

SERFF Tracking Number: MRKC-126231872 State: Arkansas  
Filing Company: Markel Insurance Company State Tracking Number: 43027  
Company Tracking Number: MCCS100 (11/08)  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Complications of Cosmetic Surgery  
Project Name/Number: Complications of Cosmetic Surgery/MCCS100 (11/08)

## Filing at a Glance

Company: Markel Insurance Company

Product Name: Complications of Cosmetic Surgery SERFF Tr Num: MRKC-126231872 State: Arkansas

TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed- State Tr Num: 43027  
Disapproved

Sub-TOI: H04.000 Health - Blanket Accident/Sickness Co Tr Num: MCCS100 (11/08) State Status: Waiting Industry Response

Filing Type: Form

Reviewers: Rosalind Minor

Disposition Date: 10/06/2009  
Authors: Carol Depuy, Jolene Kaczmar, Katie Savino, Amy Geary, Sue Bogusz

Date Submitted: 07/23/2009 Disposition Status: Disapproved

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

## General Information

Project Name: Complications of Cosmetic Surgery

Project Number: MCCS100 (11/08)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/06/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/09/2009

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Blanket

Explanation for Other Group Market Type:

State Status Changed: 08/14/2009

Created By: Sue Bogusz

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Sarah Bunyan

Filing Description:

New Filing.

Forms: MCCS100 (11/08) - Policy; MCCS100C (02/09) - Certificate; MCCS123 (09/08) - Application; and MCCS128 (09/08) - Blank Amendatory Endorsement.

This is a niche-market accident & health product. The product was developed to cover certain complications of 17 listed cosmetic surgeries, which most traditional health insurance plans will not cover.

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To assist you in your review process, following are some of the main product features:

- This is a limited benefit product.
- This coverage will be marketed to plastic surgeons/group practices, who will be the group policyholder. The group policyholder pays all premiums.
- All patients of the plastic surgeon (and group practice) that undergo one or more of the 17 procedures shown in the policy will be eligible.
- This coverage is NOT medical malpractice coverage.
- No expenses for any follow-up care to the group policyholder are covered by this policy.
- Marketing for this product will be done through licensed agents and brokers.

This limited benefit coverage is not "health insurance coverage" as defined under the federal Health Insurance Portability and Accountability Act (HIPAA), it is not subject to the requirements in the HIPAA law.

Please note that we are making this filing under Arkansas' blanket health insurance law, Code 23-86-101 (7).

## Company and Contact

### Filing Contact Information

Bogusz Sue, Regulatory Compliance Assistant sbogusz@markelcorp.com  
184 Shuman Blvd 630-778-7770 [Phone] 245 [Ext]  
Suite 390 804-527-7915 [FAX]  
Naperville, IL 60563

### Filing Company Information

Markel Insurance Company CoCode: 38970 State of Domicile: Illinois  
4600 Cox Road Group Code: 785 Company Type: Property &  
Casualty  
Glen Allen, VA 23060 Group Name: State ID Number:  
(800) 431-1270 ext. [Phone] FEIN Number: 36-3101262

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$200.00  
Retaliatory? Yes  
Fee Explanation: 4 forms @ \$50 each = \$200.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Markel Insurance Company	\$200.00	07/23/2009	29395815

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	10/06/2009	10/06/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Rosalind Minor	08/12/2009	08/12/2009	Sue Bogusz	08/13/2009	08/17/2009

Industry Response

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
09/29/2009 Note to Filer	Note To Reviewer	Sue Bogusz	10/05/2009	10/05/2009
Your response of 8/17/09	Note To Filer	Rosalind Minor	09/29/2009	09/29/2009

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## **Disposition**

Disposition Date: 10/06/2009

Implementation Date:

Status: Disapproved

Comment:

Our Department is exercising our Discretionary Authority under ACA 23-86-101 (7) by disapproving this submission.

We are concerned about the marketing of the product. This coverage appears to be for the benefit of the provider rather than the patient.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Cover Letter	Disapproved	Yes
Form	Blanket Complications of Cosmetic Surgery Policy	Disapproved	Yes
Form	Blanket Complications of Cosmetic Surgery Certificate	Disapproved	Yes
Form	Blanket Complications of Cosmetic Surgery Insurance Application	Disapproved	Yes
Form	Blank Amendatory Endorsement	Disapproved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/12/2009  
Submitted Date 08/12/2009

Respond By Date

Dear Bogusz Sue,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Blanket Complications of Cosmetic Surgery Policy, MCCS100 (11/08) (Form)
- Blanket Complications of Cosmetic Surgery Certificate, MCCS100C (02/09) (Form)
- Blanket Complications of Cosmetic Surgery Insurance Application, MCCS123 (09/08) (Form)
- Blank Amendatory Endorsement, MCCS128 (09/08) (Form)

### Comment:

Before our Department continues our review of this submission, please advise if these policies were submitted for approval in other states. If so, please advise as to the states that approved this product and/or the states that have disapproved this product.

We appreciate your cooperation in this matter.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 08/13/2009  
Submitted Date 08/17/2009

Dear Rosalind Minor,

### Comments:

Thank you for beginning review of this submission. Following is our response to your Objection.

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## Response 1

Comments: Our Complications of Cosmetic Surgery Policy has been Approved in 15 states and Disapproved in 7. States in which the Policy has been approved are: IL (our State of Domicile), AL, AZ, DC, FL, IN, MA, MI, OH, RI, SC, TN, TX, VA and WI. It has been Disapproved in CA, CO, GA, LA, NJ, NY and PA.

### Related Objection 1

Applies To:

- Blanket Complications of Cosmetic Surgery Policy, M CCS100 (11/08) (Form)
- Blanket Complications of Cosmetic Surgery Certificate, M CCS100C (02/09) (Form)
- Blanket Complications of Cosmetic Surgery Insurance Application, M CCS123 (09/08) (Form)
- Blank Amendatory Endorsement, M CCS128 (09/08) (Form)

Comment:

Before our Department continues our review of this submission, please advise if these policies were submitted for approval in other states. If so, please advise as to the states that approved this product and/or the states that have disapproved this product.

We appreciate your cooperation in this matter.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Should you require any additional information, please let us know. Thank you for your continued review of this submission.

Sincerely,

Amy Geary, Carol Depuy, Jolene Kaczmar, Katie Savino, Sue Bogusz

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**Note To Reviewer**

**Created By:**

Sue Bogusz on 10/05/2009 01:21 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

10/06/2009 03:01 PM

**Subject:**

09/29/2009 Note to Filer

**Comments:**

Ms. Minor,

In response to your Note to Filer dated 09/29/2009, following are the reasons for the Disapprovals we have received:

CA, CO, LA, NY, PA -- Does not fit Blanket categories. We plan to appeal these dispositions in Fall, 2009.

GA -- Does not fit Blanket categories. A&H Regulatory Compliance Manager met with Tom Carswell on 07/31/2009, and the filing is under reconsideration.

NJ -- No sickness benefits allowed under Blanket coverage.

Thank you for your continued review of this submission.

Respectfully,

Sue Bogusz

A&H Regulatory Compliance Assistant

sbogusz@markelcorp.com

800-338-1938 x245

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**Note To Filer**

**Created By:**

Rosalind Minor on 09/29/2009 09:44 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

10/06/2009 03:01 PM

**Subject:**

Your response of 8/17/09

**Comments:**

Thank you for your response of 8/17/09.

We appreciate your patience with our Department's review of this submission. Since this is a new type of policy, we are devoting extra time and review to the submission.

In your response of 8/17/09, you state that the states of CA, CO, GA, LA, NJ, NY & PA had disapproved this policy. It is requested that you provide our Department with the reasons that the states disapproved the policy.

We appreciate your continued cooperation in this matter.

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## Form Schedule

### Lead Form Number: MCCS100 (11/08)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved 10/06/2009	MCCS100 (11/08)	Policy/Contract Certificate	Blanket Complications of Cosmetic Surgery Policy	Initial		35.100	MCCS100 11-08.pdf
Disapproved 10/06/2009	MCCS100 C (02/09)	Certificate	Blanket Complications of Cosmetic Surgery Certificate	Initial		28.900	MCCS100C 02-09.pdf
Disapproved 10/06/2009	MCCS123 (09/08)	Application/Enrollment Form	Blanket Complications of Cosmetic Surgery Insurance Application	Initial		31.400	MCCS123 09-08.pdf
Disapproved 10/06/2009	MCCS128 (09/08)	Policy/Contract Certificate: Amendment, Insert Page, Endorsement or Rider	Blank Amendatory Endorsement	Initial		26.000	MCCS128 09-08 John Doe.pdf



A STOCK COMPANY

# [MARKEL INSURANCE COMPANY]

[Deerfield, Illinois]

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## BLANKET COMPLICATIONS OF COSMETIC SURGERY POLICY

PLEASE READ THIS POLICY CAREFULLY.

