EXHIBIT 2

AFFIDAVIT OF VICTORIA STOTZER

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

I, Victoria Stotzer, having first been duly sworn, do depose and state the following:

1. I currently serve as Health Policy Compliance Analyst in the Actuarial Services Section of the Tennessee Insurance Division ("Division") of the Department of Commerce and Insurance ("Department"), a position I have held for 19 years. I have been employed by the Department for 19 years. I am over the age of 18 and have personal knowledge of the matters stated in this Affidavit.

2. In my position with the Division, I am responsible for reviewing all types of health insurance policies, certificates, and endorsements forms filed by insurance companies for review and approval. I review these forms and endorsements to ensure compliance with those statutes applicable to such forms.

3. The law requires all group accident and health insurance policy forms and certificates of coverage under such master policies to be filed with the Department at least thirty days prior to their sale in this state. Tenn. Code Ann. § 56-26-202. The law requires all individual accident and health insurance policy forms to be filed with the Department at least thirty days prior to their sale in this state. Tenn. Code Ann. § 56-26-102. An insurance company may not issue a group accident and health insurance policy or certificates of coverage if the Department notifies the company that it does not comply with the requirements under the law for health insurance.

4. If the group contract is issued to a policyholder outside of the state of Tennessee and certificates of insurance are issued to Tennessee residents, it is presumed to be subject to the jurisdiction of the Department. Any person or entity that is unable to show that it is subject to the jurisdiction of another agency must submit to an examination by the Commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not the person or entity is in compliance with the applicable provisions of this code. Tenn. Code Ann. § 56-7-1010. If a company is not authorized to do business in Tennessee, it would not be appropriate for the Department to approve their policy and certificate forms or the premium rates.

5. A group health and accident policy is a contract in which an insurance company provides accident and health insurance to groups of persons, as defined in the policy, under a policy issued to an employer, an association or a labor union, who shall be deemed the policyholder, insuring employees of the employer for the benefit of persons other than the employer, or insuring members or employees of the association or labor union for the benefit of persons other than officers of the association or labor union.

6. Accident and health insurance means providing benefits and payment for: 1) accidental bodily injury, disablement or death or the expense of accidental bodily injury, disablement or death; 2) disablement or expense resulting from sickness; 3) providing for an individual's and his family's mental and emotional welfare by defraying the cost of legal services; or, 4) providing aggregate or excess stop-loss coverage in connection with employee welfare benefit plans, managed care organizations participating in commercial plans or the TennCare program, health maintenance

organizations, long-term care facilities, and physician-hospital organizations as defined in Tenn. Code Ann. § 56-32-102.

7. Typically under a group health and accident insurance policy, the policyholder issues certificates of coverage to the insured in exchange for monthly premium payments collected by the employer, association or union and remitted to the insurance company that issued the group health and accident insurance policy to the employer, association or union.

8. On or about the end of February 2010, I became familiar with Smart Data Solutions ("SDS"), American Trade Association ("ATA") and Serve America Assurance ("SAA") and the type of product they are offering. SDS, ATA and SAA have not submitted any insurance policies, forms or products to this Department for approval or review prior to use, nor are any such approved at this time, as these companies or entities are not licensed to issue insurance in Tennessee. I visited the website for ATA at http://www.myatabenefits.com and reviewed the information contained therein on March 18, 2010.

9. I have been instructed to examine and have reviewed a document entitled Master Policy of Insurance that purportedly was issued to ATA by Serve America Assurance. (A true and exact copy of this document is attached hereto and marked as **Exhibit A**.) The Master Policy of Insurance purports to be a group accident and health insurance policy issued to Real Benefits Association ("RBA") as the policyholder; however, ATA admits that this group accident and health insurance policy is the policy issued to ATA to insure its members. Paragraph 17 of **Exhibit H** attached to the affidavit of Robert Heisse. The document provided does not address the terms of any contract

between SAA and ATA. The coverage provided under this contract, is not the coverage currently advertised on the ATA website, and as stated, the coverage terms do not describe any contractual benefits for ATA.

10. It is my conclusion, based upon my review and experience in reviewing group accident and health insurance policies, that the Master Policy of Insurance issued to the policyholder Realty Benefits Associates purportedly on behalf of ATA is a group accident and health insurance policy. This conclusion is based on the characteristics of a group accident and health insurance policy described above, as well as its similarities to group accident and health insurance policy contracts that have been filed with the Division by insurance companies. It is not, however, the master policy providing the current coverage offered to the members of ATA.

11. I have been instructed to examine and have reviewed a document entitled Certificate of Coverage that was issued to Durenda Hood, a citizen and resident of Tennessee, by ATA. This document does not list the insured or identify the certificate number. The Certificate of Coverage provided purports to be a "mini-medical indemnity plan." A true and exact copy of this document is attached hereto and marked as **Exhibit B**. The certificate provides minimal coverage if the insured incurs medical charges. It pays a fixed daily benefit for hospital coverage ($500 per day up to 30 days) and provides limited indemnity benefits with visit limits for doctor visits ($50), surgery (up to $1000), emergency room ($50), lab ($50), wellness ($50), drug and alcohol ($300 per day with an annual and lifetime maximum), mental health and prescriptions (same as drug and alcohol). The insurance coverage also includes a lump sum accident benefit of $500. This limited coverage is usually marketed as a supplement to comprehensive medical

coverage. It is not meant to provide full medical coverage. Durenda Hood's insurance coverage is included in the "Plus" plan on the ATA website, http://www.myatabenefits.com. The coverage is titled Plus 500 Limited Indemnity Benefits Plan.

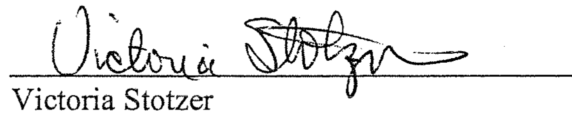
12. It is my conclusion, based upon my review and experience in reviewing group accident and health insurance policies, that the Certificate of Coverage in Exhibit B is a contract of insurance issued to an insured member of ATA. This conclusion is based on the characteristics of a group health and accident insurance policy described above, as well as its similarities to group health insurance policy contracts that have been filed with the Division by insurance companies.

13. Further, it is my conclusion, based upon my review and experience in reviewing group health and accident insurance policies, that the benefits provided on the web site and in the Certificate of Coverage issued to Durenda Hood are not reasonable in relation to the premium charged. Specifically, the charges appear to be excessive for the limited insurance being furnished, and a healthy individual, depending on their age, could purchase full medical coverage for similar premiums. If a person expected to be purchasing comprehensive health insurance coverage through ATA, rather than what is apparently furnished under the policy provided, the person might not recognize that they were being overcharged.

14. In summary, I have reviewed the master policy of insurance between SAA and RBA, the certificate of insurance providing coverage under the ATA Plus 500 Limited Indemnity Benefit Plan, the Accident Medical Expense In-Hospital Only Accidental Death and Dismemberment certificate and the ATA website

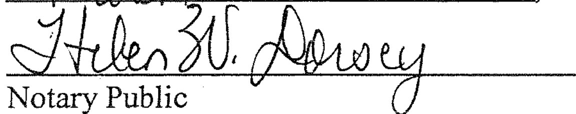
http://www.myatabenefits.com. The master policy, the indemnity certificate and the accident certificate are all contracts that provide health insurance coverage. The coverage offered on the website, under the heading HEALTH BENEFITS, described as Limited Indemnity Benefit Plan, Per Occurrence Plans, Accident Medical Plan and the Critical Illness Plan are health insurance. This health insurance coverage is offered as a part of the packages listed as Basic, Plus, Premier, Advantage, Bronze and Silver.

FURTHER AFFIANT SAITH NOT.



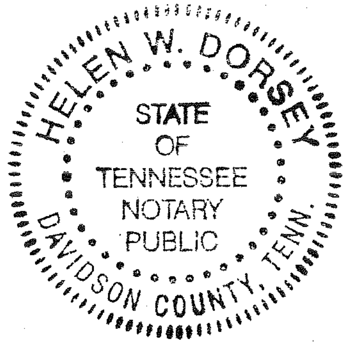
Victoria Stotzer

SWORN TO AND SUBSCRIBED before me on this 19th day of March, 2010.



Notary Public

My Commission Expires: 05/22/2010



My Commission Expires MAY 22, 2010

does not match website

SERVE AMERICA ASSURANCE

Administrative Office
SDS, LLC
4676 Highway 41 North
Springfield, TN 37172

MASTER POLICY OF INSURANCE

This is your Master Policy of Insurance for your Association. It explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and US. The Policyholder is shown on the Schedule.

