

SERFF Tracking Number: ACEH-126633345 State: Arkansas
Filing Company: ACE American Insurance Company State Tracking Number: 45704
Company Tracking Number: GROUP POLICY - PATIENT PROTECTION
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Group Policy - Patient Protection
Project Name/Number: Group Policy - Patient Protection/Group Policy - Patient Protection

Filing at a Glance

Company: ACE American Insurance Company

Product Name: Group Policy - Patient Protection SERFF Tr Num: ACEH-126633345 State: Arkansas

TOI: H21 Health - Other SERFF Status: Closed- Disapproved State Tr Num: 45704

Sub-TOI: H21.000 Health - Other Co Tr Num: GROUP POLICY - PATIENT PROTECTION State Status: Disapproved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Karen Moore, Anne Hickey Disposition Date: 05/19/2010

Date Submitted: 05/18/2010 Disposition Status: Disapproved

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Group Policy - Patient Protection

Project Number: Group Policy - Patient Protection

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: Pennsylvania, our domiciliary state, does not require the filings of forms intended for issue in the Commonwealth of Pennsylvania (PA Notice 96-1).

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 05/19/2010

Created By: Karen Moore

Corresponding Filing Tracking Number: Group Policy - Patient Protection

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/19/2010

Deemer Date:

Submitted By: Karen Moore

Filing Description:

RE: ACE American Insurance Company

FEIN#: 95-2371728 / NAIC#: 626-22667

Group Policy - AH-29512

SERFF Tracking Number: ACEH-126633345 State: Arkansas
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Certificate of Insurance – AH-29513
Description of Coverage - AH-29514
Administrative Amendment – AH-10895
Group Application – AH-29515
Member Application – AH-29516

In- and Out-of-State Filing

Dear Commissioner:

We submit the form filing referenced above on behalf of ACE American Insurance Company. These forms are new and are not intended to replace any forms currently on file. Pennsylvania, our domiciliary state, does not require the filings of forms intended for issue in the Commonwealth of Pennsylvania (PA Notice 96-1).

This product is intended for a niche market to cover a specific risk to patients undergoing cosmetic or elective surgery. Most healthcare policies exclude benefits for cosmetic surgery. This policy is intended to pay supplemental limited indemnity benefits that may otherwise be excluded from healthcare coverage that arise as a result of complications of certain named procedures commonly known as cosmetic or elective surgery.

Typically, an individual must cover the cost of cosmetic or elective surgery out-of-pocket, and in most instances, the cost of additional enhancements if the initial procedure did not meet the final goals of the patient and physician. A patient chooses to undertake and plan for the financial obligations set by the physician in regard to the initial procedure, but undoubtedly he or she does not plan to pay for subsequent care for specific unanticipated medical outcomes. Generally, recovery for these expenses often requires expensive protracted legal proceedings taken against the surgeon for wrongful or negligent conduct. This product is intended to fill this 'gap' in coverage by supplementing benefits on a "no-fault" basis where complications occur.

The Patient Protection Policy will be marketed and issued to Professional Associations with members who are board certified cosmetic/plastic surgeons. Members may elect coverage and pay the required premium for all qualified patients.

These forms are intended for issue directly to the Association or to a trust on behalf of the Association. We certify that the benefits provided to patients will not be made a condition of receiving care and treatment by the surgeon. We maintain the product meets a need in the marketplace to help offset the costs associated with possible risks of cosmetic surgery and is not contrary to the public interest.

We certify that all associations will be submitted to the Department for review and approval prior to marketing, in accordance with Arkansas requirements.

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Given the potential of the risk, we maintain the benefits provided are reasonable in relation to the premiums.

Group Policy, AH-29512, Certificate of Insurance, AH-29513, and Description of Coverage, AH-29514 are designed to describe the benefits provided to patients of members due to a complication of cosmetic surgery. In addition, any of the listed Benefits may be included in the policy at the option of the policyholder.

The other forms included in the filing are Administrative Amendment, AH-10895, designed to accommodate administrative changes to the policy form. Coverage will be applied for using the Group Application form AH-29515, and Member Application, AH-29516.

The referenced forms have been written in readable language and are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, positioning and format. However, printing standards will never be less than required under your law. Optional material is indicated by ([]) hard brackets and will be included or excluded as requested by the policyholder. Variable material indicated by soft brackets ({ }), may be included, excluded or modified, but will never be more restrictive than permitted by law. Such modifications may result from negotiations between us and the policyholder.

I trust this filing meets with your approval. If you have any questions, or require additional information, please contact me directly at karen.moore@acegroup.com.

Regards,

Karen N. Moore
Compliance Manager

Company and Contact

Filing Contact Information

Karen Moore, Compliance Manager karen.moore@acegroup.com
436 Walnut Street 215-640-5134 [Phone]
WA09D 215-640-5548 [FAX]
Philadelphia, PA 19106

Filing Company Information

ACE American Insurance Company CoCode: 22667 State of Domicile: Pennsylvania
PO Box 1000 Group Code: 626 Company Type:
436 Walnut Street Group Name: State ID Number:
Philadelphia, PA 19106 FEIN Number: 95-2371728

SERFF Tracking Number: ACEH-126633345 State: Arkansas
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(215) 640-5123 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$300.00
Retaliatory? No
Fee Explanation: 6 forms X \$50 = \$300
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ACE American Insurance Company	\$300.00	05/18/2010	36619053

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	05/19/2010	05/19/2010

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Disposition

Disposition Date: 05/19/2010

Implementation Date:

Status: Disapproved

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

We are concerned about the product itself and that product being for the benefit of the provider (doctor) 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	Health - Actuarial Justification	Disapproved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Supporting Document	Description of Variability	Disapproved	Yes
Form	Group Policy - Patient Protection	Disapproved	Yes
Form	Certificate of Insurance	Disapproved	Yes
Form	Description of Coverage	Disapproved	Yes
Form	Administrative Amendment	Disapproved	Yes
Form	Group Application	Disapproved	Yes
Form	Member Application	Disapproved	Yes

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Form Schedule

Lead Form Number: AH-29512

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved 05/19/2010	AH-29512	Policy/Contract/Certificate	Group Policy - Patient Protection	Initial		51.200	AH-29512 - Group Policy - Patient Protection.pdf
Disapproved 05/19/2010	AH-29513-AR	Certificate	Certificate of Insurance	Initial		51.400	AR - AH-29513-AR - Group Certificate of Insurance - Patient Protection.pdf
Disapproved 05/19/2010	AH-29514	Policy/Contract/Certificate: Amendment, Insert Page, Endorsement or Rider	Description of Coverage	Initial		50.600	AH-29514 - Group Policy - Patient Protection - Description of Coverage.pdf
Disapproved 05/19/2010	AH-10895	Policy/Contract/Certificate: Amendment, Insert Page, Endorsement or Rider	Administrative Amendment	Initial		51.200	AH-10895 Administrative Amendment.pdf
Disapproved d	AH-29515	Application/Group Enrollment	Application	Initial		51.200	AH-29515 Group

<i>SERFF Tracking Number:</i>	<i>ACEH-126633345</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>ACE American Insurance Company</i>	<i>State Tracking Number:</i>	<i>45704</i>
<i>Company Tracking Number:</i>	<i>GROUP POLICY - PATIENT PROTECTION</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Group Policy - Patient Protection</i>		
<i>Project Name/Number:</i>	<i>Group Policy - Patient Protection/Group Policy - Patient Protection</i>		
05/19/2010	Form		Application - Patient Protection.pdf
Disapprove AH-29516	Application/Member Application Initial	51.400	AH-29516 - Group Policy - Patient Protection - Member Application.pdf
d	Enrollment		
05/19/2010	Form		



ACE American Insurance Company
 (A Stock Company)
 Philadelphia, PA 19106

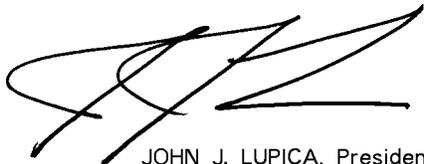
Group Policy

POLICYHOLDER: {ABC Association}
POLICY NUMBER: {XXX XXXXXXXX}
POLICY EFFECTIVE DATE: {MM/DD/YYYY}
POLICY ANNIVERSARY DATE: {MM/DD/YY} and each {MM/DD} thereafter
STATE OF DELIVERY: {State}

The Policy takes effect at 12:00 a.m. (midnight) at the Policyholder's address on the Policy Effective Date shown above. In return for payment of the required premiums, We will pay benefits according to the terms and conditions of coverage described in the Policy.