Non-Participating Policy

OPTIONALLY RENEWABLE

### THIS IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND THE COMPANY.

[Markel Insurance Company] agrees with the named Policyholder in consideration of the payment of the premium and subject to the limits of liability, exclusions, conditions, and other terms of this Policy to pay the benefits as described in the Schedule of Benefits.

This Policy is governed by the laws and jurisdiction in the state in which it is delivered.

[Markel Insurance Company]

[ \_\_\_\_\_ ]  
President

[ \_\_\_\_\_ ]  
Secretary

[ \_\_\_\_\_ ]  
[Countersigned]

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## **POLICY EFFECTIVE AND TERMINATION DATES**

### **Effective Date:**

This Policy is effective on the Effective Date at 12:01 am Standard Time at the address of the Policyholder as shown in the Schedule of Benefits.

### **Termination Date:**

This Policy terminates automatically on the earlier of:

- (1) The Policy Expiration Date shown in the Schedule of Benefits; or
- (2) The premium due date if premiums are not paid when due, subject to the Grace Period.

Termination takes place at 12:01 am Standard Time at the address of the Policyholder as shown in the Schedule of Benefits.

We may terminate this Policy by giving [30] days advance notice in writing to the Policyholder for the following reasons: (1) material change in business operation; and (2) failure to provide requested information.

The Policyholder may terminate this Policy on any premium due date by giving [30] days advance notice in writing to Us.

This Policy may, at any time, be terminated by mutual written consent of the Company and the Policyholder.

## **INSURED'S EFFECTIVE AND TERMINATION DATES**

The persons eligible for inclusion as insured persons shall be all persons denoted in the Class of Insured Persons as described in the Schedule of Benefits.

### **Effective Date:**

An Insured's coverage under this Policy begins on the later of:

- (1) The Policy Effective Date;
- (2) The date the person becomes a member of an eligible class of persons as described in the Class of Insured Persons in the Schedule of Benefits; or
- (3) The date for which the premium for the Insured's coverage is paid.

### **Termination Date:**

An Insured's coverage under this Policy ends on the earliest of:

- (1) The date the Policy expires or is terminated;
- (2) The date the Insured ceases to be a member of any eligible class of persons as described in the Class of Insured Persons in the Schedule of Benefits; or
- (3) The premium due date if You fail to pay the required premium for the Insured, subject to the Grace Period, except as the result of a Clerical Error.

Termination of an Insured's coverage will not affect a claim for a Covered Complication due to a Qualified Cosmetic Surgical Procedure that took place while the Insured's coverage was in force under this Policy.

**SCHEDULE OF BENEFITS**

**Policy Number:** [12345]

**Name of Policyholder:** [ABC Physician Group]

**Policyholder's Address:** [Address]  
[City, State, Zip Code]

**Effective Date:** [Month, Day, Year], 12:01 am Standard Time at the Policyholder's address indicated above.

**Expiration Date:** [Month, Day, Year], 12:01 am Standard Time at the Policyholder's address indicated above.

**Class of Insured Persons:** All patients of the Policyholder who undergo one or more of the Qualified Cosmetic Surgical Procedures performed by a Plastic Surgeon of the Policyholder at or in a Hospital or an Accredited Surgical Center with which the Plastic Surgeon has an affiliation.

**Description of Coverage:** This Policy provides coverage to an Insured if such Insured seeks medical treatment within the Incurral Period for a Covered Complication that arises from a Qualified Cosmetic Surgical Procedure and results in: (1) an unscheduled Inpatient admission to a Hospital; or (2) a Hospital emergency visit; or (3) an ambulance service to a Hospital. Covered Medical Expenses are payable during the Benefit Period up to the Maximum Benefit Amounts indicated in the Benefit Schedule, subject to any Coinsurance provisions of this Policy.

**Benefit Period:** The Benefit Period is 6 months from the date of the Insured's first: (1) unscheduled Inpatient admission to a Hospital; or (2) Hospital emergency visit; or (3) ambulance service to a Hospital within the Incurral Period due to a Covered Complication arising from a Qualified Cosmetic Surgical Procedure.

**Incurral Period:** The Incurral Period is the 30-day period immediately following the administration of either general anesthesia, or intravenous sedation in preparation of a Qualified Cosmetic Surgical Procedure.

**Qualified Cosmetic Surgical Procedures:** Only the following procedures apply to this Policy.

[Abdominoplasty]	[Face Lift]
[Breast Augmentation]	[Gynecomastia, Treatment of]
[Breast Lift]	[Liposuction]
[Breast Reduction]	[Lower Body Lift]
[Brow Lift]	[Otoplasty]
[Buttock Lift]	[Rhinoplasty]
[Cheek Implants]	[Thigh Lift]
[Chin Augmentation]	[Upper Arm Lift]
[Cosmetic Eyelid Surgery]	

**Covered Complications:** Only the following complications are covered under this Policy:

Cardiopulmonary Related:

Arrhythmia	Pulmonary Dysfunction
Cardiac Arrest	Pulmonary Embolus
Deep Vein Thrombosis	Rule Out Deep Vein Thrombosis
Fluid Overload	Rule Out Myocardial Infarction
Hypoxia	Rule Out Pulmonary Embolus

Myocardial Infarction	Shock
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Surgery Related:

Hemorrhage	Infection
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Anesthesia Related:

Severe hypotension (systolic blood pressure equal to or less than 80 three hours after the Qualified Cosmetic Surgical Procedure).	Severe hypertension (systolic blood pressure equal to or greater than 200 or a diastolic blood pressure equal to or greater than 100 three hours after the Qualified Cosmetic Surgical Procedure).
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**Benefit Schedule**

The benefit amount shown is the limit selected by the Policyholder. If the coverage was not requested by the Policyholder, that is indicated by the word NIL.

BENEFIT	MAXIMUM AMOUNT
Inpatient Hospital Expense	[[80% -100%] of Usual & Customary up to [\$1,000 - \$25,000] per day up to a maximum of [30, 45] days]
Intensive Care / Trauma Expense	[Additional [\$1,000 - \$5,000] per day at [80% - 100%] of Usual and Customary up to a maximum of [5, 10] days]
Emergency Medical Expense	[[80% - 100%] of Usual and Customary up to [\$1,000 - \$10,000]]
Ambulance Expense	[[80% -100%] of Usual & Customary up to [\$1,000 - \$5,000]]
Follow-Up Outpatient Physician Expense	[[80% - 100%] of Usual and Customary up to [\$1,000 - \$5,000]]
Outpatient Procedure to Rule Out Deep Vein Thrombosis	[[80% - 100%] of Usual and Customary up to [\$750 - \$2,000]]

**Additional Coverage Conditions:**

The amounts indicated in the Benefit Schedule are the maximums that apply during any one Benefit Period for all Covered Complications due to the same Surgical Event.

Multiple Qualified Cosmetic Surgical Procedures: If an Insured has more than one Qualified Cosmetic Surgical Procedure performed during the same Surgical Event, any complications that arise from any of the Qualified Cosmetic Surgical Procedures will be treated as one Covered Complication and only one benefit will be payable for the Covered Complication.

Successive Qualified Cosmetic Surgical Procedures: In order for Qualified Cosmetic Surgical Procedures to be covered as separate individual Qualified Cosmetic Surgical Procedures, they must be performed at least 30 days from each other.

Covered Medical Expenses for a Covered Complication are payable until the earliest of:

1. The date the Covered Complication no longer requires further treatment;
2. The date the Maximum Benefit Amounts are paid; or
3. The expiration of the Benefit Period.

#### **Inpatient Hospital [and Intensive Care / Trauma] Expense**

When an Insured's Covered Complication requires an unscheduled Inpatient admission to a Hospital, We will pay the following Inpatient Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Hospital room and board charge, up to the Hospital's average semi-private room rate [and intensive care unit and/or trauma unit charge];
- (2) Miscellaneous Hospital ancillary charges, including but not limited to, oxygen, diagnostic tests, radiological procedures and professional fees;
- (3) Recovery room;
- (4) Operating room;
- (5) Observation room;
- (6) Blood or blood derivatives that are not donated or replaced, and their administration;
- (7) Anesthesia, including the administration thereof;
- (8) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure;
- (9) Prescription Drugs prescribed during the hospitalization, and as a follow-up thereto; and
- (10) Registered nurse (R.N.).]

