, and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints;
4) movement, complete and irreversible paralysis of such limbs.

This Benefit will be paid according to the General Provisions of the Policy.

Your amount of Principal Sum is shown in the Schedule of Insurance.

Special Aviation Activity Benefit: If You suffer a Loss of life as a result of flying or riding as a Pilot (with a valid license) or Crew Member in an airplane or aircraft which has a valid and current airworthiness certificate issued by the FAA, **while that airplane or aircraft is performing (including aerobatics) at an XYZ event,** We will pay the deceased person's amount of Principal Sum after We receive Proof of Loss, in accordance with the Proof of Loss provision.

This Benefit includes airplane or aircraft flown outside of the United States, its protectorates, territories, and Canada.

The Special Aviation Activity Benefit is subject to the following conditions. The aircraft must not be used for:

- Crop dusting;
- Spraying or seeding;
- Commercial advertising;
- Banner towing or sky writing;
- Fire fighting;
- Pipeline or power line inspection;
- Aerial photography or exploration;
- Sky diving or hang gliding;
- Speed racing;
- Endurance tests or an attempt at record setting flights;
- Maneuvers which are willful and intentional violation of current Regulations.
- Any operation which requires a special permit from the FAA, even if that permit is granted, except if the permit is required solely because of the territory flown over or landed on, or for an air show, unless at an XYZ event.

Definitions
In addition to the Definitions contained in the Policy and Certificate, the following Definitions apply to this Rider:

"Passenger" means a person traveling on an aircraft who bears no responsibility for the tasks required for that aircraft to arrive at its destination.

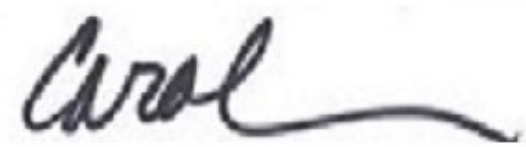
"Pilot" means a person who is licensed by the FAA to operate an aircraft in flight.

"Crew Member" means a person operating or serving aboard an aircraft in flight.

Benefits are subject to all terms and conditions of the Policy. This Rider does not waive, alter or extend any provisions or limitations of the Policy except to the extent shown above.

This Rider takes effect and ends concurrently with the Policy and Certificate to which it is attached.

Signed for **Solartis Insurance Company:**



Carol Mowry,
General Counsel and Secretary

Nick Richardson,
President and Chief Executive Officer