The Policy is governed by the laws of the state in which it is delivered.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania



JOHN J. LUPICA, President



GEORGE D. MULLIGAN, Secretary

THIS IS NOT MEDICAL MALPRACTICE INSURANCE, NOR IS IT A SUBSTITUTE FOR MEDICAL MALPRACTICE INSURANCE.

THIS IS A LIMITED BENEFIT GROUP INSURANCE POLICY. IT PAYS BENEFITS FOR COMPLICATIONS OF SURGERY FROM SPECIFIC PROCEDURES ONLY.

PLEASE READ THE POLICY CAREFULLY.

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SCHEDULE OF BENEFITS

POLICYHOLDER: {ABC Association}

POLICY EFFECTIVE DATE: {MM/DD/YYYY}

POLICY NUMBER: {XXX XXXXXXXX}

PREMIUM DUE DATE: The {Variable: One of the following will be included: 1st/15th/or some other date as agreed to by the Policyholder and Us} of the month following the Policy Effective Date for all [Qualified] {P/p}atients of Members registered for the prior month}. Premium payments must be accompanied by an eligibility report showing the registered patients for whom premium is remitted, the date of the Covered Procedure and the type of Covered Procedure for each registered patient.

CLASSES OF ELIGIBLE PERSONS:

A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class.

Class 1 {All Full-time Active Members of the Policyholder}

PLAN BENEFITS

Covered Procedures: {Optional – Any one or more of the following may be included:}

{Abdominoplasty	Face Lift
Alloplastic Facial Augmentation	Facial Fillers [including Autologous Fat Transplantation]
Belt Lipectomy	Facial Scar Revision
Blepharoplasty	Facial Skin Resurfacing
Breast Augmentation	Gynecomastia (Treatment of)
Breast Lift	Hair Transplant/Restoration
Breast Reduction	Liposuction [of the Chin/Neck]
Brow Lift	Lower Body Lift
Buttock Lift	Mentoplasty [including Genioplasty or Alloplastic Augmentation]
Cheek Implants	Otoplasty
Chin Augmentation	Rhinoplasty
Cosmetic Eyelid Surgery	Thigh Lift
Cosmetic Orthognathic Surgery	Upper Arm Lift}

Incurral Period: The {30/60/90}-day period immediately following the administration of general anesthesia, intravenous sedation or local anesthesia in preparation for a Covered Procedure.

Maximum Benefit Amounts: The following amounts are the maximums that apply during any one Benefit Period for all Covered Complications due to the same Surgical Event.

<u>Benefit</u>	<u>Benefit Maximum</u>
Hospitalization of 24 hours or more:	\${Variable: any amount from: 1,000 to 5,000} per day, up to a maximum of {Variable: any time period from: 15 to 45} days OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges, subject to a maximum of {Variable: any time period from: 15 to 45} days

OPTIONAL BENEFITS: {elected by the Member}

[Intensive Care Unit/Trauma Admittance:	Additional \${Variable: any amount from: 500 to 1,000} per day, up to a maximum of {Variable: any time period from: 5 to 10} days OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges, subject to a maximum of {Variable: any time period from: 5 to 10} days]
[Hospitalization of less than 24 hours:	\${Variable: any amount from: 1,000 to 2,500} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]
[Ambulance Service:	\${Variable: any amount from: 500 to 2,000} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]
[Follow Up Doctor Services:	\${Variable: any amount from: 500 to 1,500} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]
[Non-Hospital Procedure for Rule Out Deep Vein Thrombosis:	\${Variable: any amount from: 250 to 750} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]

Admission Diagnosis:

Cardiopulmonary Related

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

Surgery Related

{Hemorrhage (including hematoma)	Infection (infection only related to the Covered Procedure)}
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Anesthesia Related

{Severe Hypotension (systolic BP equal to or less than 80 three hours after the Covered Procedure)}

Severe Hypertension (systolic BP equal to or greater than 200 or diastolic BP equal to or greater than 100 three hours after the Covered Procedure)}

PREMIUM RATES per Member per Covered Person:

Single or multiple procedures without abdominoplasty:	\$XXX per Surgical Event /
Single or multiple procedures with abdominoplasty:	\$XXX per Surgical Event}

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the *Schedule of Benefits*.

“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.

“Admission Diagnosis” means one or more of the diagnoses set out in the Schedule of Benefits which are made by a Doctor at a Hospital, an Accredited Surgical Center, or a non-Hospital facility to Rule-Out Deep Vein Thrombosis.

“Benefit Period” means the {*Variable: One of the following periods will be included: 6/12/24*} month period from the date of the Covered Person’s original Qualifying Hospital Admission due to a Covered Complication.

“Covered Complication(s)” means physical complications suffered by a Covered Person that arise from a Covered Procedure and results in the Covered Person’s Qualifying Hospital Admission within the Incurral Period shown in the *Schedule of Benefits*. The Covered Person must have followed all pre- and post-operative instructions and kept all Post-Operative Examination Visits.

“Covered Procedure” means an [elective] surgical procedure listed in the *Schedule of Benefits* provided it is performed by the Member. The surgery must take place while the Policy is in force in order to be eligible for benefits under the Policy.

“Covered Person” means a patient who undergoes one or more of the Covered Procedures performed by the Member at/on the Member’s Premises, a Hospital or an Accredited Surgical Center with which the Member has an affiliation.

“Doctor” means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person’s Immediate Family or household. [*Optional: The following text may be included: If, while covered under the Policy, a Member fails to meet Our underwriting criteria or fails to report he or she is named as a defendant in a legal action within 30 days, insurance for any Covered Procedure may be excluded.*]

“Experimental or Investigative” means treatment, a device or prescription medication which is recommended by a Doctor, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

“Follow Up Doctor Services” means Medically Necessary services, supplies and treatments received by the Covered Person from a Doctor during a follow-up visit following the Covered Person’s discharge from a Qualifying Hospital Admission. The Follow Up Doctor Services must have been ordered by a Doctor, other than the {Plastic/Cosmetic} Surgeon who performed the

Covered Procedure, during the Covered Person's Qualifying Hospital Admission. The first service must be obtained within the Incurral Period shown in the *Schedule of Benefits*, after the Covered Person's discharge from the Qualifying Hospital Admission.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of inpatient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide organized facilities for diagnosis, treatment, and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a prearranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing, or section of a Hospital used as such; and 6) is not a place for drug addicts, alcoholics, or the aged.

"Immediate Family Member" means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); [son- or daughter-in-law;] [and] [brother- or sister-in-law].