#### **Emergency Medical Expense**

When an Insured's Covered Complication requires a Hospital emergency visit, We will pay the following Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Emergency room;
- (2) Blood or blood derivatives that are not donated or replaced, and their administration;
- (3) Diagnostic tests, including professional fees;
- (4) Observation room;
- (5) Supplies;
- (6) Oxygen, including the administration thereof;
- (7) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure;
- (8) Prescription Drugs prescribed during the Hospital visit and as a follow-up thereto;
- (9) Radiological procedures, including professional fees;
- (10) Registered nurse (R.N.);
- (11) Anesthesia, including the administration thereof; and
- (12) Miscellaneous Hospital ancillary charges, including but not limited to, operating room.]

#### **Ambulance Expense**

When an Insured's Covered Complication requires the use of an ambulance to a Hospital within 50 miles of the Insured's home or air ambulance to a Hospital when such service is ordered by a Physician and is accomplished in an aircraft used primarily for transporting sick or injured persons, We will pay the Expense up to the Maximum Amount shown in the Benefit Schedule.]

#### **Follow-Up Outpatient Physician Expense**

When an Insured's Covered Complication requires follow-up Outpatient services rendered no later than 30 days after: (1) an unscheduled Inpatient admission to a Hospital; or (2) a Hospital emergency visit; or (3) an ambulance service to a Hospital, We will pay the following Outpatient Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Diagnostic tests, including professional fees;
- (2) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure;
- (3) Prescription Drugs prescribed during a follow-up visit or as a follow-up thereto;
- (4) Radiological procedures, including professional fees
- (5) Anesthesia, including the administration thereof;
- (6) Oxygen, including the administration thereof;

- (7) Blood or blood derivatives that are not donated or replaced, and their administration; and
- (8) Supplies.

The follow-up Outpatient services must be ordered by a Physician, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure.]

**Outpatient Procedure to Rule Out Deep Vein Thrombosis Expense**

When an Insured's Covered Complication requires an Outpatient procedure to rule out deep vein thrombosis after: (1) an unscheduled Inpatient admission to a Hospital; or (2) a Hospital emergency visit; or (3) an ambulance service to a Hospital, We will pay the following Outpatient Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Diagnostic tests, including professional fees;
- (2) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure; and
- (3) Radiological procedures, including professional fees.]

## EXCLUSIONS

[The Policy does not cover Loss nor provide benefits for:

- (1) Expenses resulting from any declared or undeclared war;
- (2) Suicide, attempted suicide or intentionally self-inflicted injury;
- (3) Expenses while in the armed forces of any country;
- (4) Expenses covered by any workers' compensation or occupational disease law;
- (5) The Insured being under the influence of alcohol or drugs unless taken on a Physician's advice;
- (6) Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
- (7) Experimental or Investigative service, supply, or treatment;
- (8) Sickness or disease, mental incapacity or bodily infirmity, except as provided for herein;
- (9) Infections of any kind, except as provided for herein;
- (10) Treatment for mental disorders;
- (11) Medical Expenses that are a result of an Insured's dissatisfaction with the cosmetic results of a surgical procedure or additional surgery to improve the appearance of the affected area;
- (12) Treatment that is normally managed on an Outpatient basis by a Plastic Surgeon such as, but not limited to, minor infections, tissue sloughing, and hematoma;
- (13) Charges related to transportation, except where specifically covered in this Policy;
- (14) Procedures, services or supplies that are not Medically Necessary;
- (15) Expenses that are not specifically identified under this Policy;
- (16) Charges for items or services of convenience, including but not limited to: admission kits; telephone; slippers; or homemaker services; supportive service focusing on activities of daily life such as bathing; dressing; feeding; or skin and/or bladder care; administration of oral medication or eye drops, except as specifically covered in this Policy; or
- (17) Any services, supplies or treatment furnished by the Insured or an Insured's Immediate Family.]

## EXCESS BENEFITS PROVISION

Such insurance as is afforded by this Policy for Complications of Cosmetic Surgery, is payable only in excess of any Expenses payable by Other Valid and Collectible Insurance. When a claim is made, Other Valid and Collectible Insurance pays its benefits without regard to this Policy. This Policy then adjusts benefits so that the total benefits available will not exceed the Allowable Expenses. In the absence of Other Valid and Collectible Insurance, it is Our intention that Expenses incurred in connection with any Covered Complication shall be fully payable subject to the terms, conditions, and limitations of the Policy. This provision shall apply in determining the benefits as to a person covered under this Policy for any claim determination period.

“Other Valid and Collectible Insurance” shall mean any plan providing medical Expense benefits for or by reason of dental, physician, nurse, hospital care, treatment, or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by any:

- (1) group or blanket insurance;
- (2) employee benefit plan or any plan arranged through an employer, trustee, union or employee benefit association; or
- (3) plan or program created or administered by national or state government, or agencies thereof.

We will not limit or exclude payment on a claim because the Insured is eligible for or is provided medical assistance under the provisions of Title XIX of the Social Security Act.

“Allowable Expense” shall mean 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. 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. The following are examples of Expenses that are not Allowable Expenses:

- (1) An Expense that is not covered by any plan covering the person.
- (2) An Expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- (3) The difference between the cost of a semi-private Hospital room and private Hospital room, unless one of the plans provides coverage for a private Hospital room and the patient’s stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
- (4) Any amount in excess of the highest reimbursement amount for a specific benefit when any plan covering the person computes their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology.

Right to Receive and Release Needed Information: Certain facts are needed to apply to this Excess Benefits Provision. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Us any facts it needs to pay the claim.

## **CLAIM PROVISIONS**

### **Notice of Claim**

Notice of claim must be given to Us [or Our designated representative] within 30 days after a Loss occurs or as soon thereafter as reasonably possible. The notice can be given to [Us at: [Address,] [City,] [State,] [Zip Code]] [or] [Our designated representative at: [Address,] [City,] [State,] [Zip Code]]. Notice should include the Insured's name and Policy Number.

### **Claim Forms**

When We [or Our designated representative] receive[s] the Notice of Claim, Proof of Loss forms will be sent to the Insured. If these forms are not sent within 15 days after the giving of notice, the Insured can meet the Proof of Loss requirement by submitting a written statement of the nature and extent of the Loss within the time limit in the Proof of Loss section.

### **Proof of Loss**

Written Proof of Loss must be furnished to Us [or Our designated representative] within 90 days after such Loss. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than 1 year from the time proof is otherwise required.

### **Time of Payment of Claims**

After receiving written Proof of Loss, We [or Our designated representative] will promptly pay all benefits as they accrue.

### **Payment of Claims**

After receiving written Proof of Loss, We [or Our designated representative] will pay all benefits to the Insured, if living, or at the Insured's request, to the Hospital or person rendering services.

Benefits remaining unpaid after the death of the Insured, if any, will be paid to the named beneficiary, if then living. If no beneficiary is named, or the named beneficiary predeceases the Insured, such benefits will be paid to the Insured's estate.

## **GENERAL PROVISIONS**

### **Assignment**

This Policy is non-assignable. An Insured may assign all of his or her rights, privileges and benefits under this Policy except that benefits may not be assigned to the Policyholder, an employee of the Policyholder or a Physician affiliated with the Policyholder. We are not bound by an assignment until We receive and file a signed copy. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to the laws of the jurisdiction in which this Policy is issued and the terms of this Policy.

### **Certificates**

The Certificate describes the main features of the Policy. In the event of any conflict, the terms of the Policy will govern. Individual Certificates will be issued to each Insured or to the Policyholder for delivery to each Insured. The rights described in the Certificate are controlled by the provisions of the Policy and are subject to any changes in the Policy. The Policyholder must have the Policy available for inspection by the Insured at all reasonable times.

### **Change of Beneficiary**

The Insured can change the beneficiary at any time giving Us written notice. The beneficiary's consent is not required for this or any other change in coverage.

### **Clerical Error**

Clerical Error, whether by the Policyholder or Us, will not void the insurance of any Insured if that insurance would otherwise have been in effect; nor extend the insurance of any Insured if that insurance would otherwise have ended or been reduced as provided in this Policy. We have the right to offset or recover any overpayment of benefits made under this Policy.

### **Conformity with State Statutes**

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it is issued is hereby amended to conform to the minimum requirements of such statutes.

### **Entire Contract; Changes**

This Policy, any attached Applications, and endorsements signed by the Policyholder and Insurer are the entire contract. Any change, modification or waiver of this Policy or a certificate issued under it must be in writing and signed by one of the following: Our President, Our Vice-President, a Secretary, or Assistant Secretary. We are not bound by any promises or representations made by an agent or other person except as stated above.