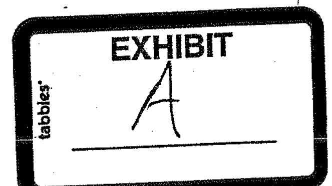
The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payments are determined by all the terms, conditions and limitations of the Policy. The Policy may be amended from time to time without your Consent or notice to you. Any such amendment will not affect a claim starting before the Amendment takes effect.

The Policy has been issued and delivered to the Policyholder. The Policy is held by the Policyholder. As a participant of the Policy, you may inspect it at any time during business hours at the office of the Policyholder.

President

HIGH DEDUCTIBLE MAJOR MEDICAL EXCESS COVERAGE

NON-PARTICIPATING



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GENERAL DEFINITIONS

Accident: A sudden, unforeseen event which results in injury.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory authority to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the necessary care. Air ambulance charges are payable only for the transportation from the site of an emergency to the nearest available Hospital that is equipped to treat the condition instead of local ground Ambulance service.

Class: A category of persons based on student status, job, salary or some other condition of employment or membership. Eligible classes are shown on the Schedule.

Company: SERVE AMERICA ASSURANCE. Also hereinafter referred to as We, Us, and Our.

Complications of Pregnancy: A condition which 1) When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: a) acute nephritis; b) nephrosis; c) cardiac decomposition; d) missed abortion; e) eclampsia; f) puerperal infection; g) R.H. Factor problems; h) severe loss of blood requiring transfusion; i) and other similar medical and surgical conditions of comparable severity related to pregnancy; or when pregnancy is terminated: a) non-elective caesarean section; b) ectopic pregnancy that is terminated; and c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of pregnancy will not include: a) false labor; b) occasional spotting; c) Doctor prescribed rest during the period of pregnancy; d) morning sickness; e) preclampsia; and f) Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or injury to the child or mother.

Covered Charge: The reasonable and customary charge incurred for a service or supply which is performed or given under the direction of a Doctor for Medically Necessary treatment of a sickness or injury which is covered by the Policy and incurred by a Covered Person. That portion of any charge which is in excess of the Reasonable and Customary charge for a particular service or supply in the area where it is incurred is not a covered charge. A covered charge is considered incurred on the date the treatment or service rendered or the supply is furnished.

Covered Person: A Person: a) who is eligible for coverage as the insured or as a Dependent; b) Who has been accepted for coverage or has been automatically added; c) who has paid the required premium; and d) whose coverage has become effective and is not terminated.

Dependent: A person who is the insured's: a) Legally married spouse residing with the insured; b) child who is dependent upon the insured for support and maintenance and is under the age of nineteen (19); c) Child who is dependent upon the insured for support and maintenance, is between 19 and 25 years of age and is attending school full-time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the insured's unmarried: a)natural child; b) stepchild; A stepchild is a dependent on the date the insured marries the child's parent; c) adopted child, including a child places with the insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

In the event both parents of a dependent child are insured persons, such child is considered a dependent of either parent. The child may not be considered a dependent of both parents.

Doctor: A legally qualified person licensed in the healing arts and practicing within scope of his or her license and is not a direct Family Member.

Emergency: A sickness or injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonable be expected to result in any of the following: a) the patient's life or health would be in serious jeopardy; b) bodily functions would be seriously impaired; or c) a body organ would be seriously damaged.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if reliable evidence shows that's the prevailing opinion among experts regarding the drug, device or medical care and treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and article sin authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

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 or father-in-law, parent (includes stepparent), brother, sister (includes stepsister or brother), or child (includes legally adopted or step-child). A Family Member includes an individual who normally lives in the Covered Person's household.

Hospital: An Institution licensed, accredited or certified by the State which: a) is accredited by the Joint Commission of Accreditation of Healthcare Organizations; b) Provides 24-hour nursing service by licensed registered nurses, (RN); c) mainly provides diagnostic and therapeutic care under the supervision of Doctors while hospital confined; and d) maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged, a nursing home, or an institution mainly rendering treatment or services for mental or nervous disorders or substance abuse, except as specifically provided in the Policy
Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 24 consecutive hours for which a room and board charge is made by reason of sickness or injury for which benefits are payable.

Injury: Bodily injury due to an accident which: a) results solely, directly and independently of disease or bodily infirmity; b) Occurs after the Covered Person's effective date of coverage; and c) Occurs while coverage is in force.

All injuries sustained in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of a sickness or injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it; a) Is experiment/investigational or for research purposes; b) is provided solely for educational purposes or the convenience of the patient, the patients family, Doctor, Hospital or any other provider; c) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where on going treatment is merely for maintenance or preventative care; d) could have been omitted without adversely affecting the patient's condition or the quality of medical care; e) involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S..Food and Drug Administration (FDA); f) involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues manual; or g) can be safely provided to the patient in a more cost-effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is medically necessary.

Mental or Nervous Disorder: Nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a covered person.

Policyholder: The entity shown as the Policyholder on the Schedule

Pre-Existing Condition: A Sickness or injury for which medical care, treatment, diagnosis or advice was received or recommended within the 12 month period immediately prior to the Covered Person's effective date of coverage under the Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months prior to the covered person's effective date of coverage under this Policy. Treatment includes taking of Prescriptions Medicines or drugs.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal Law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current AMA policies.

Reasonable and Customary Charges, Fees or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of: a) the actual amount charged by the provider; b) the negotiated rate, if any; or c) the charge which would have been make by the provider of medical services for a comparable service or supply make by other providers in the same geographic area, as reasonably determined by Us for the same service or supply.

Geographic area means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary Charges, Fees or Expenses will be based on statistically valid data for the most current medical and surgical codes and nomenclature and will be updated at least every six months.

In determining whether a charge is reasonable, We may consider such factors as We, in the reasonable exercise of Our discretion, determine are appropriate, including but not limited to: a) the complexity of the service or supply involved; b) the degree of professional skill, experience and training required for a Doctor to be able to perform the procedure or service; c) the severity or nature of the Injury or Sickness being treated; d) the provider's adherence or failure to adhere to charging and billing practices generally accepted by the established United States medial society as determined by Us; or e) the cost to the provider of providing the service or supplies, or performing the procedure.

Sickness: Illness and disease which begin after the effective date of a Covered Person's coverage.

Sound Natural Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of filling and caps and is not carious, abscessed, or defective.

You, Your and Yours: The insured shown in the Schedule

We, Ours, and Us: The SERVE AMERICA ASSURANCE

ADDITIONAL DEFINITIONS

Calendar Year: The period of time beginning January 1 and ending on December 31 of the same year. The first Calendar year of the Certificate will begin on the date this Certificate becomes effective and end on the first December 31st after a Covered Person's effective date of coverage.

Durable Medical Equipment: A device which: a)is primarily and customarily used for medical purposes, is specifically equipped with features and functions that are generally not required in the absence of sickness or injury and is able to withstand repeated use; b) is used exclusively by the patient; c) is routinely used in a Hospital but can be used effectively in a non-medical facility; d) can be expected to make a meaningful contribution tot eh patient's sickness or injury; and e) is prescribed by a Doctor and the device is medically necessary for rehabilitation.

Durable medical equipment does not include: a) comfort and convenience items; b) equipment that can be used by Family members other than the covered person; c) health exercise equipment; and d) equipment that may increase the value of the insured's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to, modifications to the patient's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Home Health Care: The provision of health service in the patient's residence under a plan of care established, approved in writing by the attending Doctor and certified by the attending Doctor as an alternative to Hospital Confinement or confinement in a skilled nursing facility. Each visit by a representative of a Home Health Agency is considered as one Home Health Care visit. Four hours of home health aide service is considered as one Home Health Care Visit. If service extends beyond four hours, each four hour or portion of that period is considered as one Home Health Care visit.

Home Health Care includes: part time nursing care by or supervised by a licensed registered nurse part-time home health care aid services which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; and medical supplies. Orthopedic appliances; durable medical equipment; prescription drugs and insulin, but only to the extent that such charges would have been considered covered expenses had the patient required Hospital Confinement or confinement in a skilled nursing facility.

Home Health Agency: An Agency or organizational that: a) Specializes in giving nursing care or therapeutic services in the home; b) is licensed to provide such care or services by the appropriate licensing agency where services are performed or is certified as a Home Health Agency under Title XVIII of the Social Security Act of 1965, as amended; c) is operating within the scope of its license or certification; and d) maintains a complete medical record for each patient.