"Medically Necessary" means a treatment, service, or supply that is: 1) essential for diagnosis, treatment or care of the condition for which it is prescribed or performed; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. The fact that a Doctor may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by this Policy.

"Member" means a Board-Certified {Plastic/Cosmetic} Surgeon licensed to perform {plastic/cosmetic} surgery in the United States[and who is a member of the American Society of Plastic Surgeons].

"{Plastic/Cosmetic} Surgeon" means a Doctor who 1) is 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); and 3) is a practicing Member {Plastic/Cosmetic} Surgeon of the Policyholder; and 4) whose name is on file with Us.

"Post Operative Examination Visits" means regular post procedure check ups with the {Plastic/Cosmetic} Surgeon who performed the Covered Procedure.

"Qualifying Hospital Admission" means an unscheduled admission, including emergency room or observation, to a Hospital that: 1) is Medically Necessary; and 2) is based on an Admission Diagnosis.

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

"Usual and Customary Charges" means a charge that: 1) is made for a Covered Complication; 2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred; and 3) does not include charges that would not have been made if no insurance existed.

"We," "Our," "Us" means the Company underwriting this insurance or its authorized agent.

ELIGIBILITY FOR INSURANCE

Each person in a Class of Eligible Persons shown in the *Schedule of Benefits* is eligible to be insured on the Policy Effective Date, or the day he or she becomes a Member of the Policyholder, if later.

We maintain the right to investigate eligibility status and membership records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that coverage under the Policy.

EFFECTIVE DATE OF INSURANCE

A Member's insurance will be in effect on the later of:

1. the Policy Effective Date;
2. the date We accept the Member's application; or
3. the date the required premium is paid.

TERMINATION DATE OF INSURANCE

A Member's coverage will end on the earliest of the date:

1. the Policy terminates (unless the Policyholder and We agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
2. the Member is no longer eligible;
3. the period ends for which premium is paid;
4. the Member ends participation under the Policy; or
5. the Member's medical license is revoked, suspended, or his or her medical privileges or staff privileges are restricted or taken away, or the Member resigns unless the Company agrees in writing to continue the Member's coverage under the Policy.

[Coverage will remain in force for any Covered Person for whom premium has been paid.]

Termination of a Member's coverage will not affect a Covered Person's claim for a Covered Complication due to a Covered Procedure that occurs while the Member's coverage was in effect under the Policy, except We will have no liability beyond the *{Variable: One of the following will be included: 30/60/90}*-day period immediately following the date the Covered Procedure was performed.

CLAIM PROVISIONS

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within *{Variable: Any one of the following time periods may be included: 30 days to 90 days}* after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

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

Time Payment of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment of Claims: Upon receipt of due written proof of loss, payment for all losses will be made to the Covered Person (or on behalf of, if applicable) suffering the loss. If the Covered Person dies before all payments due have been made, We will pay benefits in equal shares to the first surviving class of the following: 1) Spouse; 2) Children; 3) Parents; 4) Brothers and sisters. If there are no survivors in any of these classes, We will pay the Covered Person's estate.

If the payee is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at Our option, to any relative by blood or in connection by marriage of the payee who, in Our Opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment made in good faith will end Our liability to the extent of the payment.

{Optional: The following provision may be included.}

[Assignment: [At the request of the Covered Person or his or her parent or guardian, if the Insured is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.] A Covered Person may assign all of his or her rights, privileges and benefits under the Policy, except that benefits may not be assigned to the Member, an employee of the Member or a Doctor affiliated with the Member. We are not bound by an assignment until We receive and file a signed copy of the assignment. 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 the Policy is issued and the terms of the Policy.]

Physical Examinations [Optional: and Autopsy]: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. [Optional: We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.]

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy before 60 days following the date proof of loss was given to Us. No such action can be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

ADMINISTRATIVE PROVISIONS

Premiums: The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes in Premium Rates: We may change the premium rates from time to time with at least {Variable: Any period from: 31 to 90} days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until {Variable: Any period form: 12 to 36 months} after the Policy Effective Date. An increase in rates will not be made more often than once in a {Variable: Any period form: 12 to 36 months} period. However, We reserve the right to change rates at any time if any of the following events take place:

{Optional: Any of the following conditions may be included.}

- {1.} [The terms of the Policy change.]
- {2.} [A division, subsidiary, affiliated organization, or eligible class is added or deleted from the Policy.]
- {3.} [Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.]
- {4.} [There is a change in the market factors or other factors bearing on the risk assumed.]

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium: The first Premium is due on the Policy Effective Date. If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period: A Policy Grace Period of {Variable: Any time frame from: 31 days to 60 days} will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

Newly Acquired Organizations: The premium shown on the *Schedule of Benefits* applies only to Members and any affiliates or subsidiary corporations covered on Members' Effective Dates. However, eligible employees of organizations acquired by Members during the term of the Policy may be covered if reported to Us, within {Variable: Any time frame from: 31 days to 90 days} of the acquisition, the name of the newly acquired organization and any underwriting information we may need to underwrite the additional risk.

CHANGES IN A MEMBER'S LOCATION: ANY CHANGE IN THE LOCATION OF A MEMBER [OR ANY AFFILIATES OR SUBSIDIARY CORPORATIONS COVERED UNDER THE POLICY,] MUST BE APPROVED IN WRITING BY THE COMPANY BEFORE COVERAGE FOR THOSE PREMISES WILL BE EFFECTIVE.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including any endorsements or amendments), the signed application of the Policyholder, and any applications of Members, are the entire contract. Any statements made by the Policyholder or Members will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by our president or secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Incontestability: The validity of the Policy will not be contested after it has been in force for two years from the Member's Effective Date, except for nonpayment of premiums.

Policy Effective Date and Termination Date: The Policy begins on the Policy Effective Date shown on page 1 of the Policy. We may terminate this Policy by giving *{Variable: One of the following will be included: 31/45/60}* days advance notice in writing (or authorized electronic or telephonic means) to the Policyholder. The Policyholder may terminate this Policy [on any Premium Due Date] by giving *{Variable: One of the following will be included: 31/45/60}* days advance written (or authorized electronic or telephonic) notice to Us. This Policy terminates automatically on the Premium Due Date if Premiums are not paid when due. Termination takes effect at 12:00 a.m. (midnight) at the Policyholder's address on the date of termination. [Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.]

Clerical Error: If a clerical error is made, it will not affect the insurance of any Member. No error will continue the insurance of a Member beyond the date it should end under the Policy terms.

Examination of Records and Audit: We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after the final termination of the Policy as they relate to the premiums or subject matter of this insurance. This provision also applies to any Member covered under the Policy.

[Reporting Requirements: The Member must report all of the following to Us by the premium due date:

1. the names of all persons insured;
2. the names of those persons whose insurance has terminated; and
3. any additional information required by Us.]

Conformity with State Laws: On the effective date of this Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

Not in Lieu of Workers' Compensation: This Policy is not a workers' compensation policy. It does not provide workers' compensation benefits.

{Optional-The following provision will be included based on the plan design or at the Policyholder's election.}

[Subrogation and Right Of Recovery Provision: As a condition to receiving benefits under the Policy, the Covered Person (or, if he or she is deceased, an authorized representative of the Covered Person) agrees, except as may be limited or prohibited by applicable law:

1. to reimburse Us for any such benefits paid to or on behalf of the Covered Person, if such benefits are recovered, in any form, from any third party or coverage; and
2. without limiting the preceding, that We are subrogated, for the purpose of Our recovery of any such benefits paid to or on behalf of the Covered Person, to any and all claims, causes of action or rights that he or she has or that may rise against any third party who has or may have caused, contributed to or aggravated the Covered Complication for which the Covered Person claims an entitlement to Policy benefits, and to any claims, causes of action or rights he or she may have against any coverage for the Covered Complication for which the Covered Person claims to have an entitlement to Policy benefits.