### **Examination and Audit**

At any reasonable time and for any purpose relating to this Policy, Your records shall be open for Our inspection and audit. Such examination may be made during the Policy Term; within three years after this Policy is terminated; or until final settlement of all claims hereunder, whichever is later.

### **Grace Period**

This Policy has a 31-day Grace Period. If the premium is not paid by the due date, it may be paid during the 31 days immediately following the due date. This Policy will remain in force during the Grace Period. The Grace Period does not apply:

- (a) To the first premium due; or
- (b) To premiums due thereafter if We have given You 60 days prior notice that We will not renew the Policy.

If the premium is not paid by the end of the Grace Period, all such insurance will end as of the due date of such premiums, and no Expenses incurred during the Grace Period will be considered for benefits.

### **Incontestability**

Any statement in applications by You or an Insured will, in the absence of fraud, be deemed representations and not warranties. Only statements in an application by You or an Insured will be used to void this Policy or defend against a claim. However, such statements cannot be used to void coverage or defend a claim of an Insured unless a copy of the application with this statement was given to the Insured, beneficiary or personal representative. The validity of this Policy will not be contested after it has been in force for 2 years from the Policy Effective Date, except as to non-payment of premiums.

### **Legal Actions**

No legal action may be brought to recover on this Policy: (a) within 60 days after written Proof of Loss has been given as required; or (b) after 3 years from the time written Proof of Loss is required, or after the expiration of the applicable statute of limitations, if greater.

### **Medical Malpractice**

This Policy is not intended to be nor take the place of medical malpractice insurance.

### **New Entrants**

This Policy will allow from time to time, that new eligible Insureds of the Policyholder be added to the Class of Insured Persons originally insured under this Policy.

### **Noncompliance with Policy Requirements**

Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any General Provision will not operate as a waiver or amendment of that provision.

### **Physical Examination**

We, at Our expense, have the right to have any Insured examined by a Physician of Our choice as often as reasonably necessary while a claim is pending.

### **Premiums**

All premiums are payable to Us [, or if We direct, to Our authorized representative]. The premium due date shall be the Policy Effective Date indicated in the Schedule of Benefits. We reserve the right to change premium rates on any premium due date by giving 60 days advance written notice to You of such change, but not more often than once every 12 months. The premium rates may also be changed at any time the terms of the Policy are changed.

### **Renewal**

With Our consent, this Policy may be renewed by paying the renewal premium within the Grace Period. We reserve the right to refuse to renew this Policy.

### **Subrogation and Right of Reimbursement**

Upon payment of benefits for a Covered Complication, We will be subrogated to all rights of recovery an Insured Person may have against any third party responsible for such Covered Complication. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against an Insured's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverage. Such right extends to all proceeds of any settlement or judgment; but is limited to the amount of benefits We have paid. You must: (1) do nothing to prejudice any right of recovery; (2) execute and deliver any required instruments or papers; and (3) do whatever else is necessary to secure such rights.

If We are precluded by law from exercising Our Subrogation Right, We may exercise Our Right of Reimbursement as defined in this Policy.

Right of Reimbursement: If an Insured incurs Expenses for a Covered Complication that occurred due to the negligence of a third party: (a) We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same Expenses whether by action at law, settlement, or compromise, by the Insured, the Insured's parents (if the Insured is a minor), or Insured's legal representative as a result of the Covered Complication; and (b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits We paid for that Covered Complication. We shall have the right to first reimbursement out of all funds the Insured, the Insured's parents (if the Insured is a minor), or the Insured's legal representative, is or was able to obtain for the same Expenses We have paid as a result of that Covered Complication. You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability. ]

### **Workers' Compensation**

This Policy is not in place of and does not affect any requirement for such coverage by workers' compensation insurance.

## DEFINITIONS

Any capitalized terms in the Policy, Application, and any riders, amendments, or other attached papers are to be given the meanings as described in this section unless otherwise defined in those documents.

**Accredited Surgical Center** – means a facility that has been certified by the: (1) American Association for Accreditation of Ambulatory Surgical Facility (AAAASF); or (2) Accreditation Association for Ambulatory Health Care (AAAHC); or (3) Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or (4) has been certified to participate in the Medicare program under Title XVIII; or (5) is licensed by the state in which the facility is located.

**Benefit Period** – means the time during which an Insured's incurred Expense for a Covered Complication is eligible for reimbursement.

**Coinsurance** – means the portion of eligible Covered Medical Expense which is payable by Us.

**Covered Complication(s)** – means the physical complication(s) indicated in the Schedule of Benefits suffered by an Insured that arise out of a Qualified Cosmetic Surgical Procedure and results in the Insured's: (1) unscheduled Inpatient admission to a Hospital; or (2) Hospital emergency visit; or (3) ambulance service to a Hospital within the Incurral Period. Covered Complications include any other physical complication(s) incurred as a direct result of the initial Covered Complication. The Insured must have followed all pre and post-operative instructions and kept all Post-operative Examination Visits.

**Covered Medical Expense** – means the Usual and Customary Expense for Medically Necessary services, supplies, or treatments which are: (1) not in excess of the Maximum Amount payable per Benefit as specified in the Schedule of Benefits; and (2) made for services and supplies included in the Schedule of Benefits.

**Expense** – means the Usual and Customary charge for Medically Necessary treatment, service, or supply. Such Expense shall not include any amount not customarily charged to persons without insurance.

**Experimental or Investigative** – means those practices, treatments, drugs, and or therapies not accepted and approved by the American Medical Association, Federal Drug Administration and Health Care Financing Administration; not consistent with currently accepted medical practice; not legally obtainable; or not proven safe and effective.

**Hospital** – means a licensed institution including a tax-supported institution of the state which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Physician. It must have a registered nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a Hospital, unless such confinement is because of a lack of space in the Hospital's full service wing.

**Inpatient** – means confinement in a Hospital as a registered bed-patient for a minimum of 24 consecutive hours for which room and board charges are made.

**Insured** – means a person: (1) who is a member of the eligible class of persons as described in the Classification of Insured Persons in the Schedule of Benefits; (2) for whom premium as been paid; and (3) who is covered under this Policy.

**Immediate Family** – means a person who is related to the Insured in any of the following ways: spouse (including common-law), parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild), brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law.

**Loss** – means medical Expense caused by a Covered Complication and covered by this Policy.

**Medically Necessary** – means a service, drug, or supply needed for the diagnosis or treatment of a Covered Complication in accordance with generally accepted standards of medical practice in the United States at the time of the service, drug, or supply is provided. A service, drug, or supply shall be considered "needed" if it: (1) is ordered by the attending Physician; and (2) is commonly and customarily recognized through the medical

profession as appropriate for the particular condition for which it was ordered. A service, drug, or supply shall not be considered as Medically Necessary if it is Experimental, Investigational or educational.

**Outpatient** – means care an Insured receives for a Covered Medical Expense under this Policy for a Covered Complication without a Hospital admission of 24 consecutive hours or more.

**Physician** – means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. The term Physician shall not include the Insured or a member of the Insured's Immediate Family.

**Plastic Surgeon** – means a Physician who: (1) is certified [or is eligible to be certified] by the American Board of Plastic Surgery; (2) is a member of the American Society for Aesthetic Plastic Surgery (ASAPS) and/or the American Society of Plastic Surgeons (ASPS); (3) is a practicing Plastic Surgeon of the Policyholder; and (4) whose name is on file with the Company.

**Post-operative Examination Visits** – means regular post-procedure check-ups with the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure.

**Prescription Medicines or Drugs** – means any medicine or drug under applicable state law that is dispensed only with a written prescription from a Physician and has a label bearing the legend: "Caution: Federal Law prohibits the dispensing without a prescription." It is also any mixed medicine with at least one ingredient bearing the above legend.

**Qualified Cosmetic Surgical Procedure(s)** – means one or more of the surgical procedures indicated in the Schedule of Benefits provided that they are performed by a Plastic Surgeon.

**Surgical Event** – means one or more Qualified Cosmetic Surgical Procedures performed during the same, uninterrupted period of general anesthesia or intravenous sedation.

**Usual and Customary** – means an Expense which: (1) is charged for treatment, supplies, or medical services Medically Necessary to treat an Insured's Covered Complication; and (2) does not exceed the usual level of charges made for similar treatment, supplies, or medical services in the locality where the Expense is incurred.