Home Health Agency does not mean any other similar service or agency which does not meet this definition, even is the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a Home Health Agency.

Hospice: means an agency which provides a coordinated, interdisciplinary program for meeting the physical, psychological and social needs of a dying person and their families. A Hospice must: a) Be certified as a Hospice care program by Medicare; b) meet the standards of the National Hospice Organization, the Joint Commission of Accreditation of Hospitals, or similar standards; c) operate primary for Hospice Care; and d) provide full time supervision of at least one Doctor.

Hospice Care: Services provided by a Hospice providing care to an individual for whom a certified medical prognosis has been make indicating life expectancy of 6 months or less and who has elected to receive such care in lieu of other medical benefits provided herein.

Intensive Care: A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured..

Such facility must be separate and apart from the surgical recovery room and from other rooms, beds and wards customarily used for patient care. Additionally they must be staffed and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusive to the intensive care unit.

Intensive Care Unit does not mean any of these step-down units: Progressive care intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for intensive care.

Medicaid: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as the Constituted or Later Amended.

Medicare: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as the Constituted or Later Amended.

Nurse: A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) who: a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and b) provides medical services which are within the scope of the nurse's license or certificate.

Physiotherapy: Any form of the following administered by a Doctor: a) physical or mechanical therapy; b) diathermy; c) ultra-sound therapy; d) heat treatment in any form; or e) manipulation or massage.

Skilled Nursing Care: A place that meets all of the following requirements: a) Is legally operated as a Skilled Nursing Facility; b) primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Doctor; c) provides continuous 24-hour a day nursing service by or under the supervision of a licensed nurse; and d) maintains a daily medical record on each patient.

Skilled Nursing Facility also means a place which may not meet the above rules, but is a nursing facility that is either approved for payment of Medicare benefits or could get such approval upon request.

Skilled Nursing Facility does not mean or include any home or facility, or part thereof, used primarily for rest, residential, retirement, or custodial care.

CONDITIONS OF INSURANCE

ELIGIBILITY

Insured: You are eligible for coverage when you complete a valid application, meeting Our underwriting standards for coverage and pay the initial premium.

Dependent Spouse: Your dependent lawful spouse is eligible for coverage the later of: a) the date You become eligible for insurance; or b) The date of the marriage to You.

Your dependent spouse must complete a valid application, meeting Our underwriting standards for coverage, and pay the initial premium.

Dependent Child: A dependent child is eligible for coverage on the later of: a) the day You become eligible for insurance; or b) the date you acquire the dependent child.

A dependent child is deemed to be acquired as follows: a) Natural birth: On date of birth; b) Adopted child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement; or c) Stepchild: On the date of Your marriage to the child's parent.

Your dependent child (ren) must complete a valid application, meeting Our underwriting standards for coverage, and pay the initial premium.

EFFECTIVE DATE

Insured and Dependents, except Dependents Acquired After the Effective Date: Coverage is effective as stated on the schedule.

Dependents Acquired After Effective Date

Newborn Children: Your newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However you must notify Us in writing within 31 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child to continue beyond such 31 day period.

Adopted Child: Coverage for an adopted child is effective upon the date of placement for adoption. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, You must notify Us in writing within the 31 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child to continue beyond such 31 day period.

"Placement for Adoption" means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with You terminates upon the termination of the legal obligations.

Dependent Spouse: A dependent spouse is eligible for coverage on the date of lawful marriage to You. Application and premium must be received within 31 days of the marriage. Coverage will become effective following Our acceptance of the spouse's application and payment of the required premium.

Enrollment under Court Orders: If pursuant to a court order which meets the specifications of 20-7-1200 of the statutes, You are required to provide health coverage for a child and You are eligible for dependent coverage, we shall: a) permit you to enroll a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions; b) if you are enrolled but fail to make application to

obtain coverage for the child, enroll the child under the Policy upon applications of: 1) the child's other parent; 2) the state agency administering the Medicaid program; or 3) the state agency administering 42 U.S.C. 651 to 699, the child support enforcement program; and c) continue coverage of the child unless We are provided satisfactory written evidence that: 1) Court order is no longer in effect; 2) Child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or 3) the Policyholder has eliminated family health coverage for all its members.

TERMINATION

Covered Person: Coverage with respect to a covered person will terminate at 12:01 A.M. standard time at your residence on the earliest of: a) the date the Policy terminates; b) the date coverage is terminated by Us for all certificate holders in your state; c) the date we receive your written request to terminate coverage; d) the last day of the period for which the premium is paid; e) the last day of the period for which premium has been paid following the date a dependent ceases to be a dependent as defined; or f) the date a covered person enter full time military service. Upon written request within 30 days of entering the military, We will refund any unearned premium pro-rata with respect to such person.

At least 45 days prior to written notice will be given to you if We terminate your coverage for any reason, except nonpayment of premium.

If We discontinue the Policy form or plan of Insurance, We will provide you 90 days written notice and the opportunity to purchase without submitting proof of good health, any similar insurance coverage which we offer in that state. If we uniformly discontinue all coverage in a market in your state of residence, We will provide you at least 90 days written notice before the coverage terminates.
The continued coverage will cover the covered person and his insured dependents.

Continued coverage will terminate on the earlier of: a) the date 18 months after the date on which the group coverage would otherwise have terminated because of termination of the group membership. B) if the covered person fails to make timely payment of premium, the end of the period for which premium payment was made; or c) the date the Policy is terminated and is not replaced by another group policy within 31 days.

If a group policy is replaced, covered persons covered under continued coverage shall remain under such coverage under the replaced policy until as provided in the termination of Continued Coverage provision.

In the Event of Dissolution of Marriage

If your marriage is dissolved by a valid decree of dissolution and if your spouse is a covered person on the date of the decree of dissolution then the dependent spouse's coverage will continue in force under the policy, subject to its provisions, if the dependent spouse pays the first premium required for the continued coverage within 31 days after the entry of the decree of dissolution.

If the dependent spouse continues coverage pursuant to this provision, we will issue him or her a new Certificate as evidence of coverage under the Policy.

For a Dependent child reaching the limiting age

If a dependent child no longer qualifies as a dependent, then the dependent child's coverage will continue in force under the policy, subject to its provisions, if the dependent child pays the first premium required for continued coverage within 31 days after the date her or she no longer qualifies as a dependent child.

If the dependent child continues coverage pursuant to this provision, we will issue him or her a new certificate as evidence of coverage under the Policy.

MEDICAL EXPENSE BENEFITS

We will pay for Covered Charges incurred by the covered person due to Sickness or Injury while covered under the Policy. Covered charges as defined and limited are shown on the Schedule and are, during a Calendar Year, subject to: a) deductible; b) insured percent; c) our-of-pocket maximums; d) coordination of benefits; e) the lifetime aggregate maximum amount; and f) definitions, limitations, exclusions and other provisions of the Policy.

Deductible: A dollar amount of covered charges a covered person must pay each calendar year before benefits are paid. The deductible is shown in the Schedule. A new deductible will apply each calendar year.

Insured Percent: The percentage of covered charges we pay for covered charges during each calendar year after the deductible is satisfied. The insured percent is shown in the Schedule.

Calendar Year Maximum: The maximum amount that will be paid in benefits within a calendar year.

Lifetime Aggregate Maximum Amount: The maximum amount of benefits We will pay while a covered person is covered under this Certificate. The Lifetime Aggregate Maximum Amount is inclusive of all benefit amounts received under this Certificate. The Lifetime Aggregate Maximum Amount is shown on the Schedule.

Our of Pocket Maximum: The amount of covered charges a covered person must pay during a Calendar Year before his or her benefits are paid at 100%. The Out-Of-Pocket Maximum is in addition to the Deductible and applies only to out-of-network expenses. The Out-of-Pocket Maximum is stated in the Schedule.

GENERAL EXCLUSIONS

We won't pay benefits for:

Treatment, services or supplies which:

- Are not Medically Necessary
- Are not prescribed by a Doctor as necessary treatment to treat a Sickness or Injury
- Are determined to e Experimental/Investigational in nature by Us
- Are received without charge or legal obligation to pay
- Would not routinely be paid in the absence of insurance
- Are received form family members
- Are received outside the United States

Expenses incurred as a result of loss due to war, declared or undeclared; service in the armed forces of any country.

Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.