The Covered Person agrees that he or she will make a decision on pursuing any and all claims, causes of action and rights coverage within {Variable-Any time period from: 30 to 90} days of the date We require that the Covered Person provide Notice of Claim for the Covered Complication for which the Policy benefits are sought, and within such {30 to 90}-day period will so notify Us in writing.

If the Covered Person is a minor or is not competent to make this agreement, the legal guardian of the Covered Person's property makes the agreement on the Covered Person's behalf as a condition to receiving benefits under this Policy on behalf of the Covered Person. If the Covered Person has no guardian for his or her property, the person or persons who, in Our opinion, have assumed the custody and support of the minor or responsibility for the incompetent person's affairs make the agreement on the Covered Person's behalf as a condition to receiving such benefits under this Policy on behalf of the Covered Person.

We will not pay or be responsible, without Our written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of a Covered Person against any third party or coverage.]



ACE American Insurance Company
 (A Stock Company)
 Philadelphia, PA 19106

Group Certificate of Insurance

POLICYHOLDER: {ABC Association}

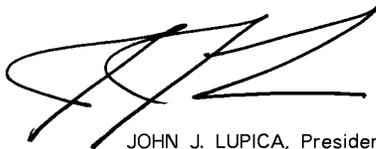
POLICY NUMBER: {XXX XXXXXXXX}

This Certificate of Insurance is issued under the terms of the Policy issued to the Policyholder. We insure each person in one of the Classes of Eligible Persons provided the required premium is paid when due.

We will pay the benefits described in the policy for losses resulting directly from Covered Complications of Covered Procedures that:

1. occur while the Policy is in force and Your coverage is in effect; and
2. subject to all the provisions, conditions, exclusions and limitations of the Policy.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania



JOHN J. LUPICA, President



GEORGE D. MULLIGAN, Secretary

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THIS IS A CERTIFICATE FOR GROUP INSURANCE.

PLEASE READ THE CERTIFICATE CAREFULLY.

LIMITED BENEFIT - PLEASE READ CAREFULLY.

SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS:

You are eligible for coverage if you are a full-time Active Member of the Policyholder.

PLAN BENEFITS

Covered Procedures: *{Optional – Any one or more of the following may be included:}*

<i>{Abdominoplasty</i>	Face Lift
Alloplastic Facial Augmentation	Facial Fillers [including Autologous Fat Transplantation]
Belt Lipectomy	Facial Scar Revision
Blepharoplasty	Facial Skin Resurfacing
Breast Augmentation	Gynecomastia (Treatment of)
Breast Lift	Hair Transplant/Restoration
Breast Reduction	Liposuction [of the Chin/Neck]
Brow Lift	Lower Body Lift
Buttock Lift	Mentoplasty [including Genioplasty or Alloplastic Augmentation]
Cheek Implants	Otoplasty
Chin Augmentation	Rhinoplasty
Cosmetic Eyelid Surgery	Thigh Lift
Cosmetic Orthognathic Surgery	Upper Arm Lift}

Incurral Period: The {30/60/90}-day period immediately following the administration of general anesthesia, intravenous sedation or local anesthesia in preparation for a Covered Procedure.

Maximum Benefit Amounts: The following amounts are the maximums that apply during any one Benefit Period for all Covered Complications due to the same Surgical Event.

Benefit

Benefit Maximum

Hospitalization of 24 hours or more:

#{Variable: any amount from: 1,000 to 5,000} per day, up to a maximum of {Variable: any time period from: 15 to 45} days OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges, subject to a maximum of {Variable: any time period from: 15 to 45} days

OPTIONAL BENEFITS: *{elected by the Member}*

[Intensive Care Unit/Trauma Admittance:

Additional #{Variable: any amount from: 500 to 1,000} per day, up to a maximum of {Variable: any time period from: 5 to 10} days OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges, subject to a maximum of {Variable: any time period from: 5 to 10} days]

[Hospitalization of less than 24 hours: \${Variable: any amount from: 1,000 to 2,500}
OR
{Variable: any percentage from: 80 to 100}%
of Usual and Customary Charges]

[Ambulance Service: \${Variable: any amount from: 500 to 2,000}
OR
{Variable: any percentage from: 80 to 100}%
of Usual and Customary Charges]

[Follow Up Doctor Services: \${Variable: any amount from: 500 to 1,500}
OR
{Variable: any percentage from: 80 to 100}%
of Usual and Customary Charges]

[Non-Hospital Procedure for Rule Out Deep
Vein Thrombosis: \${Variable: any amount from: 250 to 750} OR
{Variable: any percentage from: 80 to 100}%
of Usual and Customary Charges]

Admission Diagnosis:

Cardiopulmonary Related

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

Surgery Related

{Hemorrhage (including hematoma)	Infection (infection only related to the Covered Procedure)}
----------------------------------	--

Anesthesia Related

{Severe Hypotension (systolic BP equal to or less than 80 three hours after the Covered Procedure)}

Severe Hypertension (systolic BP equal to or greater than 200 or diastolic BP equal to or greater than 100 three hours after the Covered Procedure)}

INITIAL PREMIUM RATES per Member per Covered Person:

{Determined on the basis of the plan design selected by the Member.}

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the *Schedule of Benefits*.

“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.

“Admission Diagnosis” means one or more of the diagnoses set out in the Schedule of Benefits which are made by a Doctor at a Hospital, an Accredited Surgical Center, or a non-Hospital facility to Rule-Out Deep Vein Thrombosis.

“Benefit Period” means the {*Variable: One of the following periods will be included: 6/12/24*} month period from the date of the Covered Person’s original Qualifying Hospital Admission due to a Covered Complication.

“Covered Complication(s)” means physical complications suffered by a Covered Person that arise from a Covered Procedure and results in the Covered Person’s Qualifying Hospital Admission within the Incurral Period shown in the *Schedule of Benefits*. The Covered Person must have followed all pre- and post-operative instructions and kept all Post-Operative Examination Visits.

“Covered Procedure” means an [elective] surgical procedure listed in the *Schedule of Benefits* provided it is performed by You. The surgery must take place while the Policy is in force in order to be eligible for benefits under the Policy.

“Covered Person” means a patient who undergoes one or more of the Covered Procedures performed by You at/on Your Premises, a Hospital or an Accredited Surgical Center with which You have an affiliation.

“Doctor” means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person’s Immediate Family or household. [*Optional: The following text may be included: If, while covered under the Policy, You fail to meet Our underwriting criteria or fail to report You are named as a defendant in a legal action within 30 days, insurance for any Covered Procedure may be excluded.*]

“Experimental or Investigative” means treatment, a device or prescription medication which is recommended by a Doctor, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

“Follow Up Doctor Services” means Medically Necessary services, supplies and treatments received by the Covered Person from a Doctor during a follow-up visit following the Covered Person’s discharge from a Qualifying Hospital Admission. The Follow Up Doctor Services must have been ordered by a Doctor, other than the {Plastic/Cosmetic} Surgeon who performed the

Covered Procedure, during the Covered Person's Qualifying Hospital Admission. The first service must be obtained within the Incurral Period shown in the *Schedule of Benefits*, after the Covered Person's discharge from the Qualifying Hospital Admission.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of inpatient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide organized facilities for diagnosis, treatment, and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a prearranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing, or section of a Hospital used as such; and 6) is not a place for drug addicts, alcoholics, or the aged.