**We, Us, or Our** – means [Markel Insurance Company].

**You, Your, or Yours** – means the Policyholder shown in the Schedule of Benefits.

**[Service Address:**  
[Markel Insurance Company];  
[P.O. Box 3870];  
[Glen Allen, [VA] [23058-3870]]



# [MARKEL INSURANCE COMPANY]

A STOCK COMPANY

[Deerfield, Illinois 60015]

## CERTIFICATE OF INSURANCE BLANKET COMPLICATIONS OF COSMETIC SURGERY

Policyholder: [ABC Physician Group]  
[Address]  
[City, State, Zip Code]

Policy Date: [Effective and Termination Dates]

Policy Number: [1234567890]

This Certificate is part of, and is governed by, a Policy that has been issued in the State of [State].

**SCOPE OF CERTIFICATE:** This Certificate summarizes the Policy provisions affecting the Insured. The Policy is a contract between the Policyholder and [Markel Insurance Company]. The Policy is held by the Policyholder and may be inspected at any reasonable time on request. This Certificate is not a contract. It does not amend or modify the Policy.

### SCHEDULE OF BENEFITS

**CLASS OF INSURED PERSONS:** All patients of the Policyholder who undergo one or more of the Qualified Cosmetic Surgical Procedures performed by a Plastic Surgeon of the Policyholder at or in a Hospital or an Accredited Surgical Center with which the Plastic Surgeon has an affiliation.

**DESCRIPTION OF COVERAGE:** The Policy provides coverage to an Insured if such Insured seeks medical treatment within the Incurral Period for a Covered Complication that arises from a Qualified Cosmetic Surgical Procedure and results in: (1) an unscheduled Inpatient admission to a Hospital; or (2) a Hospital emergency visit; or (3) an ambulance service to a Hospital. Covered Medical Expenses are payable during the Benefit Period up to the Maximum Benefit Amounts indicated in the Benefit Schedule, subject to any Coinsurance provisions of the Policy.

**BENEFIT PERIOD:** The Benefit Period is 6 months from the date of the Insured's first: (1) unscheduled Inpatient admission to a Hospital; or (2) Hospital emergency visit; or (3) ambulance service to a Hospital within the Incurral Period due to a Covered Complication arising from a Qualified Cosmetic Surgical Procedure.

**INCURRAL PERIOD:** The Incurral Period is the 30-day period immediately following the administration of either general anesthesia, or intravenous sedation in preparation of a Qualified Cosmetic Surgical Procedure.

**QUALIFIED COSMETIC SURGICAL PROCEDURES:** Only the following procedures apply to the Policy.

[Abdominoplasty]	[Face Lift]
[Breast Augmentation]	[Gynecomastia, Treatment of]
[Breast Lift]	[Liposuction]
[Breast Reduction]	[Lower Body Lift]
[Brow Lift]	[Otoplasty]
[Buttock Lift]	[Rhinoplasty]
[Cheek Implants]	[Thigh Lift]
[Chin Augmentation]	[Upper Arm Lift]
[Cosmetic Eyelid Surgery]	

**COVERED COMPLICATIONS:** Only the following complications are covered under the Policy:

Cardiopulmonary Related:

Arrhythmia	Pulmonary Dysfunction
Cardiac Arrest	Pulmonary Embolus
Deep Vein Thrombosis	Rule Out Deep Vein Thrombosis

Fluid Overload	Rule Out Myocardial Infarction
Hypoxia	Rule Out Pulmonary Embolus
Myocardial Infarction	Shock

Surgery Related:

Hemorrhage	Infection
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Anesthesia Related:

Severe hypotension (systolic blood pressure equal to or less than 80 three hours after the Qualified Cosmetic Surgical Procedure).	Severe hypertension (systolic blood pressure equal to or greater than 200 or a diastolic blood pressure equal to or greater than 100 three hours after the Qualified Cosmetic Surgical Procedure).
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**BENEFIT SCHEDULE**

The benefit amount shown is the limit selected by the Policyholder. If the coverage was not requested by the Policyholder, that is indicated by the word NIL.

BENEFIT	MAXIMUM AMOUNT
Inpatient Hospital Expense	[[80% -100%] of Usual & Customary up to [\$1,000 - \$25,000] per day up to a maximum of [30, 45] days]
Intensive Care / Trauma Expense	[Additional [\$1,000 - \$5,000] per day at [80% - 100%] of Usual and Customary up to a maximum of [5, 10] days]
Emergency Medical Expense	[[80% - 100%] of Usual and Customary up to [\$1,000 - \$10,000]]
Ambulance Expense	[[80% -100%] of Usual & Customary up to [\$1,000 –\$5,000]]
Follow-Up Outpatient Physician Expense	[[80% - 100%] of Usual and Customary up to [\$1,000 - \$5,000]]
Outpatient Procedure to Rule Out Deep Vein Thrombosis	[[80% – 100%] of Usual and Customary up to [\$750 - \$2,000]]

**ADDITIONAL COVERAGE CONDITIONS:**

The amounts indicated in the Benefit Schedule are the maximums that apply during any one Benefit Period for all Covered Complications due to the same Surgical Event.

Multiple Qualified Cosmetic Surgical Procedures: If an Insured has more than one Qualified Cosmetic Surgical Procedure performed during the same Surgical Event, any complications that arise from any of the Qualified Cosmetic Surgical Procedures will be treated as one Covered Complication and only one benefit will be payable for the Covered Complication.

Successive Qualified Cosmetic Surgical Procedures: In order for Qualified Cosmetic Surgical Procedures to be covered as separate individual Qualified Cosmetic Surgical Procedures, they must be performed at least 30 days from each other.

Covered Medical Expenses for a Covered Complication are payable until the earliest of:

1. The date the Covered Complication no longer requires further treatment;
2. The date the Maximum Benefit Amounts are paid; or
3. The expiration of the Benefit Period.

### **[Inpatient Hospital [and Intensive Care / Trauma] Expense**

When an Insured's Covered Complication requires an unscheduled Inpatient admission to a Hospital, We will pay the following Inpatient Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Hospital room and board charge, up to the Hospital's average semi-private room rate [and intensive care unit and/or trauma unit charge];
- (2) Miscellaneous Hospital ancillary charges, including but not limited to, oxygen, diagnostic tests, radiological procedures and professional fees;
- (3) Recovery room;
- (4) Operating room;
- (5) Observation room;
- (6) Blood or blood derivatives that are not donated or replaced, and their administration;
- (7) Anesthesia, including the administration thereof;
- (8) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure;
- (9) Prescription Drugs prescribed during the hospitalization, and as a follow-up thereto; and
- (10) Registered nurse (R.N.)]

### **[Emergency Medical Expense**

When an Insured's Covered Complication requires a Hospital emergency visit, We will pay the following Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Emergency room;
- (2) Blood or blood derivatives that are not donated or replaced, and their administration;
- (3) Diagnostic tests, including professional fees;
- (4) Observation room;
- (5) Supplies;
- (6) Oxygen, including the administration thereof;
- (7) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure;
- (8) Prescription Drugs prescribed during the Hospital visit and as a follow-up thereto;
- (9) Radiological procedures, including professional fees;
- (10) Registered nurse (R.N.);
- (11) Anesthesia, including the administration thereof; and
- (12) Miscellaneous Hospital ancillary charges, including but not limited to, operating room.]

### **[Ambulance Expense**

When an Insured's Covered Complication requires the use of an ambulance to a Hospital within 50 miles of the Insured's home or air ambulance to a Hospital when such service is ordered by a Physician and is accomplished in an aircraft used primarily for transporting sick or injured persons, We will pay the Expense up to the Maximum Amount shown in the Benefit Schedule.]

### **[Follow-Up Outpatient Physician Expense**

When an Insured's Covered Complication requires follow-up Outpatient services rendered no later than 30 days after: (1) an unscheduled Inpatient admission to a Hospital; or (2) a Hospital emergency visit; or (3) an ambulance service to a Hospital, We will pay the following Outpatient Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Diagnostic tests, including professional fees;
- (2) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure;
- (3) Prescription Drugs prescribed during a follow-up visit or as a follow-up thereto;
- (4) Radiological procedures, including professional fees;
- (5) Anesthesia, including the administration thereof;
- (6) Oxygen, including the administration thereof;
- (7) Blood or blood derivatives that are not donated or replaced, and their administration; and
- (8) Supplies.

The follow-up Outpatient services must be ordered by a Physician, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure.]