Expenses incurred as a result of suicide or attempted suicide or intentionally self-inflicted injury whether sane or insane.

Injury or sickness arising out of or in the course of employment which is compensable under any Worker's Compensation or Occupational Disease Act or Law.

Cosmetic Surgery other than:

a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
b) reconstructive surgery because of a congenital disease or anomaly, except as provided for Dependent newborns.

Injury due to being legally intoxicated, as defined by the jurisdiction in which an accident occurs.

Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.

Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial scheduled airline.
Any service or supply not specifically listed as a covered charge.
Sexual reassignment surgery and related expenses.
Routine physical examinations, health examinations or preschool physical examinations including routine care of a newborn infant, other than Hospital nursery expense of a dependent newborn baby.
Temporomandibular Joint Dysfunction (TMJ)
Expenses incurred as a result of dental treatment or dental x-rays, except as specifically provided and then only when injury occurs to sound natural teeth.
Eye examinations, contact lenses, eyeglasses, replacement of eyeglasses or prescription, therefore, or radial keratotomy or laser surgery; hearing aids or prescriptions or examinations, except as required for repair caused by injury.
Treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted contraception.
Manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, application of heat or cold.
Expenses to the extent they are paid under Medicare or any other government insurance plan (except Medicaid).
Expenses covered by automobile "no fault" contracts (group, group-type or individual).
Chelation treatments.
Artificial limbs or prosthetics, except as specifically provided.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are not covered for the first twelve (12) months following a Covered Person's effective date of coverage under this Policy.

The Pre-existing Condition Limitation does not apply to: a) a newborn Dependent Child; or b) a child adopted by you or placed with you for adoption, if the adoption or placement for adoption occurs while you are covered under this Policy.

COORDINATION OF BENEFITS PROVISION

The following provisions are applied to determine which Insurance Plan pays benefits first when a Covered Person is covered by tow or more plans. A Plan that pays first is called "Primary". All other plans called "Secondary".

If these provisions apply, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The Benefits of the Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits first before another plan; but
(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of the Plan".

Definitions:

"Plan" is any of these which provide benefits or services for, or because of, medical or dental or treatment.

(1) Group Insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.) as amended form time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"This Plan" is not part of the group contract that provides benefits for health care expenses.

"Primary Plan/Secondary Plan": The order of benefit determination rules state where this plan is a primary plan or secondary plan as to another plan covering the person.

(1) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
(2) When this Plan is a Secondary Plan, its benefits are determined after those of he other plan and may be reduced because of the other plan's benefits.

(3) When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and my be a Secondary plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

(1) The difference between the cost of a private room and a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
(2) When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year. However it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules:

General: When there is a basis for a claim under this Plan and another plan, this plan is a Secondary plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of this Plan; and
(2) Both those rules and this Plan's rules, in subsection B below, require that this Plan's benefits be determined before those of the other plan.

Rules: This Plan determines its order of benefits using the first of the following rules which apply:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that : if the person is also a Medicare beneficiary, Medicare is:
    a. Secondary to the plan covering the person as a dependent; and
    b. Primary to the plan covering the person as other than a dependent; for example a retired employee.

(2) Dependent Child/Parents not separated or divorced. Except as state in subsection (b) (3) below, when this plan and another plan cover the same child as a dependent of a different person, called "parents".
    a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year; but
    b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    c. However, if the other plan does not have the rule described in subsection (2) (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits the rule in the other plan will determine the order of benefits.

(3) Dependent Child/ Separated or Divorced. If tow or mare plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First the plan of the parent with custody of the child;
    b. Then, the plan of the spouse of the parent with the custody of the child; and
    c. Finally, the plan of the parent not having custody of the child

d. However, if the specific terms of a court decree state that one of the parents is responsible for health insurance expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.

(4) Dependent/ Child/Joint Custody: If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection (2) (b) above.

(5) Active/Inactive Employee. The benefit of a plan which covers a person as an employee who is neither laid off nor retired (or as the employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination.

a. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
b. Second, the benefits under the continuation coverage.

(7) Longer/Shorter length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plans which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

Effects on the Benefits of the Plan

(1) When this Section applies. This section applies when, in accordance with the above Section, "Order of Benefit Determination Rules," This Plan is Secondary plan as to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (2) immediately below.
(2) Reduction in this Plans Benefits. The benefits of this Plan will be reduced when the sum of:
(a) The benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
(b) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable expenses.
(c) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply this COB rules. Insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Insurer needs not tell, or get

the consent of, any person to do this. Each person claiming benefits under this Plan must give insurer any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable case value of the benefits.

Right of Recovery

If the amount of the payment made by insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of: a) The persons it has paid or for whom it has paid; b) Insurance companies; or c) other organizations.

PREFEFFED PROVIDER BENEFIT

We encourage Covered Providers by providing benefit incentives when Preferred Providers are used.

In the event of an emergency, services rendered by any Hospital due to and within the first 24 hours after the onset of the emergency are covered as if the service had been provided by Preferred Hospital. After the first 24 hours, service rendered by a non-preferred Hospital to treat the emergency will continue to be covered as if rendered by a preferred provider only until the covered person can reasonably and safely be transferred to a preferred Hospital.

In the event a covered person is traveling or away from home, needs medical attention, and cannot use a Participating Provider for the area, contact our Customer Service department. We will refer the covered person to a participating provider that may be available in the area nearest to such person at the time. If there is no participating provider available benefits for covered charges will be subject to the reduced insured percentage and out-or-pocket maximum.
A covered person is not required to seek treatment from a preferred provider. Each covered person is free to elect the services of a provider and benefits payable will be made in accordance with the terms and conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a preferred provider or to their respective staff or Doctors. We shall not have any liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the preferred provider, their staff or Doctors.

Out-of-Network: Any Hospital or Doctor that is not a member of the preferred provider network arrangement that has contracted with Us.

Preferred Provider: Any Hospital or Doctor that has contracted with Us to provide services, as described in this Certificate, through a preferred provider network arrangement, to be reimbursed at discounted rates.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim for loss must be given to Us or Our authorized representatives within 30 days after a covered loss starts, or, because of incapacity or some similar reason, as soon as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Form: Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished by Us within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss submitting, within the time fixed in the Policy for filing the Poof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

Proof of Loss: Written Proof of Loss must be given to Us or Our authorized representative within 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as was reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper Proof of Loss unless this Policy provides for periodic payment. When this Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

Payment of Claims: Benefits will be payable to You or the medical services provider if We have received a valid assignment by the covered person.

If any benefit is payable to the estate of a covered person or to a covered person who is a minor or otherwise not competent to give a valid release, we may pay the benefit, up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the covered person who is considered by Us to be equitably entitled to the benefit.

Subject to any written direction of the covered person or of the legal or natural guardian of the covered person, if the covered person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular hospital or person.

Physical Examination: We, at Our expense, shall have the right and opportunity to examine the covered person as it may reasonably be required while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Policy within 60 days after written proof of loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a covered person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such covered person against any person who might be acknowledgedly liable or found legally liable by Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefit was paid. Such subrogation rights shall extend only to Our recovery of the benefits we have paid for such hospitalization and treatment and We shall pay fees and costs associated with such recovery.

If the Director of Serve America Assurance or his or her designee, upon being petitioned by a covered person, determines that the exercise of subrogation by Us is inequitable and commits an injustice to the covered person, subrogation under this provision is not allowed. This determination by the Director or his or her designee may be appealed by Us.

PREMIUM

Payment of Premium/Due Date: All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at Our home office of by Our authorized representative.

Returned or Dishonored Payment: If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under State law. A dishonored check shall be considered a failure to pay Premium and coverage will lapse.

Change in Premium Rates: We have the right to change the table of premium rates from time to time. Premiums will change if dependents are added or removed. If benefits are changed, or if a new table of premium rates applies. Premiums will also increase as your age and the age of other covered persons increase. A change in the table if premium rates or a premium increase due to age will be effective on the first premium due date following such written notice. We can only change the table of premium rates if We change it for all the policies with this form in your state.

Grace Period: We allow a grace period of 31 days for the payment of premium after the first premium is paid. Coverage is in force during the grace period. If a t least 60 days prior to the premium due date We send written notice to You of Our intent not to renew this Certificate, then the Grace Period will not apply to any period after the date of the non-renewal is to be effective. If you send written notice to Us that you are not renewing your coverage, then the grace period will not apply after the date the non-renewal is effective.