"Immediate Family Member" means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); [son- or daughter-in-law;] [and] [brother- or sister-in-law].

"Medically Necessary" means a treatment, service, or supply that is: 1) essential for diagnosis, treatment or care of the condition for which it is prescribed or performed; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. The fact that a Doctor may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by this Policy.

"Member" means a Board-Certified {Plastic/Cosmetic} Surgeon licensed to perform {plastic/cosmetic} surgery in the United States[and who is a member of the American Society of Plastic Surgeons].

"{Plastic/Cosmetic} Surgeon" means a Doctor who 1) is 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); and 3) is a practicing Member {Plastic/Cosmetic} Surgeon of the Policyholder; and 4) whose name is on file with Us.

"Post Operative Examination Visits" means regular post procedure check ups with the {Plastic/Cosmetic} Surgeon who performed the Covered Procedure.

"Qualifying Hospital Admission" means an unscheduled admission, including emergency room or observation, to a Hospital that: 1) is Medically Necessary; and 2) is based on an Admission Diagnosis.

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

"Usual and Customary Charges" means a charge that: 1) is made for a Covered Complication; 2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred; and 3) does not include charges that would not have been made if no insurance existed.

"We," "Our," "Us" means the Company underwriting this insurance or its authorized agent.

"You, Your, Yours" means the Member.

ELIGIBILITY FOR INSURANCE

If You are in one of the Classes of Eligible Persons shown in the Schedule of Benefits, You are eligible to be insured on the Policy Effective Date, the date We accept Your application, or the day the required premium is paid. We retain the right to investigate eligibility status and membership records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for coverage under the Policy.

EFFECTIVE DATE OF INSURANCE

Your insurance will be in effect on the later of:

1. the Policy Effective Date;
2. the date We accept Your application; or
3. the date the required premium is paid.

TERMINATION DATE OF INSURANCE

Your coverage will end on the earliest of the date:

1. the Policy terminates (unless the Policyholder and We agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
2. You are no longer eligible;
3. the period ends for which premium is paid;
4. You end participation under the Policy; or
5. Your medical license is revoked, suspended, or Your medical privileges or staff privileges are restricted or taken away, or You resign unless We agree in writing to continue Your coverage under the Policy.

[Coverage will remain in force for any Covered Person for whom premium has been paid.]

Termination of Your coverage will not affect a Covered Person's claim for a Covered Complication due to a Covered Procedure that occurs while Your coverage was in effect under the Policy, except We will have no liability beyond the {*Variable: One of the following will be included: 30/60/90-*} day period immediately following the date the Covered Procedure was performed.

CLAIM PROVISIONS

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within {*Variable: Any one of the following time periods may be included: 30 days to 90 days*} after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

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

Time Payment of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment of Claims: Upon receipt of due written proof of loss, payment for all losses will be made to the Covered Person (or on behalf of, if applicable) suffering the loss. If the Covered Person dies before all payments due have been made, We will pay benefits in equal shares to the first surviving class of the following: 1) Spouse; 2) Children; 3) Parents; 4) Brothers and sisters. If there are no survivors in any of these classes, We will pay the Covered Person's estate.

If the payee is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at Our option, to any relative by blood or in connection by marriage of the payee who, in Our Opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment made in good faith will end Our liability to the extent of the payment.

{ Optional: The following provision may be included. }

[Assignment: [At the request of the Covered Person or his or her parent or guardian, if the Insured is a minor, medical benefits may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.] A Covered Person may assign all of his or her rights, privileges and benefits under the Policy, except that benefits may not be assigned to You, Your employee or a Doctor affiliated with You. We are not bound by an assignment until We receive and file a signed copy of the assignment. 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 the Policy is issued and the terms of the Policy.]

Physical Examinations [Optional: and Autopsy]: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. *[Optional: We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.]*

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy before 60 days following the date proof of loss was given to Us. No such action can be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

ADMINISTRATIVE PROVISIONS

Changes in Premium Rates: We may change the premium rates from time to time with at least {*Variable: Any period from: 31 to 90*} days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until {*Variable: Any period form: 12 to 36 months*} after the Policy Effective Date. An increase in rates will not be made more often than once in a {*Variable: Any period form: 12 to 36 months*} period. However, We reserve the right to change rates at any time if any of the following events take place:

{*Optional: Any of the following conditions may be included.*}

- {1.} [The terms of the Policy change.]
- {2.} [A division, subsidiary, affiliated organization, or eligible class is added or deleted from the Policy.]
- {3.} [Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.]
- {4.} [There is a change in the market factors or other factors bearing on the risk assumed.]

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium: Your first Premium is due on Your Member Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, coverage will be canceled as of the Premium Due Date, except as provided in the Your Grace Period section.

Your Grace Period: If the required premium is not paid on the Premium Due Date, there is a 31-day grace period after each Premium Due Date after the first. If the required premium is not paid during the grace period, Your insurance will end on the last day of the period for which premium was paid.

[Reporting Requirements: The Member must report all of the following to Us by the premium due date:

1. the names of all persons insured;
2. the names of those persons whose insurance has terminated; and
3. any additional information required by Us.]

Examination of Records and Audit: We shall be permitted to examine and audit the Member's books and records at any time during the term of the Policy and within 2 years after the final termination of the Policy as they relate to the premiums or subject matter of this insurance.

GENERAL PROVISIONS

Conformity with State Laws: On the effective date of the Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws. Certificates issued to residents of Arkansas will be governed by the laws of that state.

DESCRIPTION OF COVERAGE

The following Provisions explain the benefits available under the Policy. [Please see the *Schedule of Benefits* for the applicability of these benefits on a class level.]

Complication of Surgery Benefit

We will pay the Usual and Customary Charges for Covered Expenses incurred by a Covered Person, up to the Benefit Maximum shown in the *Schedule of Benefits*, if he or she suffers a Covered Complication as a direct result of undergoing a Covered Procedure. The Covered Complication must result within the Incurral Period shown in the *Schedule of Benefits*.

If a Covered Person has more than one Covered Procedure performed during the same Surgical Event, any complications that arise from any of the Covered Procedures will be treated as one Covered Complication and only one benefit will be payable for the Covered Complication. Successive Covered Procedures will be covered if the succeeding procedure is performed at least {*Variable-One of the following time periods will be included: 30/60/90*} days after the date of the prior Covered Procedure.

Covered Expenses means the charges incurred by the Covered Person for the following Medically Necessary medical services, supplies and treatments:

{*Optional-Any one of the following may be included in the Certificate of Insurance issued to the Member.*}

1. [during a Qualifying Hospital Admission][; or]
- {2.} [with respect to ambulance services, while en route to a Hospital][; or]
- {3.} [for non-Hospital procedure to Rule-Out Deep Vein Thrombosis][; or]
- {4.} [for treatment in an Accredited Surgical Center][; or]
- {5.} [for Follow Up Doctor Services].