### **[Outpatient Procedure to Rule Out Deep Vein Thrombosis Expense**

When an Insured's Covered Complication requires an Outpatient procedure to rule out deep vein thrombosis after: (1) an unscheduled Inpatient admission to a Hospital; or (2) a Hospital emergency visit; or (3) an ambulance service to a Hospital, We will pay the following Outpatient Expenses up to the Maximum Amount shown in the Benefit Schedule:

- (1) Diagnostic tests, including professional fees;
- (2) Physician services, other than the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure; and
- (3) Radiological procedures, including professional fees.]

### **EXCLUSIONS**

[The Policy does not cover Loss nor provide benefits for:

- (1) Expenses resulting from any declared or undeclared war;
- (2) Suicide, attempted suicide or intentionally self-inflicted injury;
- (3) Expenses while in the armed forces of any country;
- (4) Expenses covered by any workers' compensation or occupational disease law;
- (5) The Insured being under the influence of alcohol or drugs unless taken on a Physician's advice;
- (6) Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
- (7) Experimental or Investigative service, supply, or treatment;
- (8) Sickness or disease, mental incapacity or bodily infirmity, except as provided for herein;
- (9) Infections of any kind, except as provided for herein;
- (10) Treatment for mental disorders;
- (11) Medical Expenses that are a result of an Insured's dissatisfaction with the cosmetic results of a surgical procedure or additional surgery to improve the appearance of the affected area;
- (12) Treatment that is normally managed on an Outpatient basis by a Plastic Surgeon such as, but not limited to, minor infections, tissue sloughing, and hematoma;
- (13) Charges related to transportation, except where specifically covered in the Policy;
- (14) Procedures, services or supplies that are not Medically Necessary;
- (15) Expenses that are not specifically identified under the Policy;
- (16) Charges for items or services of convenience, including but not limited to: admission kits; telephone; slippers; or homemaker services; supportive service focusing on activities of daily life such as bathing; dressing; feeding; or skin and/or bladder care; administration of oral medication or eye drops, except as specifically covered in the Policy; or
- (17) Any services, supplies or treatment furnished by the Insured or an Insured's Immediate Family.]

### **EXCESS BENEFITS PROVISION**

Such insurance as is afforded by this Policy for Complications of Cosmetic Surgery, is payable only in excess of any Expenses payable by Other Valid and Collectible Insurance. When a claim is made, Other Valid and Collectible Insurance pays its benefits without regard to this Policy. This Policy then adjusts benefits so that the total benefits available will not exceed the Allowable Expenses. In the absence of Other Valid and Collectible Insurance, it is Our intention that Expenses incurred in connection with any Covered Complication shall be fully payable subject to the terms, conditions, and limitations of the Policy. This provision shall apply in determining the benefits as to a person covered under this Policy for any claim determination period.

"Other Valid and Collectible Insurance" shall mean any plan providing medical Expense benefits for or by reason of dental, physician, nurse, hospital care, treatment, or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by any:

- (1) group or blanket insurance;
- (2) employee benefit plan or any plan arranged through an employer, trustee, union or employee benefit association; or
- (3) plan or program created or administered by national or state government, or agencies thereof.

We will not limit or exclude payment on a claim because the Insured is eligible for or is provided medical assistance under the provisions of Title XIX of the Social Security Act.

"Allowable Expense" shall mean 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. 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. The following are examples of Expenses that are not Allowable Expenses:

- (1) An Expense that is not covered by any plan covering the person.
- (2) An Expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- (3) The difference between the cost of a semi-private Hospital room and private Hospital room, unless one of the plans provides coverage for a private Hospital room and the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
- (4) Any amount in excess of the highest reimbursement amount for a specific benefit when any plan covering the person computes their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology.

Right to Receive and Release Needed Information: Certain facts are needed to apply to this Excess Benefits Provision. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Us any facts it needs to pay the claim.

## GENERAL PROVISIONS

### Incontestability

Any statement in applications by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties. Only statements in an application by the Policyholder or an Insured will be used to void this Policy or defend against a claim. However, such statements cannot be used to void coverage or defend a claim of an Insured unless a copy of the application with this statement was given to the Insured, beneficiary or personal representative. The validity of this Policy will not be contested after it has been in force for 2 years from the Policy Effective Date, except as to non-payment of premiums.

### Legal Actions

No legal action may be brought to recover on this Policy: (a) within 60 days after written Proof of Loss has been given as required; or (b) after 3 years from the time written Proof of Loss is required, or after the expiration of the applicable statute of limitations, if greater.

### Physical Examination

We, at Our expense, have the right to have any Insured examined by a Physician of Our choice as often as reasonably necessary while a claim is pending.

## DEFINITIONS

**Accredited Surgical Center** – means a facility that has been certified by the: (1) American Association for Accreditation of Ambulatory Surgical Facility (AAAASF); or (2) Accreditation Association for Ambulatory Health Care (AAAHC); or (3) Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or (4) has been certified to participate in the Medicare program under Title XVIII; or (5) is licensed by the state in which the facility is located.

**Benefit Period** – means the time during which an Insured's incurred Expense for a Covered Complication is eligible for reimbursement.

**Coinsurance** – means the portion of eligible Covered Medical Expense which is payable by Us.

**Covered Complication(s)** – means the physical complication(s) indicated in the Schedule of Benefits suffered by an Insured that arise out of a Qualified Cosmetic Surgical Procedure and results in the Insured's: (1) unscheduled Inpatient admission to a Hospital; or (2) Hospital emergency visit; or (3) ambulance service to a Hospital within the Incurral Period. Covered Complications include any other physical complication(s) incurred as a direct result of the initial Covered Complication. The Insured must have followed all pre and post-operative instructions and kept all Post-operative Examination Visits.

**Covered Medical Expense** – means the Usual and Customary Expense for Medically Necessary services, supplies, or treatments which are: (1) not in excess of the Maximum Amount payable per Benefit as specified in the Schedule of Benefits; and (2) made for services and supplies included in the Schedule of Benefits.

**Expense** – means the Usual and Customary charge for Medically Necessary treatment, service, or supply. Such Expense shall not include any amount not customarily charged to persons without insurance.

**Experimental or Investigative** – means those practices, treatments, drugs, and or therapies not accepted and approved by the American Medical Association, Federal Drug Administration and Health Care Financing Administration; not consistent with currently accepted medical practice; not legally obtainable; or not proven safe and effective.

**Hospital** – means a licensed institution including a tax-supported institution of the state which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Physician. It must have a registered nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a Hospital, unless such confinement is because of a lack of space in the Hospital's full service wing.

**Inpatient** – means confinement in a Hospital as a registered bed-patient for a minimum of 24 consecutive hours for which room and board charges are made.

**Insured** – means a person: (1) who is a member of the eligible class of persons as described in the Classification of Insured Persons in the Schedule of Benefits; (2) for whom premium as been paid; and (3) who is covered under the Policy.

**Immediate Family** – means a person who is related to the Insured in any of the following ways: spouse (including common-law), parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild), brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law.

**Loss** – means medical Expense caused by a Covered Complication and covered by the Policy.

**Medically Necessary** – means a service, drug, or supply needed for the diagnosis or treatment of a Covered Complication in accordance with generally accepted standards of medical practice in the United States at the time of the service, drug, or supply is provided. A service, drug, or supply shall be considered "needed" if it: (1) is ordered by the attending Physician; and (2) is commonly and customarily recognized through the medical profession as appropriate for the particular condition for which it was ordered. A service, drug, or supply shall not be considered as Medically Necessary if it is Experimental, Investigational or educational.

**Outpatient** – means care an Insured receives for a Covered Medical Expense under the Policy for a Covered Complication without a Hospital admission of 24 consecutive hours or more.

**Physician** – means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. The term Physician shall not include the Insured or a member of the Insured's Immediate Family.

**Plastic Surgeon** – means a Physician who: (1) is certified [or is eligible to be certified] by the American Board of Plastic Surgery; (2) is a member of the American Society for Aesthetic Plastic Surgery (ASAPS) and/or the American Society of Plastic Surgeons (ASPS); (3) is a practicing Plastic Surgeon of the Policyholder; and (4) whose name is on file with the Company.

**Post-operative Examination Visits** – means regular post-procedure check-ups with the Plastic Surgeon who performed the Qualified Cosmetic Surgical Procedure.

**Prescription Medicines or Drugs** – means any medicine or drug under applicable state law that is dispensed only with a written prescription from a Physician and has a label bearing the legend: "Caution: Federal Law prohibits the dispensing without a prescription." It is also any mixed medicine with at least one ingredient bearing the above legend.

**Qualified Cosmetic Surgical Procedure(s)** – means one or more of the surgical procedures indicated in the Schedule of Benefits provided that they are performed by a Plastic Surgeon.