Coverage terminates on the last day for which premium has been paid.

Reinstatement: If coverage terminates due to non-payment of premium, then a subsequent acceptance of premium by Us or by an agent, without requiring an application for reinstatement, will reinstate the business.

If We do not require an application for reinstatement and accept premium, then We may issue a conditional premium receipt. If we approve the application, then insurance will be reinstated as of the date of Our approval. If we do not approve the application, then We will notify you in writing within 45 days after the date of the application.
If we do not notify you within 45 days, then coverage will be reinstated on the 45th day after the date of the conditional premium receipt.

The reinstated Certificate will cover only losses due to conditions that begin after the date of reinstatement. In all other respects, Your rights and Ours will be same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium We accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.

GENERAL PROVISIONS

Entire Contract Changes: The policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

Failure by Us to enforce any Policy provision, shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Time Limit on Certain Defenses: After 2 years from the covered person's effective date, no misstatements, except fraudulent misstatements, made by the covered person in the application for such coverage shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the 2 year period.

No claim for loss incurred commencing after 2 years from the covered person's effective date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage.

Misstatement of Age: If the age of the covered person has been misstated, all amounts payable under the Policy will be such as the premium paid would have been if purchased at the correct age.

Other Insurance with Us: Insurance effective at any one time on the insured under a like policy or policies with Us is limited to one such Policy elected by the Insured, his beneficiary or his estate, as the case may be and We will return all premiums paid for all other such policies.

Non-Participating: This Certificate is non-participating. It does not share in Our profits or surplus earnings.

Conformity with State Statutes: If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Workers Compensation: This certificate is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Clerical Error: If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: a) the Policyholder makes a written request for coverage on a form approved by Us; and b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the covered is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

Information and Records: We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a covered person's coverage terminates.

SERVE AMERICA ASSURANCE

SCHEDULE

POLICYHOLDER

Realty Benefits Associates
1351 Forest Ave
PMB 124
Staten Island, New York 10302

MEDICAL EXPENSE BENEFITS

LIFETIME AGGREGATE MAXIMUM AMOUNT PER COVERED PERSON:	$1,000,000
ANNUAL CALENDAR YEAR MAXIMUM AMOUNT PER COVERED PERSON:	$250,000
DEDUCTIBLE, PER CALENDAR YEAR, PER COVERED PERSON:	$10,000
INSURED PERCENT (EXCEPT AS SPECIFICALLY STATED IN CHARGES)	
IN-NETWORK:	100%
OUT-OF-NETWORK: An Additional Deductible of $10,000 at 80%/20% then	100%

OUT-OF-POCKET MAXIMUM APPLIES ONLY TO OUT-OF-NETWORK SERVICES AND IS IN ADDITION TO THE DEDUCTIBLE.

COVERED CHARGES

Covered Charges are treatment, services or supplies incurred for:

INPATIENT

- Hospital room and board and general nursing care while Hospital Confined, up to the daily semi-private room rate
- Hospital miscellaneous charges, such as the cost of the operating room, laboratory tests, x-ray examinations.
- Speech and occupational therapy
- Intensive Care Unit/Hospital expenses, not to exceed 2 times the Hospital rate for semi-private room
- Doctor's fee for surgery. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession
- Anesthetist expenses
- Assistant surgeon's expense
- Pathologist expense
- Radiologist's expense
- Nurse expense for private duty nursing, when prescribed by the attending Doctor, up to $250 a day, not to exceed $10,000 per Calendar year
- Doctors visits
- Physiotherapy
- Radiation therapy and chemotherapy
- Dialysis treatment
- Blood and blood derivative not replaced; charges for processing and administration of blood or blood derivatives
- Treatment of Mental or Nervous Disorders limited to a maximum benefit of $10,000 per lifetime
- Treatment of alcoholism

OUTPATIENT

- Doctor's fees for surgery. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.
- Anesthetist expense
- Assistant surgeon's expense
- Doctor's visits
- Physiotherapy
- Emergency room expenses and supplies
- Diagnostic x-ray expense
- Laboratory services expense
- CAT Scan/MRI expense
- Radiation therapy and chemotherapy
- Dialysis treatment
- Blood and blood derivatives not replaced; charges for processing and administration of blood or blood derivatives

OTHER

- Rental and expense of wheelchairs, hospital beds and other Durable Medical Equipment of this type, not to exceed the purchase price
- Casts, splints, braces, trusses, crutches and other devices of this type

- Dental treatment for injury to sound natural teeth
- Rental of mechanical equipment for medical or surgical treatment, not to exceed the purchase price
- Home health care expense up to $250 per week not to exceed $10,000 lifetime
- Hospice care expense for up to six months per lifetime
- Bereavement counseling received from a hospice for the immediate family of the deceased covered person, up to $500 lifetime
- Skilled nursing care up to $250 per week not to exceed $10,000 lifetime. Confinement must be prescribed by the attending Doctor. Skilled Nursing Care benefits will be paid only after the covered person was Hospital Confined for at least 3 consecutive days and Skilled Nursing Care begins within 14 days of such Hospital Confinement
- Ambulance expense, up to a maximum benefit of $250 per trip, not to exceed $1,000 per calendar year
- Prescription expense, up to a maximum benefit of $10,000 lifetime

Applies Only to Dependent Children: Care and treatment of congenital cleft in the lip or palate or both, including but not limited to:

- Oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate
- Prosthetic treatment such as obdurators, speech appliances, and feeding appliances
- Prosthodontic treatment and management
- Otolaryngology treatment and management
- Audio logical assessment, treatment, and management performed by or under the supervision of a Doctor of medicine, including surgically implanting amplification devise; and
- Physical therapy assessment and treatment

Hospital Confinement for at least 48 hours following a mastectomy. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending Doctor.
Prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined Medically Necessary by the patient's attending Doctor.

SERVE AMERICA ASSURANCE
PRIVACY NOTICE

At SERVE AMERICA ASSURANCE INSURANCE COMPANY, we know the importance of an individual's right to privacy. That's why protecting information that personally identifies you is high priority and a matter we take very seriously.

Our primary goal is, and will continue to be, provide you with competitive, exceptional quality insurance products to meet the long term financial needs or you and your family.

We want to assure you that the personal, financial and medical information you share with us for applying coverage to claims is the cornerstone in providing you the highest quality coverage we can for the most affordable price. That information, unique to you, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with you.

The following is a summary of our privacy policy and practices.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION
In order for SERVE AMERICA ASSURANCE to provide and administer the products we offer, we collect personal information about you. Some of the information we collect about you is non-public. The non-public information we collect is obtained from the following sources:

Information we receive from you on your application for insurance or other forms, such as your name, address, telephone number, age, social security number, and beneficiary designation.

Information about your transactions with us and our affiliates, such as the type of insurance products you buy, the premium you pay, the method of purchase and your payment history.

Information we receive from third party reports such as consumer reporting agencies, credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.

INFORMATION WE DISCLOSE
SERVE AMERICA ASSURANCE does not disclose any non-public information about our policyholders or former policyholders to anyone, except as permitted or required by law.

We may also disclose all of the information we collect as described above, with the following:

Affiliates – We may share information with our affiliates.

Service Providers – We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction that you request or authorize; to develop or maintain computer software; or to perform market research.

Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY
Your medical information is kept confidential. We will not use or share, internally or with third parties, your medical information except for the purpose of:

- Underwriting;
- Administering your policy or claim
- As permitted or required by law; or
- As authorized by you.

SECURITY AND CONFIDENTIALITY OF YOUR INFORMATION
We restrict access to nonpublic information about you to those employees (or people working on your behalf under confidentiality agreements) who need to know the information in order to provide products and services to you. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your non-public personal information.

ACCIDENT MEDICAL
IN-HOSPITAL ACCIDENT ONLY
ACCIDENTAL DEATH AND DISMEMBERMENT

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of all other causes, from bodily injury which is suffered in an Accident, and occurs while the person is a Covered Person under this Policy and is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

INSURED PERSONS include all members and their lawful spouses under age 70.

Accident means a sudden, unforeseeable external event which causes injury to one or more Covered Persons and occurs while coverage is in effect for the Covered Person.

THIS IS A LIMITED ACCIDENT ONLY INSURANCE, IT IS ACCIDENT ONLY POLICY AND DOES NOT COVER LOSS OR EXPENSE RESULTING FROM SICKNESS, DISEASE, OR BODILY INFIRMITY. In order to receive benefits, an insured person must sustain an injury while the policy is in force and such injury directly and independently causes a loss covered by the policy.