We will pay Covered Expenses for:

1. Hospitalization of 24 hours or longer and Intensive Care Unit (ICU)/Trauma Admittance:
 - a. Doctors' services, other than the Member who performed the Covered Procedure, and registered nurses;
 - b. anesthetics and their administration;{*Optional-Any one of the following may be included in the Certificate of Insurance issued to the Member.*}
 - {c.} [laboratory tests;]
 - {d.} [oxygen and its administration;]
 - {e.} [blood and blood derivatives that are not donated or replaced and their administration;]
 - {f.} [radiological procedures;]
 - {g.} [prescription drugs prescribed during the Hospitalization and as a follow-up thereto;][and]
 - {h.} [room and board, up to the most common charger for a semi-private room or ICU/Trauma, when required, and Hospital ancillary services (including, but not limited to, the use of the operating room)].
2. Hospitalization of less than 24 hours:
 - a. Doctors' services, other than the Member who performed the Covered Procedure, and registered nurses;
 - b. anesthetics and their administration;

{Optional-Any one of the following may be included in the Certificate of Insurance issued to the Member.}

- {c.} [laboratory tests;]
- {d.} [oxygen and its administration;]
- {e.} [blood and blood derivatives that are not donated or replaced and their administration;]
- {f.} [radiological procedures;]
- {g.} [prescription drugs prescribed during the Hospitalization and as a follow-up thereto;] [and]
- {h.} [Hospital ancillary services (including, but not limited to, the use of the operating room or an observation room)].

{Optional-Any one of the following may be included in the Certificate of Insurance issued to the Member.}

- {3.} [Ambulance Service:
 - a. professional ambulance service to a Hospital within 50 miles of the Covered Person's home; or
 - b. air ambulance service to a Hospital when such service is ordered by a Doctor and travel occurs in an aircraft used primarily for transporting sick or injured persons.]
- {4.} [Non-Hospital procedure to Rule-Out Deep Vein Thrombosis
 - a. Doctor's services, other than the Member who performed the Covered Procedure;
 - b. laboratory tests; and
 - c. radiological procedures.]
- {5.} [Follow up Doctor Services
 - a. Doctors' services, other than the Member who performed the Covered Procedure;
 - b. anesthetics and their administration;
 - {c.} [laboratory tests;]
 - {d.} [oxygen and its administration;]
 - {e.} [blood and blood derivatives that are not donated or replaced and their administration;]
 - {f.} [radiological procedures;] [and]
 - {g.} [prescription drugs prescribed during the Hospitalization and as a follow-up thereto].]

We will pay benefits until the earliest of the following dates:

1. the Covered Complication no longer requires further hospitalization or Follow Up Doctor Services;
2. the Benefit Maximums are paid; or
3. the Benefit Period ends.

GENERAL EXCLUSIONS

{Optional-Each of the following exclusions is optional. Any combination of the following exclusions may be included.}

No benefits are available under the Policy for any loss resulting from, or contributed to by, or as a natural and probable consequence of:

1. [the Covered Person being under the influence of drugs unless taken under the advice of and as specified by a Doctor.]

- {2.} [the Covered Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.]
- {3.} [Experimental or Investigative treatment or procedures.]
- {4.} [suicide or any attempted suicide, or intentionally self-inflicted injury or any attempt thereof, or acts of autoeroticism.]
- {5.} [sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly, except as specifically provided in the Policy.]
- {6.} [infections of any kind, except as specifically provided in the Policy.]
- {7.} [treatment of mental disorders.]
- {8.} [medical expenses that are a result of a Covered Person's dissatisfaction with the cosmetic results of a surgical procedure or additional surgery to improve the appearance of the affected area.]
- {9.} [treatment that is normally managed on an outpatient basis by a Member such as, but not limited to, minor infections, tissue sloughing, and hematoma.]
- {10.} [procedures, services or supplies that are not Medically Necessary.]
- {11.} [expenses that exceed the Usual and Customary Charges for the same medical issue.]

In addition, the Policy does not cover a Member's liability:

- 1. [arising out of bodily injury, sickness, death or disease sustained by any person, or arising out of any act, error, or omission in providing or failing to provide professional services. This includes anyone for whose acts, errors, or omissions a Member is responsible.]
- {2.} [assumed by a Member under any contract with any other party other than the arrangement between a Member and the Covered Person.]
- {3.} [that is due to an association or affiliation in any business or professional organization.]
- {4.} [arising from any dishonest, fraudulent, criminal, or malicious acts, whether intentional or negligent.]
- {5.} [due to a violation of any anti-trust, price fixing, or restraint of trade law, whether based upon statute, common law, or administrative directive.]
- {6.} [arising from sexual intimacy, sexual molestation, sexual harassment, sexual exploitation, or sexual assault.]
- {7.} [under any unemployment, workers' compensation, disability benefits, or similar law.]
- {8.} [pursuant to any order of court, judge, arbitrator or arbitration panel, administrator, governmental agency, or licensing body.]
- {9.} [arising from the use of any non-Federal Drug Administration (FDA) approved medication.]
- {10.} [arising out of peer review, quality assurance, or utilization review done on behalf of any managed care or insurance organization.]

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.



ACE American Insurance Company
436 Walnut Street
Philadelphia, PA 19106
(Herein called We, Us, Our)
800.352.4462

Amendment

[Policyholder: {ABC Association}]

[Policy Number: {XXX XXXXXXXX}]

[Effective Date: {MM/DD/YYYY}]

This Amendment form is made a part of the Policy and any Certificate to which it is attached as of the Effective Date shown above. If no Effective Date is shown, this Amendment takes effect as of the Policy Effective Date. This Amendment ends at the same time as the Policy and Certificate. It is subject to all of the terms, limitations and conditions of the Policy and Certificate except as they are changed by it.

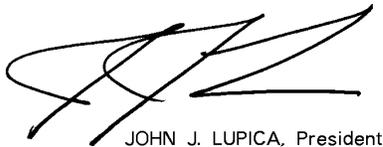
[Any changes in premium apply as of the first premium due date on or after the Effective Date of this Amendment.]

{The Policy has been changed as follows:

1. The name of the Policyholder is changed to XYZ.
2. The Policy Number is changed to XXX XXXXXXXX.}

LIMITED BENEFIT - PLEASE READ CAREFULLY.

Signed for ACE American Insurance Company in Philadelphia, Pennsylvania.



JOHN J. LUPICA, President



GEORGE D. MULLIGAN, Secretary



ACE American Insurance Company
 436 Walnut Street
 Philadelphia, PA 19106

Application for Group Insurance

{The Applicant requests Group Insurance for Eligible Persons based on the following statements and representations, and where applicable, agrees to be bound by the terms and conditions of any trust agreement establishing a trustee as Policyholder. Insurance will not go into effect until the required premium is paid.

Applicant Information

Applicant (Full Legal Name): {ABC Association} Requested Effective Date: {MM/DD/YYYY}

Phone: {XXX.XXX.XXXX} Fax: {XXX.XXX.XXXX} E-Mail: XXX@XXX.com

Address: {1234 Your Street} City, State, Zip Code: {Any City, Any State XXXXX}

Billing Address: {Same as above} City, State, Zip Code: {Same as above}

Type of Association: {Professional} Taxpayer ID # {XX-XXXXXXXXX}

Contact Person: {John Doe} Title: {President}

Number of Eligible Members: {300}

Eligibility = All Full-time Active Members of the Policyholder

"Member" means a Board-Certified {Plastic/Cosmetic} Surgeon licensed to perform {plastic/cosmetic} surgery in the United States[and who is a member of the American Society of Plastic Surgeons].

Initial Premium Rates:

Premiums are paid by participating Members based on the number of Qualified Patients registered for a premium period (monthly, unless another time period is otherwise agreed to by Us.

PREMIUM RATES per Member per Covered Person:

{Single or multiple procedures without abdominoplasty:	\$XXX per Surgical Event /
Single or multiple procedures with abdominoplasty:	\$XXX per Surgical Event}}

No brochures or any marketing material referencing this insurance shall be published without the prior written approval of the Company.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature and Title

Date

Signed by Licensed Resident Agent
(Where Required by Law)



MEMBER APPLICATION

I, the Member applicant shown below, apply for coverage under Group Policy Number {XXX XXXXXXX} based on the following statements and representations. I understand this insurance is underwritten by ACE American Insurance Company and marketed by {Variable-Will include licensed agent or agency}.