**Surgical Event** – means one or more Covered Procedures performed during the same, uninterrupted period of general anesthesia or intravenous sedation.

**Usual and Customary** – means an Expense which: (1) is charged for treatment, supplies, or medical services Medically Necessary to treat an Insured's Covered Complication; and (2) does not exceed the usual level of charges made for similar treatment, supplies, or medical services in the locality where the Expense is incurred.

**We, Us, or Our** – means [Markel Insurance Company].

## **CLAIM PROCEDURES**

### **TO FILE A CLAIM**

1. Complete a claim form which can be obtained from [ABC Physicians Group] [or] [Markel Insurance Company].
2. Submit itemized bills.
3. Send to: [Markel Insurance Company]; [4600 Cox Road]; [Glen Allen], [VA] [23060].  
Phone: [(123) 456-7890]  
Fax: [(123) 456-7890]

## **CLAIM PROVISIONS**

### **Notice of Claim**

Notice of claim must be given to Us [or Our designated representative] within 30 days after a Loss occurs or as soon thereafter as reasonably possible. The notice can be given to [Us at: [Address,] [City,] [State,] [Zip Code]] [or] [Our designated representative at: [Address,] [City,] [State,] [Zip Code]]. Notice should include the Insured's name and Policy Number.

### **Claim Forms**

When We [or Our designated representative] receive[s] the Notice of Claim, Proof of Loss forms will be sent to the Insured. If these forms are not sent within 15 days after the giving of notice, the Insured can meet the Proof of Loss requirement by submitting a written statement of the nature and extent of the Loss within the time limit in the Proof of Loss section.

### **Proof of Loss**

Written Proof of Loss must be furnished to Us [or Our designated representative] within 90 days after such Loss. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than 1 year from the time proof is otherwise required.

### **Time of Payment of Claims**

After receiving written Proof of Loss, We [or Our designated representative] will promptly pay all benefits as they accrue.

### **Payment of Claims**

After receiving written Proof of Loss, We [or Our designated representative] will pay all benefits to the Insured, if living, or at the Insured's request, to the Hospital or person rendering services.

Benefits remaining unpaid after the death of the Insured, if any, will be paid to the named beneficiary, if then living. If no beneficiary is named, or the named beneficiary predeceases the Insured, such benefits will be paid to the Insured's estate.



**[MARKEL INSURANCE COMPANY]**

[Ten Parkway North]  
[Deerfield, IL 60015]

(A Stock Insurance Company, Herein Called the Company)

**BLANKET COMPLICATIONS OF COSMETIC SURGERY INSURANCE APPLICATION**

**Instructions:** Please type or print in ink all sections applicable to the surgical practice. If not applicable, please indicate N/A. Please attach requested documents. **NOTE: THIS APPLICATION IS NOT FOR PROFESSIONAL LIABILITY INSURANCE.**

**A.) APPLICANT**

- 1. Applicant Name and Title: \_\_\_\_\_  
  - a. Office Manager: \_\_\_\_\_
  - b. Patient Representative: \_\_\_\_\_
  - c. Accounting Representative: \_\_\_\_\_
- 2. Business Name: \_\_\_\_\_
- 3. Primary Business Address: \_\_\_\_\_
- 4. Billing Address (if different): \_\_\_\_\_
- 5. FEIN Number: \_\_\_\_\_
- 6. Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- 7. Email: \_\_\_\_\_ Web Address: \_\_\_\_\_
- 8. Type of Practice (check one):  
  - Sole Practitioner [ ]
  - Group (2-4 Surgeons) [ ]
  - Group (5 or more) [ ]
  - Multi-Specialty Group [ ]
  - Academic Practice [ ]
  - Other [ ] (Please Specify) \_\_\_\_\_
- 9. Requested Effective Date of Coverage: \_\_\_\_\_

**B). STATE LICENSURE AND CERTIFICATION**

- 1. Indicate the name of all Board Certified Surgeons that perform Aesthetic Surgery and list the state where their current medical license is held (attach an additional sheet, if needed).  
  - a. Name: \_\_\_\_\_  
Medical License State(s): \_\_\_\_\_ License Number(s) \_\_\_\_\_  
% of Practice \_\_\_\_\_ Status \_\_\_\_\_
  - b. Name: \_\_\_\_\_  
Medical License State(s): \_\_\_\_\_ License Number(s): \_\_\_\_\_  
% of Practice \_\_\_\_\_ Status \_\_\_\_\_
  - c. Name: \_\_\_\_\_  
Medical License State(s): \_\_\_\_\_ License Number(s): \_\_\_\_\_  
% of Practice \_\_\_\_\_ Status \_\_\_\_\_
  - d. Name: \_\_\_\_\_  
Medical License State(s): \_\_\_\_\_ License Number(s): \_\_\_\_\_  
% of Practice \_\_\_\_\_ Status \_\_\_\_\_

- e. Name: \_\_\_\_\_  
 Medical License State(s): \_\_\_\_\_ License Number(s): \_\_\_\_\_  
 % of Practice \_\_\_\_\_ Status \_\_\_\_\_
- Are any of the above named surgeons Board Certified by an American Board of Medical Specialties (ABMS) Member Board?  Yes  No  
 Name of Board(s): \_\_\_\_\_  
 Date Certified: \_\_\_\_\_
  - Are any of the above named surgeons American Board of Medical Specialties (ABMS) Board Eligible?  Yes  No  
 Name of Board: \_\_\_\_\_  
 Status: \_\_\_\_\_  
 Est. Date of Certification: \_\_\_\_\_
  - Has any of the above named surgeons had their medical license, certification by a specialty board, membership in a professional society, or hospital privileges revoked, suspended or cancelled? (If yes, an explanation on a separate sheet of paper must accompany this application).  Yes  No
  - Are any of the above named surgeons a member of the American Society of Plastic Surgeons (ASPS)?  Yes  No If No, are any a Candidate member of the ASPS?  Yes  No
  - Are any of the above named surgeons a member of the American Society for Aesthetic Plastic Surgery (ASAPS)?  Yes  No

**C). SURGICAL PRACTICE INFORMATION**

- Please estimate the number of each procedure performed per year. **A minimum of 15 separate surgical events must be performed during a given year in order to obtain coverage.**

Abdominoplasty		Cheek Implants		Lower Body Lift	
Breast Augmentation		Chin Augmentation		Otoplasty	
Breast Lift		Cosmetic Eye Surgery		Rhinoplasty	
Breast Reduction		Facelift		Thigh Lift	
Brow Lift		Gynecomastia, Treatment of		Upper Arm Lift	
Buttock Lift		Liposuction		<b>Total Procedures per year:</b>	

- What percentage of the procedures listed above occur subsequent to bariatric surgery? \_\_\_\_\_
- Please describe your pre-operative assessment and screening process for surgeries performed on patients subsequent to bariatric surgery including timing of the cosmetic surgery and medical clearance requirements. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Please indicate the percentage of where the procedures shown above were performed during the last 12 months:

Location	% of Surgeries	Location	% of Surgeries
Hospital		Accredited Surgical Center	
Office Based Operating Room		Other	

- For each Accredited Surgical Center (Outpatient Facility) and Office Based Operating Room referenced in question 4, list the facility and its accreditation (i.e. JCAHO, AAAHC, and AAAASF). For non-accredited facilities, please attach the most recent state inspection report if available.