Benefits are payable for Eligible Expenses for non-work related injuries on the following basis:

DESCRIPTION OF BENEFITS

BENEFIT AMOUNT: $25,000 DEDUCTIBLE: $1,000 PER INJURY

If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible as shown above and not to exceed the maximum benefit amount shown therein, all covered expenses incurred within one year from such date.

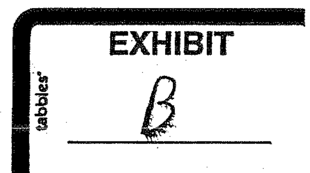
Covered expenses mean the usual, reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following usual, reasonable and customary charges for treatment, services and supplies provided or prescribed by a Doctor:

(1) Hospital Room & Board, or Surgical Center care and treatment; (2) Outpatient Hospital Emergency room; (3) Surgical Benefits; (4) Doctor's Visits In-Hospital; (5) Doctor Visits Out-Patient; (6) X-ray and Laboratory; (7) Nursing care; (8) Physiotherapy; (9) Ambulance (10) Medical Equipment Rental Charges; (11) Medical Services and Supplies (Blood, Blood transfusions, Oxygen); (12) Prescription Drugs; (13) Dental Treatment as a result of Injury to natural teeth

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum: $50,000

If within one year from the date of an Accident covered under this policy, Injury from such accident results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table. The amount will not exceed the Principal Sum which applies to the Covered Person.



ACCIDENT DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same hand	25%

DISCRIPTION OF HAZARDS

24 Hour Coverage. We will pay the benefits described in this Policy for any Accident which happens to a covered person while he is covered by this Policy. This includes travel or flight in an Aircraft with some restrictions. SEE EXCLUSIONS

GENERAL POLICY PROVISIONS

WORKERS' COMPENSATION INSURANCE: This Policy is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Insurance.

EXCLUSIONS

Benefits will not be paid for a Covered person's loss which:

(1) Is caused by or results from the Covered Person's own:

(a) Intentionally self-inflicted Injury, suicide or any attempt therat. (In Missouri this applies only while sane);
(b) Voluntary self administration of any drugs or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded);
(c) Commission or attempt to commit a felony;
(d) Participation in a riot or insurrection;
(e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
(f) Driving while intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;

(2) Is caused by or results from:

(a) Declared or undeclared war or act of war;
(b) An Accident which occurs while the Covered person is on active duty service in any armed forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days);
(c) Aviation, except as specifically provided in this Policy;
(d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment

bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

(e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and;

(i) The loss was caused by fire, heat, explosion or other physical trauma which was the result of the release of nuclear energy; and

(ii) The Covered Person was within a 25 mile radius of the site of the release either:

(1) At the time of the release; or

(2) Within 24 hours of the start of the release.

CLAIMS PROVISIONS

Written notice of claim must be given within 30 days after a covered loss occurs or as soon as reasonably possible. We will send forms to authorized members who ask for them.

Notice must be sent to the address below or call 1-800-591-6764

SDS, LLC
4676 HIGHWAY 41 NORTH
SPRINGFIELD, TN. 37172

Underwritten by: SERVE AMERICA, LTD.

Serve America, LTD

Administrative Office
SDS
4676 Highway 41 North
Springfield, TN. 37172

This Certificate explains the Limited Group Hospital Indemnity Insurance that is underwritten by Serve America, LTD. Please read it closely to be familiar with your coverage.

Terms important in understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice – Benefits are payable as described in this Certificate for accidents or sickness that are incurred while the Covered person is insured under the Group Master Policy ("Policy")

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. Premiums are subject to periodic changes.

The insurance made under this Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are insured and you have applied for coverage for each of your dependents. Such applications must be approved by Us, and the required premium paid for each dependent.

Policyholder: American Trade Association

Governing Jurisdiction: Arkansas

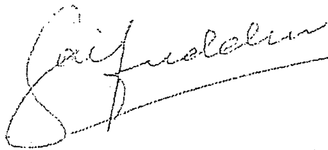
Policy Number: ATA1111

Insured:

Certificate Number:

Effective Date:

Signed for the Company at Our Home Office to take effect on the Certificate Effective Date.



President

CERTIFICATE FOR LIMITED GROUP HOSPITAL INDEMNITY INSURANCE

LIMITED BENEFIT – READ YOUR CERTICATE CAREFULLY
NONPARTICIPATING – NO ANNUAL DIVIDENDS

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SCHEDULE OF BENEFITS

INSURED: CERTIFICATE NUMBER:

AGE AT ISSUE: DEPENDENT COVERAGE:

INSURED EFFECTIVE DATE: DEPENDENT EFFECTIVE DATE:

ANNUAL MAXIMUM
BENEFIT LIMIT: NONE

BENEFIT COVERAGE

EFFECTIVE DATE:		TYPE OF COVERAGE PER COVERED PERSON
	DAILY IN-HOSPITAL INDEMNITY AMOUNT BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER CONFINEMENT	$500
	DAILY INDEMINITY BENEFIT FOR CONFINEMENT IN AN INTENSIVE CARE OR CRITICAL CARE IN-PATIENT ROOM BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER YEAR PER MEMBER	$500
	IN-HOSPITAL & IN-PATIENT ADDITIONAL HOSPITAL INDEMNITY BENEFIT PER ADMISSION PER MEMBER: MAXIMUM VISITS PER YEAR PER MEMBER:	$500 2
	SURGICAL AND ANESTHESIA INDEMINTY BENEFIT BENEFIT FOR SURGERY PER SURGICAL VISIT AS LISTED IN THE TABLE OF SURGICAL INDEMNITY BENEFIT SCHEDULE: BENEFIT FOR ANESTHESIA PER SURGICAL VISIT	$1,000 SCHEDULE EQUAL TO 20% OF SURGICAL BENEFIT AMOUNT
	OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT BENEFIT AMOUNT PER OFFICE VISIT: MAXIMUM NUMBER OF OFFICE VISITS PER YEAR PER MEMBER:	$50 6
	OFF-THE-JOB ACCIDENT INJURY BENEFIT MAXIMUM BENEFIT: MAXIMUM NUMBER PER YEAR PER MEMBER:	$500 5
	OUTPATIENT DIAGNOSTIC X-RAY & LAB INDEMNITY BENEFIT BENEFIT AMOUNT PER VISIT PER MEMBER: CALENDAR YEAR MAXIMUM VISITS PER MEMBER:	$50 4

EFFECTIVE DATE:		TYPE OF COVERAGE PER COVERED PERSON
	EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY BENEFIT	
	BENEFIT AMOUNT PAID OER ER VISIT FOR SICKNESS OR ILLNESS:	$50
	MAXIMUM NUMBER OF VISITS PER YEAR:	2
	WELLNESS INDEMNITY BENEFIT	
	BENEFIT AMOUNT PER VISIT PER MEMBER:	$50
	MAXIMUM CALENDAR YEAR VISITS PER MEMBER:	1
	WELL CHILD VISITS – 4 VISITS PER YEAR PER CHILD FROM 0 MONTHS TO 12 MONTHS	
	WELL CHILD VISITS – 2 VISITS PER YEAR PER CHILD FROM 12 MONTHS TO 24 MONTHS	
	DAILY IN-PATIENT DRUG & ALCOHOL INDEMNITY BENEFIT	
	BENEFIT PER DAY OF CONFINEMENT IF INSURED: IS CONFINED IN A REHABILITATION FACILITY FOR SUBSTANCE ABUSE	$300
	ANNUAL MAXIMUM BENEFIT:	$10,000
	LIFETIME MAXIMUM OF $30,000	
	DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY BENEFIT	
	BENEFIT PER DAY OF CONFINEMENT IF INSURED: IS CONFINED IN A REHABILITATION FACILITY FOR MENTAL OR NERVOUS DISORDERS	$300
	ANNUAL MAXIMUM BENEFIT:	$10,000
	LIFETIME MAXIMUM OF $30,000	
	EXPRESS SCRIPTS RX CARD BENEFIT	
	Insured prescription card – AWP less 16% discount Then an 50% copay per prescription up to an annual Benefit per member of $500 then an Express Scripts Discount plan beyond there – no pre-existing exclusions	$500
	GROUP TERM LIFE INSURANCE POLICY WITH ACCIDENTAL DEATH AND DISMEMBERMENT RIDER ATTACHED	
	PRIMARY MEMBER BENEFIT:	$5,000
	SPOUSE:	$2,500
	CHILD(REN) – NOT COVERED FOR AD&D BENEFIT	$2,500

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and of this Certificate:

Accident or Accidental Injury: a sudden, unexpected and unintended injury:

- This is independent of any Sickness; and
- That is caused by or the result of external means; and
- That takes place while the Covered person's coverage is in force.