Insurance will not go into effect until the Member's Application is accepted by Us and the required premium is paid for the plan of benefits selected by the Member.

Instructions: Please type or print in ink all sections applicable to your Plastic/Cosmetic Surgery practice. If not applicable, please indicate N/A. Please attach requested documents.

A. Member Applicant Information

1. Full Name _____
2. Date of Birth _____
3. SS# _____
4. Drivers License: State _____ Number _____
 - a. During the past five (5) years, have you ever been convicted of driving under the influence (DUI) or driving while intoxicated (DWI)? YES NO

B. Practice Information

1. Business Name _____
2. Primary Business Address _____
3. Office Contact(s)

Office Manager: _____	email _____
Patient Representative _____	email _____
Accounting _____	email _____
4. Billing Address (if different) _____
5. Office Phone _____ Fax _____
 Office Email _____ Web Address _____
6. Type of Practice (circle one) Solo Practitioner Group (2-4 Surgeons) Group (5 or more)
 Multi Specialty Group Academic Practice Other _____
7. Name all Board Certified Cosmetic Surgeons practicing with you that perform procedures

8. Practice Locations

Location Name	Address and Phone	% of Practice	Type of Facility	Procedures Performed at Location
			<input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting	

Location Name	Address and Phone	% of Practice	Type of Facility	Procedures Performed at Location
			<input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting	
			<input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting	
			<input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting	

C. Educational Background

1. Medical School:

Name: _____

Address: _____

City: _____ State: _____

Country: _____

Degree: _____

Completed From: _____ To: _____

If you are a Foreign Medical School Graduate: Are you certified by the Educational Council of Foreign Medical Graduates or have you completed the Fifth Pathway Program? YES NO

2. Residency: Please list all training locations:

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
City: _____ State: _____	City: _____ State: _____
Country: _____	Country: _____
Specialty: _____	Specialty: _____
Dates of Residency: _____	Dates of Residency: _____
Completed <input type="checkbox"/> YES <input type="checkbox"/> NO	Completed <input type="checkbox"/> YES <input type="checkbox"/> NO

Name: _____ Address: _____ _____ City: _____ State: _____ Country: _____ Specialty: _____ Dates of Residency: _____ Completed <input type="checkbox"/> YES <input type="checkbox"/> NO	Name: _____ Address: _____ _____ City: _____ State: _____ Country: _____ Specialty: _____ Dates of Residency: _____ Completed <input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

3. Have you participated in additional training? (i.e., Fellowship, etc.)

Name: _____ Address: _____ _____ City: _____ State: _____ Country: _____ Specialty: _____ Completed <input type="checkbox"/> YES <input type="checkbox"/> NO	Name: _____ Address: _____ _____ City: _____ State: _____ Country: _____ Specialty: _____ Completed <input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

Name: _____ Address: _____ _____ City: _____ State: _____ Country: _____ Specialty: _____ Completed <input type="checkbox"/> YES <input type="checkbox"/> NO	Name: _____ Address: _____ _____ City: _____ State: _____ Country: _____ Specialty: _____ Completed <input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

4. Please explain any gaps greater than six (6) months between your medical school, residency, other training or first time in private practice.

5. If you are currently in a residency or fellowship program, please enter your anticipated residency/fellowship ending date. _____

6. Are you entering private practice for the first time? YES NO

7. Have you participated in any continuing medical education within the last three years?
 YES NO
 If yes, how many category 1 credit hours? _____

8. Have you completed a risk management education course within the last twelve (12) months?
 YES NO

D. State Licensure and Certification (Please list the states where you hold or have held a medical license)

State	License Number	% of Practice	Status

1. Are you Board Certified? YES NO

Name of Board(s) _____

Date Certified _____

2. If you are not Board Certified are you Board Eligible? YES NO

Name of Board(s) _____
 Status _____
 Estimated Date of Certification _____

3. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation, or voluntarily suspended? (If yes, an explanation on a separate sheet of paper must accompany this questionnaire.) YES NO

4. Have you ever been denied a medical license by any state, denied membership in any medical society, or denied certification by a specialty board? (If yes, an explanation on a separate sheet of paper must accompany this questionnaire.) YES NO

5. Are you a Member of the American Society of Plastic Surgeons? YES NO

6. Has any fee or professional relations complaints been registered against you with your medical association, hospital, licensing authority or professional society? If yes, please explain. YES NO
7. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty (e.g., convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics or controlled substances)? If yes, please explain. YES NO

E. Practice Description

Please answer all questions fully. Attach additional sheets if necessary

1. Please provide any previous locations of practice, list most recent locations first, dating back to completion date of formal training

Name of Practice	Address	Dates in Practice

2. Please provide the number of cosmetic surgery procedures you performed each year for the past three years _____

3. Please indicate where you performed these procedures in the last 12 months (for non-accredited facilities, please attach the most recent state inspection report if available.)

Facility Name and Location	Accreditation	Contact Name and Phone

4. Do you have staff privileges at a Hospital or Accredited Surgical Center? If no, please explain. YES NO

Facility Name and Location	Accreditation	Contact Name and Phone

K

F). Professional Liability Insurance Information:

1. Current Medical Malpractice Insurer:

Effective Date of Policy

***Please attach the "Declarations" (front) page of your Medical Malpractice policy and a copy of your most recent certificate of insurance. ***

2. Are you now or have you ever been involved YES NO
directly or indirectly, in a claim, potential claim, or
suit for alleged malpractice?

3. If yes, have these been reported to your insurer? YES NO

****Please attach any claims information provided by your Medical Malpractice Insurance Company****

YES NO
4. Has your Medical Malpractice coverage ever
been non-renewed or cancelled due to claims or
nonpayment of premium?

If yes, please provide details. _____

{G.} Selection of Plan Benefits:

Hospitalization of 24 hours or more

{Optional Benefits:

- Intensive Care Unit/Trauma Admittance
- Hospitalization of less than 24 hours
- Ambulance Service
- Follow Up Doctor Services
- Non-Hospital Procedure for Rule Out Deep Vein Thrombosis}

**{Covered
Procedures:**

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Face Lift |
| <input type="checkbox"/> Alloplastic Facial Augmentation | <input type="checkbox"/> Facial Fillers [including
Autologous Fat Transplantation] |
| <input type="checkbox"/> Belt Lipectomy | <input type="checkbox"/> Facial Scar Revision |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Facial Skin Resurfacing |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Gynecomastia (Treatment of) |
| <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Hair Transplant/Restoration |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Liposuction [of the Chin/Neck] |
| <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Lower Body Lift |
| <input type="checkbox"/> Buttock Lift | <input type="checkbox"/> Mentoplasty [including
Genioplasty or Alloplastic
Augmentation] |
| <input type="checkbox"/> Cheek Implants | <input type="checkbox"/> Otoplasty |
| <input type="checkbox"/> Chin Augmentation | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Cosmetic Eyelid Surgery | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Cosmetic Orthognathic Surgery | <input type="checkbox"/> Upper Arm Lift} |

Please read and sign

I hereby declare that the above statements are true and that I have not knowingly suppressed or misstated any material facts. I authorize the Company to conduct any investigation to substantiate this information including without limitation criminal history and consumer credit reviews. I hereby agree that this questionnaire including my attachments thereto shall be the basis of any insurance contract issued by ACE American Insurance Company (the Company).