Facility # 1: Name and Location:	
Facility # 1: Accreditation:	
Facility # 1: Contact Name & Tel. #	
Facility # 2: Name and Location:	
Facility # 2: Accreditation:	
Facility # 2: Contact Name & Tel. #	

6. Does everyone in the surgical practice have staff privileges at the facilities listed in question 5 for all of the procedures listed in question 1? [  ] **Yes** [  ] **No**  
If No, please explain. \_\_\_\_\_
7. Has any Hospital or Accredited Surgical Center ever restricted, suspended or revoked your or anyone in your surgical practice privileges? [  ] **Yes** [  ] **No**  
If Yes, please explain. \_\_\_\_\_
8. Have you or anyone in your surgical practice ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? [  ] **Yes** [  ] **No**  
If Yes, please explain. \_\_\_\_\_
9. Has any fee or professional relations complaints been registered against you or anyone in your surgical practice with the medical association, hospital, licensing authority or professional society?  
[  ] **Yes** [  ] **No** If Yes, please explain. \_\_\_\_\_
10. Have you or anyone in your surgical practice ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [  ] **Yes** [  ] **No**  
If Yes, please explain. \_\_\_\_\_
11. Do you or anyone in your surgical practice have any chronic physical illnesses or defects?  
[  ] **Yes** [  ] **No** If Yes, please explain. \_\_\_\_\_
12. Have you or anyone in your surgical practice ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? [  ] **Yes** [  ] **No**  
If Yes, please explain. \_\_\_\_\_

#### **D). PROFESSIONAL LIABILITY INSURANCE INFORMATION**

1. Current Medical Malpractice Company \_\_\_\_\_
2. Current Medical Malpractice Policy Effective Date: \_\_\_\_\_
3. Are you or anyone in your surgical practice now, or have ever been involved, directly or indirectly, in a claim, potential claim, or suit for alleged malpractice? [  ] **Yes** [  ] **No** If Yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
- Have these been reported to your insurer? [  ] **Yes** [  ] **No**
4. Has your or your surgical practice's Medical Malpractice coverage ever been non-renewed or cancelled due to claims or nonpayment of premium? [  ] **Yes** [  ] **No**  
If Yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH:**

- (1) THE "DECLARATIONS" (FRONT) PAGE OF YOUR MEDICAL MALPRACTICE POLICY;**
- (2) A COPY OF YOUR MOST RECENT CERTIFICATE OF INSURANCE; AND**
- (3) ANY CLAIMS INFORMATION PROVIDED BY YOUR MEDICAL MALPRACTICE INSURANCE COMPANY.**

**E). PLEASE READ AND SIGN.**

**STATEMENT OF UNDERSTANDING AND AGREEMENT**

I hereby declare that the above statements are true and that I have not knowingly suppressed or misstated any material facts. I authorize [Markel Insurance Company] ("the Company") to conduct any investigation to substantiate this information. I hereby agree that this application including my attachments thereto shall be the basis of any insurance contract issued by the Company.

I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm or professional association. I understand and agree that the completion of this application does not bind the Company to issue, nor me to purchase, a contract of insurance, provided. However, if I am issued insurance by the Company and I purchase such contract of insurance, I understand and agree that any material misrepresentation or omission by me in this application may act to void such contract of insurance and may give the Company a right to rescind such contract.

**FRAUD WARNING: Any person who, with intent to defraud and/or knowing that he or she is facilitating a fraud against an insurer, submits an application and/or files a claim containing a false or deceptive statement, and/or conceals information for the purpose of misleading, may be guilty of insurance fraud and subject to criminal and/or civil penalties.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date Signed (Mo/Day/Yr)

\_\_\_\_\_  
Print Name of Applicant

**F). ATTACHMENTS:**

Attach to this application an explanation of any answers or requested information.

**G). MAIL OR FAX TO:**

**[Markel Insurance Company]**  
[P.O. Box 3870]  
[4600 Cox Road]  
[Glen Allen, VA 23058-3870]  
[Fax: 804-527-7915]

**[ABC Agent]**  
[Address of Agent]  
[Address of Agent]  
[City, State, Zip Code of Agent]  
[Fax number of agent]

For questions regarding this application, please contact [Markel Insurance Company] [ABC Agent] at [800-431-1270] [000-000-0000].

# [Markel Insurance Company]

[Deerfield, IL 60015]

Endorsement No. \_\_\_\_\_

[AMEND: SCHEDULE OF BENEFITS; Policyholder's Address:  
The Policyholder's address is changed to: 123 Main Street; Anywhere, USA 12345.]

[AMEND: SCHEDULE OF BENEFITS; EXPIRATION DATE:  
The Expiration Date is changed to: Month/Date/Year.]

[AMEND: EXCESS BENEFITS PROVISION:  
The Excess Benefits Provision is deleted in its entirety.]

[AMEND: DEFINITIONS; Plastic Surgeon:  
Number (1) indicated in the Plastic Surgeon definition is deleted in its entirety.  
Number (2) indicated in the Plastic Surgeon definition is deleted in its entirety.  
Numbers (1) and (2) indicated in the Plastic Surgeon definition is deleted in its entirety.]

Nothing herein contained shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the undermentioned Policy other than as stated hereon.

Effective date \_\_\_\_\_ Attached to and forming part of Policy Number \_\_\_\_\_

of \_\_\_\_\_

Issued to \_\_\_\_\_

[ \_\_\_\_\_ ]  
President

[ \_\_\_\_\_ ]  
Secretary

[ \_\_\_\_\_ ]  
[Countersigned]

SERFF Tracking Number: MRKC-126231872 State: Arkansas  
 Filing Company: Markel Insurance Company State Tracking Number: 43027  
 Company Tracking Number: MCCS100 (11/08)  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Complications of Cosmetic Surgery  
 Project Name/Number: Complications of Cosmetic Surgery/MCCS100 (11/08)

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR Readability Certification.pdf	Disapproved	10/06/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> This item is being bypassed since there is no previously approved application. Our application (MCCS123 (09/08)) is included in the Form Schedule tab. <b>Comments:</b>	Disapproved	10/06/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> <b>Attachment:</b> AR Cover Letter 072309.pdf	Disapproved	10/06/2009



# MARKEL INSURANCE COMPANY

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4600 Cox Road Glen Allen, Virginia 23060-9817 P.O. Box 3870, Glen Allen, Virginia 23058-3870  
(804) 527-2700 (800) 431-1270 Fax (804) 527-7915

## ARKANSAS READABILITY CERTIFICATION

The forms were combined to determine the Flesch reading ease score. These forms contain 10,065 words combined and therefore meet the requirement to analyze two (2) samples of 200 words from each page instead of the entire form, with each sample separated by at least ten printed lines according to 23-80-206 (b)(1)(A).

The two (2) samples analyzed were from Page 10 and Page 11 of MCCS100 (11/08). The scores from these two samples are 40.7 and 49.7 respectively. Our forms meet the minimum Flesch reading ease score of 40 pursuant to 23-80-206 (a)(1).

A handwritten signature in black ink, appearing to read "Mark Nichols", written over a horizontal line.

Mark Nichols  
Vice President  
Markel Insurance Company

07/23/2009

Date



# MARKEL INSURANCE COMPANY

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184 Shuman Boulevard, Suite #390, Naperville, Illinois 60563  
(800) 338-1938 / (630) 778-7770 / Fax (804) 527-7915 www.markelah.com

July 23, 2009

Commissioner Jay Bradford  
Arkansas Insurance Department  
Life & Health Division  
1200 W. 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

Sent via SERFF

RE: **MARKEL INSURANCE COMPANY**  
NAIC No. 38970 FEIN No. 363101262  
DOI Number: 4130  
**Accident & Health Division**  
**Complications of Cosmetic Surgery Policy**  
**Forms: MCCS100, MCCS100C, MCCS123, MCCS128**  
**Blanket Accident and Health Insurance Filing**

Dear Commissioner Bradford:

The above referenced forms are attached for your review and approval. These forms are new and do not replace any forms previously approved by your Department.

## **PRODUCT DESCRIPTION**

This is a niche-market accident & health product. The product was developed to cover certain complications of 17 listed cosmetic surgeries, which most traditional health insurance plans will not cover.

To assist you in your review process, following are some of the main product features:

- **This is a limited benefit product.**
- **This coverage will be marketed to plastic surgeons/group practices, who will be the group policyholder. The group policyholder pays all premiums.**
- **All patients of the plastic surgeon (and group practice) that undergo one or more of the 17 procedures shown in the policy will be eligible.**
- **This coverage is NOT medical malpractice coverage.**
- **No expenses for any follow-up care to the group policyholder are covered by this policy.**
- **Marketing for this product will be done through licensed agents and brokers.**

This limited benefit coverage is not "health insurance coverage" as defined under the federal Health Insurance Portability and Accountability Act (HIPAA), it is not subject to the requirements in the HIPAA law.

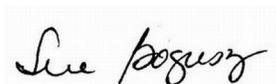
Please note that we are making this filing under Arkansas' blanket health insurance law, Code 23-86-101 (7).

The forms are in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. Printing standards will never be less than those required by law. Once approved, the Company reserves the right to use the forms in their approved format in a variety of media, including the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

If there are any questions or comments which you feel could best be handled by phone, please feel free to contact us. We would be most pleased to discuss this filing with you over the phone.

Thank you in advance for your immediate attention.

Sincerely,

A handwritten signature in black ink that reads "Sue Bogusz". The signature is written in a cursive style and is placed on a light gray rectangular background.

**Sue Bogusz**

Regulatory Compliance Assistant

Phone: 800-338-1938 ext. 245

Direct: 630-778-7770

Fax: 804-527-7915

E-mail: [sbogusz@markelcorp.com](mailto:sbogusz@markelcorp.com)