Active Service: You are:

- Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; and
- Those duties are performed at your place of business where You normally do such duties or at some location to which your employer sends you.

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day, and You were in Active Service on the last preceding regular work day.

Amendment, Endorsement or Rider: Any form issued by Us which adds, modifies, changes or deletes any Policy or Certificate provisions or benefits.

Application or Enrollment Form: The form completed and signed to apply for this insurance coverage.

Calendar year or Year: The period from January 1 through December 31 of the same year.

Certificate: The document that describes your hospital indemnity insurance coverage.

Child: A child of Yours who is unmarried; under the age of 19; dependent upon you for more than 50% of his/her support and maintenance; who lives with You; and is:

- A natural Child; or
- A legally adopted Child or a Child who has been placed for adoption with you; or
- A stepchild or foster Child; or
- A child for whom You have been appointed legal guardian; or
- A Child not living with You, but for whom you are legally required to provide support.

"Child" also includes a Child who meets the criteria described above, but who is age 19 or older, if the Child is:

- A full-time student at an accredited educational institution, college, university, vocational institution, trade school, or secondary institution, and is under the age of 24; or
- Becomes incapable of self-support because of mental retardation or physical impairment while insured, and prior to reaching the limiting age of a Child. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time, but no more often than once a year after the Child attains the age of 24.

The term "Child" does not include a child who engages in any employment or business for compensation, profit or gain for 30 or more hours per week, unless such child is a full-time student as described above.

Confinement or Confined: That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Covered Person: Any or all of the following: You, Your Spouse or Your Children, who has been accepted by Us for coverage.

Critical Illness: Any of the following conditions:

1. Cancer – A disease which is identified by the presence of a malignant tumor characterized by uncontrolled growth and spread of malignant cells, and the invasion of normal tissue. Cancer must be positively identified and diagnosed with histopathological conformation. Leukemia and Hodgkin's disease (except stage 1 Hodgkin's disease) will be considered Cancer.

- Cancer does not include
    - Pre-Malignant conditions or conditions with malignant potential;
    - Prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1 (b), or of other equivalent or lesser classifications).

2. Skin Cancer – Basel cell epithelioma or squamous cell carcinoma. Skin cancer does not include malignant melanoma or mycosis fungoides.
3. Carcinoma in situ – Cancer that is diagnosed with histopathological confirmation and confined to the site of the origin without having invaded neighboring tissue.

4. Heart Attack [the death (infarction) of a portion of heart muscle as a result of inadequate blood supply. The diagnosis must be based on all of the following criteria:
    - a) Associated new electrocardiographic (EKG) changes consistent with Injury;
    - b) Elevation of Cardiac enzymes; and
    - c) Confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

5. Stroke – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolizations of brain tissue from an extracranial source. The diagnosis must be based on:
    - Documented neurological deficits; and
    - Confirmatory neuron-imaging studies

    Stoke does not include cerebral symptoms due to:
    - Transient ischemic attack (TIA);
    - Reversible neurological deficit;
    - Migraine;
    - Cerebral injury resulting from trauma or hypoxia; or
    - Vascular disease affecting the eye, optic nerve or vestubular functions.
6. End Stage Renal Failure – Chronic, irreversible failure of the function of both kidneys, such that a Covered person must undergo regular hemodialysis or peritoneal dialysis at least weekly.
7. Major Organ Transplant Surgery – A Covered person undergoing surgery as a recipient of a human to human transplant of a heart, lung, kidney or pancreas.

Dependent – Your Child or Spouse as defined by the Certificate

Disability or Disabled – The inability, due to an injury or sickness to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child or Spouse: "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Effective Date – The date coverage is in effect is shown on the Schedule of Benefits. The effective date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability – The correct and complete answers to the questions in the Application of Enrollment Form and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered person.

Grace Period – The period of 31 days allowed for each premium payment after the first premium.

Group Master Policy or Policy: The complete contact of insurance, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to insureds, including any Amendments, Endorsement, Riders, Applications or Enrollment Forms signed by the Policyholder and each insured.

Policyholder – The entity named on the Cover Page of the Policy

Hospital – A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly Licensed Physicians.

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians.
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician.
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include any institution used by the Covered Person as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Immediate Family Member – You, Your Spouse, Child, mother, father, brother, sister or other close family member of the Covered person.

Injury or Off-the-Job injury - An injury which is caused by an Accident, and does not occur while in the course of any legal or illegal occupation, activity or employment for pay, benefit or profit.

Insured – The employee or member covered for this insurance and named on the Cover page of this Certificate,

Intensive Care Unit – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned to it on a full-time basis; and
2. Be under the full-time direction and/or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life saving equipment.

Intensive Care Unit includes: Intensive cardiac and coronary care units, neonatal intensive care units, and burn intensive care units if such units meet the conditions in this definition. This does not include any lesser treatment units.

Physician – A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an immediate Family member.

Pre-Existing Condition – A Sickness or physical condition for which the Covered person:

1. Had treatment;
2. Incurred Expense;
3. Took medications; or
4. Received a Diagnosis or advice from a Physician.

During the 12 month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-existing" will also include a condition that manifests itself in a way that would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Schedule of Benefits or Schedule – The benefit schedule set forth in this Certificate.

Sickness – An illness or disease which first manifests itself while the Covered person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse named in the Application or Enrollment Form. If you are not legally married, "Spouse" may include your common law spouse if named in the Application or Enrollment Form and if legally recognized in the state in which you reside.

Testing Day – The day on which one or more diagnostic X-rays or laboratory tests are performed.

Waiting Period – The period of time from your date of employment or membership that must expire before you are eligible to enroll for coverage, as specified in the Policyholder's Application.

We, Us, or Our – The Insurer that underwrites this coverage: Serve America, LTD

You, Your, or Yours – The Insured.

ELIGIBILITY AND EFFECTIVE DATE

Effective dates are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective dates for all persons added to coverage after this Certificate is issued will be shown on the Schedule of Benefits issued at the time of the addition.

Employer or Member Eligibility – To be eligible for insurance You must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application or Enrollment Form and must provide evidence of Insurability satisfactory to us, if we ask for it; and
3. Be Actively at work. Either as a business owner, independent contractor, work for a small business or a member of a workers union.

Employee or Member Effective Date – Your insurance will take effect on the Effective Date of the Policy if:

1. You completed an Application or Enrollment Form on or before the effective date; and
2. You are in Active Service; and
3. Your first premium is paid and received by Us.

If you are not eligible for this coverage on the Policy effective date, Your coverage will take effect on the first day of the day which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first premium must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If you are disabled on what otherwise would be the effective date, Your coverage will be deferred until the first of the month following the date you cease to be disabled.

Dependent Eligibility – If Dependent coverage is available, A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he/she first meets the definition of Dependent.

You may elect dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the dependent becomes eligible; and
2. Completing any required forms for payroll deduction or drafting of your account for payment

You must complete an Application for Enrollment of a Spouse or Child, and pay any required premium within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31 day period Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Any eligible Dependent who does not become a covered person on your effective date may be added to this Certificate subject to:

1. The Completion of an Application or Enrollment Form;
2. Satisfaction of any Evidence of Insurability requirements; and
3. Payment of any additional premium, if required.

If you and your spouse are both eligible as an employee or member, the Children may be insured as Dependents of either You or your Spouse but not both

Dependent Effective Date – The effective date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application or Enrollment Form; and
2. Our receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the effective date for dependent coverage will be the same as your effective date.

If a Dependent is Disabled on the date coverage (with respect to that particular Dependent) would otherwise be in effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

Newborn Child Effective Date – A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, so long as your coverage is in force on that date. Coverage includes premature babies, congenital defects and birth abnormalities. The Dependent newborn child's coverage will not continue past the 31 day period following the date of birth, unless:

1. You have notified Us by the end of the 31 day period of the addition of such newborn Child, and
2. You have paid any applicable additional premium.

BENEFIT PROVISIONS

Subject to the provisions of this certificate, and any maximum benefit limitations stated on the schedule of benefits, we will pay a benefit for a covered loss that occurs while the covered person is insured under the policy, subject to extension of Benefits Provision. Please see the Schedule of Benefits for the benefit amount details for each benefit listed below.