I agree to notify the Company or its authorized agent if there is any future material change in any answer to this questionnaire 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 questionnaire 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 questionnaire may act to void such contract of insurance and may give the Company a right to rescind such contract.

I understand and agree to abide by the Company's terms and conditions as set forth in this Application and the Certificate of Insurance issued to me. I understand the terms and conditions of the requested plan of insurance may vary in certain states as required by the laws of those states. The terms of the Policy when issued will govern. It is agreed the insurance applied for will not become effective unless: a) this Application is received and approved by the Insurance Company based on current rules and requirements; b) the Certificate is accepted by the Applicant; and c) the required premium is paid when due.

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

Signature and Title

Date

Signed by Licensed Agent

Agent License ID Number

Licensed Agent – Print Name

SERFF Tracking Number: ACEH-126633345 State: Arkansas
 Filing Company: ACE American Insurance Company State Tracking Number: 45704
 Company Tracking Number: GROUP POLICY - PATIENT PROTECTION
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Group Policy - Patient Protection
 Project Name/Number: Group Policy - Patient Protection/Group Policy - Patient Protection

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Disapproved	05/19/2010
Comments:		
Attachment: Group Policy - Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Disapproved	05/19/2010
Comments: Applications are included on the Forms Tab.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Disapproved	05/19/2010
Bypass Reason: Not required for this submission.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Disapproved	05/19/2010
Bypass Reason: Not required for this submission.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Description of Variability	Disapproved	05/19/2010
Comments:		
Attachment: Group Policy - Expanded Description of Variability (T).pdf		

ACE American Insurance Company

436 Walnut Street
Philadelphia, Pennsylvania 19106

READABILITY CERTIFICATION

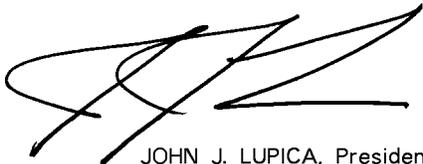
SCHEDULE OF FORMS

I hereby certify that the following forms were tested for readability using the Rudolf Flesch Formula and achieved the following results.

May 2010

RE: Group Policy, AH-29512, et al

Form Number	Description	Score
AH-29512	Group Policy	51.2
AH-29513	Certificate of Insurance	51.4
AH-29514	Description of Coverage	50.6
AH-10895	Administrative Amendment	51.2
AH-29515	Group Application	51.2
AH-29516	Member Application	51.4



JOHN J. LUPICA, President

Person responsible for this filing: Karen N. Moore, Compliance Manager
ACE USA Accident & Health Department
karen.moore@acegroup.com
215.640.5134

ACE American Insurance Company

436 Walnut Street
Philadelphia, PA 19106

Description of Variability

RE: Group Policy (AH-29512) and related forms

Please note variable information is contained in brackets. In no event will the information contained in these brackets be less favorable to an insured than the minimum standards set forth in your law.

Please note the following general comments regarding variable information.

1. Policy Schedule Pages

We have illustrated the policy schedules. Variations will occur based on the nature of the group, the classes covered, the benefits offered and the applicability of certain provisions at either the case, class or benefit level. We consider any benefits, amounts, deductibles, co-payments, benefit durations, dates or application of benefits to be completely variable unless your law requires a limitation.

Specific Policy Variability follows:

Page 3: Premium Due Date: One of the following will be included: 1st/15th/or some other date as agreed to by the Policyholder and Us.

Page 3: Classes of Eligible Persons: The following statement will be included if there are more than one class description.

Page 3: Plan Benefits: Any one or more of the listed benefits may be included.

Page 3: Incurral Period: will be included if set incurral period applies.

Page 4: Benefit Maximums:

<u>Benefit</u>	<u>Benefit Maximum</u>
Hospitalization of 24 hours or more:	\${Variable: any amount from: 1,000 to 5,000} per day, up to a maximum of {Variable: any time period from: 15 to 45} days OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges, subject to a maximum of {Variable: any time period from: 15 to 45} days
[Intensive Care Unit/Trauma Admittance:	Additional \${Variable: any amount from: 500 to 1,000} per day, up to a maximum of {Variable: any time period from: 5 to 10} days OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges, subject to a maximum of {Variable: any time period from: 5 to 10} days]
[Hospitalization of less than 24 hours:	\${Variable: any amount from: 1,000 to 2,500} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]
[Ambulance Service:	\${Variable: any amount from: 500 to 2,000} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]
[Follow Up Doctor Services:	\${Variable: any amount from: 500 to 1,500} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]
[Non-Hospital Procedure for Rule Out Deep Vein Thrombosis:	\${Variable: any amount from: 250 to 750} OR {Variable: any percentage from: 80 to 100}% of Usual and Customary Charges]

Page 5: Admission Diagnosis: Any one or more of the admission diagnoses will be included based upon the type of cosmetic or plastic surgery performed by the policyholder.

Page 8: Termination Date of Insurance: Any one or more of the listed dates will be included based upon the policy provisions and plan of benefits.

Page 9: Proof of Loss: Proof will be required within 90 days to 24 months after the date of loss based upon the policyholder's requirements.

Page 9: Assignment: This provision will be included if the insured wants benefits to be assigned to the provider of service.

Page 10: Physical Examinations: The provisions for Autopsy will be included dependent upon state requirements.

Page 10: Changes in Premium Rates: Any one or more of the events listed will be included.

Page 11: Policy Effective Date and Termination Date: Notice requirements will vary from 31 to 60 days.

Page 12: Subrogation and Right of Recovery Provision: Will be included based upon state requirements and/or underwriting requirements.

Description of Benefits Variability follows:

Any one or more of the benefits will be included based upon the plan of benefits elected by the policyholder.

Page 1: Complications of Surgery: The time period for succeeding procedures after the initial surgery will vary from 30 to 90 days after the date of the Covered Procedure. Covered Expenses will include those expenses elected by the policyholder. Any one or more of the Covered Expenses will be included.

Page 2: General Exclusions: Any one or more of the exclusions will be included.

Page 3: Additional exclusions: Any one or more of the listed exclusions will be included based upon the benefits selected.

2. Eligible Persons

We intend to market this form to professional associations of cosmetic surgeons to cover their patients by providing benefits for a complication of cosmetic surgery. We maintain that our interest in making this coverage available to cosmetic surgeons for their patients is not contrary to the public interest and that the benefits provided are reasonable in relation to the premiums charged. The premium for this coverage is paid by the cosmetic surgeon. Therefore, the description of eligible class may vary based on the nature of the patient group covered.

3. Effective Date Provisions

The premium for this coverage is paid by the cosmetic surgeon. The coverage paid for by the cosmetic surgeon is effective immediately upon the patient becoming eligible.

4. Combined Benefits

This policy is designed to provide benefits for the patients of cosmetic surgeons who are members of professional associations. All of the benefits and provisions that apply will be included in the policy text when first issued. If any of the benefits or provisions becomes applicable after the initial effective date of coverage they will be issued in rider form.

5. Trust Marketing

Policy text may change if the policy is issued to a trust on behalf of a participating association. These modifications will include any changes necessary to reflect the role of the participating association as a subscriber to the trust rather than as the policyholder. Thus, references to 'policyholder', and 'policy' may be changed to 'participating organization', 'subscriber', 'plan', etc. and other provisions relating to terms of coverage may be similarly changed.

Specific variability is throughout the forms in {italics}. We have included alternate text for those provisions where the text may vary to the extent the meaning or intent of the provision is different.