Daily In-Hospital Indemnity Benefit – If a Covered Person is confined in a hospital as a result of Accident or Sickness, We will pay the benefit amount per day shown on the schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Surgical and Anesthesia Indemnity Benefit – If a Covered Person undergoes a surgical procedure listed on the Table of Surgical Indemnity Benefits Schedule ("Surgical Table"), which is attached to this Certificate, as a result of a covered Accident or Sickness, We will pay the benefit shown on that Surgical table. We will also pay the benefit amount, if shown on the Schedule of Benefits, for the administration of anesthesia per surgical visit by a Physician in connection with the surgery.

If two or more procedures are performed through the same incision or operative field, the benefit paid will be for only the procedure that has the larger benefit If more than one procedure is performed, but each through a separate incision or in the separate operative field, the amount payable will be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Representative surgeries have been listed in the Surgical Table. A complete Surgical Schedule has been filed with the State. We will pay all surgeries in accordance with that Surgical Schedule. With respect to surgical procedures that are not listed in the Surgical Schedule, We will pay an indemnity benefit that is consistent with similar procedures within the Surgical Schedule.

Outpatient Physician Officer Visit Indemnity Benefit – We will pay this benefit as shown on the Schedule for a physician office visit as a result of an Accident or Sickness.

Off-the-Job Accidental Injury Benefit - We will pay benefits for the actually charges incurred for a covered Accident up to the amount shown on the Schedule for each Covered Person, for x-rays used to diagnose an Accidental Injury and treatment of a covered accident by a Physician in the Physician's officer, clinic, or urgent care facility or Hospital emergency room. Treatment must be received within 72 hours of such Accident for benefits to be payable. For purpose of this benefit only, "actual charges" will mean the amount actually paid by or on behalf of the Covered Person and accepted by a Hospital or Physician for services provided.

Critical Illness Indemnity Benefit – The Critical Illness Indemnity Benefit is payable only one time for each Covered Person, and will be paid in addition to any other benefit in this certificate. A Benefit is payable for any one of the following:

Critical Illness – We will pay the amount shown on the Schedule for each Covered Person when he/she is first diagnosed as having a covered Critical Illness.

Skin Cancer – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed with Skin cancer.

Carcinoma In Situ – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed as having Carcinoma In Situ.

BENEFIT PROVISIONS (Continued)

Subsequent Critical Illness Indemnity Benefit – We will pay this benefit, in the amount specified on the Schedule of Benefits, when a Covered Person is first diagnosed as having a subsequent and separate covered Critical Illness. The subsequent Critical Illness must be a Critical Illness that is defined in a separate category of conditions than the first covered Critical Illness; the subsequent and separate covered Critical Illness must first manifest itself, and be diagnosed more than 60 days after the first covered Critical Illness is initially diagnosed. This subsequent Critical Illness benefit is payable only one time for each Covered Person, and will be paid in addiction to any other benefit in this Certificate. This subsequent Critical Illness Benefit is not payable for Carcinoma In Situ or Skin Cancer.

Wellness Indemnity Benefit – We will pay this benefit as shown on the Schedule for each Covered Person who has undergone the following: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Intensive Care Indemnity Benefit – If a Covered Person is confined in an Intensive Care Unit as a result of Accident or Sickness, We will pay the benefit amount per day shown on the Schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Benefits When There is a Break in Service – If a covered Person's coverage terminates for any reason, and such person is re-enrolled for coverage as either an employee/member or Dependent under this Policy or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy, all benefits paid during the Calendar Year will be accumulated and applied towards the maximum benefit for the Calendar Year as described on the Schedule of Benefits, no matter how many times a Covered Person becomes insured under this or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy.

Physical Examinations and Autopsy – We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, we may request an autopsy where it is not forbidden by law.

Proof of Loss – Satisfactory written Proof of Loss must be given to Us at Our Administrative Office. In case of a claim for loss for which a period payment is provided contingent upon continuing loss, each satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of said loss. Satisfactory written proof of loss includes but is not limited to: itemized Physician or Hospital bills, and, with regard to Critical Illness benefits, the initial pathology report diagnosing a Critical Illness.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the date of loss, unless the claimant was legally incapacitated.

Time of Payment of Claims – benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

EXCLUSIONS AND LIMITATIONS

With respect to all the benefits provided under this Certificate, no benefits will be payable as the result of:

1. Suicide or any attempt thereof, while sane or insane;
2. Any Intentional self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment (unless provided as a benefit on the Schedule of Benefits);
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless the Wellness Indemnity Benefit is shown the Schedule of Benefits);
5. Routine newborn care (unless covered under the Wellness Indemnity Benefit on the Schedule of Benefits);
6. The treatment of:
    a. Mental illness, functional or organic nervous disorder, regardless of cause (unless the Daily In-Patient Mental and Nervous Benefit is shown the Schedule of Benefits):
    b. Alcohol abuse or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed (unless the Daily In-Patient Drug and Alcohol Benefit is shown the Schedule of Benefits);
7. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
8. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
9. Participation in:
    a. An organized contest of speed;
    b. Parachuting;
    c. Parasailing;
    d. Bungee Jumping; or
    e. Hang Gliding;
10. 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;
11. Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred);
12. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
13. The reversal of a tubal ligation or vasectomy;
14. Artificial insemination, in vitro fertilization, and test tube fertilization, including an relate testing, medications or Physician's services, unless required by law;
15. Any loss incurred while on active duty status in the armed forces (if You notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as result of this exception.);
16. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
17. Air or ground ambulance transportation (unless the Ambulance Benefit is shown on the Schedule);
18. Routine eye examinations or fitting of eye glasses;
19. Hearing aids or fitting of hearing aids;
20. Dental examinations or dental care other than expenses resulting from an Accident;
21. Care or treatment of an Accident or Sickness not specifically provided for in this plan;
22. With respect to the Off-the-Job Accidental Injury Benefit only, charges that the Covered Person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
23. Treatment of an Accident or Sickness made necessary by or arising from war, declare or undeclared, or any act of war.

PREMIUMS

All premiums are payable on or before the date they are due. You must pay any required contribution to the Policyholder.

We have the right to change the premium rates on any premium due in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder. If an increase takes place on other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due the coverage will automatically be terminated as of the date the pro rate premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increase Our liability, premium rates may be changed on the date that Our liability is increased, without regard to any premium rate guarantee.

TERMINATION OF INSURANCE

Your insurance will cease on the earliest of:

1. The last day of the payroll deduction period during which You can cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to Us;
3. The date the policy terminates; or
4. The last day of the payroll deduction period during which You terminate employment.
5.

The Insurance on a Dependent will cease on the earliest of:

1. The date Your coverage terminates;
2. The end of the last period for which premium payment has been made to Us;
3. The date of the Dependent no longer meets the definition of Dependent; or
4. The date the Policy is modified so as to exclude Dependent coverage.
5.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Extension of Benefits – Whenever termination of coverage under this section occurs due to the termination of Your employment or membership such termination will be without prejudice to:

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confine or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

CLAIMS PROVISIONS

Claim Forms – Claims forms should be used for filing Proof of Loss. We will send such form to claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, You can give proof in writing, setting for the nature and extent of loss within the time stated in the Proof of Loss Provision.

Claims Procedure – Due Proof of Loss must be submitted to us at our administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim – Written notice of claim must be given to Us at Our Administrative Officer, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to delay.

Payment of Benefits – Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your estate. We may pay up to $1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

GENERAL PROVISIONS

Changes to this Certificate - Only Our President, Vice-President, Secretary or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy of this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Conformity with State Laws – A provision of the Policy and/or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract – The entire Contract consists of the Policy, the Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, Your Applications and any Enrollment forms.

Grace period – A grace period of 31 days will be allowed for each premium payment after the first premium is paid. Coverage will stay in force during this period. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premium.

Legal Action – No legal action may be brought to recover under the Policy and or Certificate:

1. Within 60 days after proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the covered person's age has been misstated, the covered persons true age will be used to adjust the premiums or adjust the benefits paid.

No Dividends Payable – This Certificate does not participate in the profits or surplus earnings of Our Company.

Right to Contest – We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the effective date of coverage. Any such statement would have to be in a signed form. This also applies to all riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

When Notice is Given to Us – Any notice to You will be sent to your last known address.