THE DOCTORS COMPANY

March 11, 2011

FILED

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

RECEIVED

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

Honorable Michael T. McRaith
Director of Insurance
Illinois Department of Insurance
320 West Washington Street
Springfield, Illinois 62767

Attention: Mr. John Gatlin
Supervisor, Property and Casualty Compliance Unit

RE: The Doctors Company, an Interinsurance Exchange #95-3014772
NAIC Number 831-34495
Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
Rate and Rule Revision
Effective Date: July 1, 2011-New Business
July 1, 2011-Renewal Business
State of Illinois
Filing Number 2011-IL-01

On behalf of The Doctors Company, an Interinsurance Exchange (TDC), we are enclosing a rate and rule revision for our Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program. Based on our current book of business, there is a -21.6% rate level impact resulting from this revision.

This revision consists of the following changes:

- adoption of $1,000,000/$4,000,000 manual rates (including territory definitions) filed and implemented by American Physicians Assurance Corporation (APAC) (a TDC subsidiary company) effective March 1, 2010 (See Section 3-Pages IL-R-1 to IL-R-3 of Countrywide Rules and Rates Manual). For purposes of display in the Rules and Rates Manual, these rates have been adjusted to a $1,000,000/$3,000,000 basis. Manual rates have eliminated for all specialty classes where APAC currently writes no business.
- introduction of manual rates for Chiropractic, Podiatry (No Surgery) and Podiatry (Surgery) (See Section 3-Pages IL-R-1 to IL-R-3 of Countrywide Rules and Rates Manual)
- adoption of current APAC increased limits factors for limits lower than $1,000,000/$4,000,000 (See Section 3-Page IL-R-3 of Countrywide Rules and Rates Manual)
- separate and shared limit rate relativities for all ancillaries have been revised (See Section 2-Page IL-E-3 and Section 3-Page IL-R-3 of Countrywide Rules and Rates

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Manual). Ancillary premium charges for Chiropractors, Podiatrists and Psychologists have been eliminated.

- ancillary premium charges for Purfusionists have been introduced (See Section 2-Page IL-E-3 and Section 3-Page IL-R-3 of Countrywide Rules and Rates Manual)
- extended reporting period coverage rules have been revised (See Section 1-Pages GR-4 and GR-5 and Section 2-Pages IL-E-1 and IL-E-2 of Countrywide Rules and Rates Manual). Revised Endorsement MPL101IL (7/11)-Illinois Changes reflecting these changes has been submitted concurrently in SERFF Filing Number DCTR-126981567 (2011-IL-MPL01).
- "sizable risk rating" rule has been introduced (See Section 2-Page IL-E-2 of Countrywide Rules and Rates Manual)
- minimum premium have been revised (See Section 2-Page IL-E-3 of Countrywide Rules and Rates Manual)
- "Slot" Position Rating has been introduced (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual). Appropriate optional policy endorsements reflecting this change have been submitted concurrently in SERFF Filing Number DCTR-126981567 (2011-IL-MPL01).
- separate and shared limit business entity coverage premium charges have been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual)
- minimum premium for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual)
- prep ("new to practice") discounts have been revised (See Section 1-Page GR-11 of Countrywide Rules and Rates Manual)
- claims-free discount has been revised (See Section 2-Pages IL-E-3 and IL-E-4 of Countrywide Rules and Rates Manual)
- risk management discount rule has been introduced (See Section 2-Page IL-E-4 of Countrywide Rules and Rates Manual)
- current deductible discounts have been revised and additional deductible options introduced (See Section 2-Pages IL-E-4 and IL-E-5 of Countrywide Rules and Rates Manual)
- Schedule Rating Plan has been revised (See Section 2-Pages IL-E-5 and IL-E-6 of Countrywide Rules and Rates Manual)
- additional premium payment plan option introduced (See Section 2-Page IL-E-7 of Countrywide Rules and Rates Manual)
- Experience Rating Plan has been introduced (See Section 2-Pages IL-E-7 and IL-E-8 of Countrywide Rules and Rates Manual)
- various point values for imposed surcharges have been revised (See Appendix-Illinois General Rules Exception Pages)
- group size discount rule has been eliminated
- other changes of an editorial nature only have been made to current rating rules

The rates and rules included in this revision replace all currently filed rates and rules. Due to a significant change in the format of the new rates and rules manual, a "side-by side"

comparison of current and revised rules is not practical. However, we have enclosed an Explanatory Memorandum that describes our changes.

This revision will apply to all new and renewal policies effective on or after July 1, 2011.

In accordance with your requirements, we have enclosed the following:

- Two copies of the filing letter
- One copy of the filing
- Property & Casualty Transmittal Document (PC TD-1)
- Rate/Rule Filing Schedule (PC RRFS-1)
- Summary Sheet (Form RF-3)
- Actuarial Certification
- A self-addressed, postage pre-paid envelope

It should be noted that effective January 1, 2008, The Doctors Company began reporting statistical data for its Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program to Insurance Services Office (ISO). Prior to this date, statistical data was reported to the National Independent Statistical Service (NISS).

If you have any questions or if I may be of further assistance, please contact me at (800) 421-2368 Ext. 1318 or email me at modonohue@thedoctors.com.

Very truly yours,

Michael O'Donohue

Michael O'Donohue
Vice President
Regulatory Compliance

Neuman, Gayle

From: O'Donohue, Michael [MODonohue@thedoctors.com]
Sent: Tuesday, August 23, 2011 2:02 PM
To: Neuman, Gayle
Subject: The Doctors Company - Rate/Rule Filing #2011-IL-01

Dear Ms. Neuman:

The filing as amended was implemented effective July 1, 2011.

If you have any additional questions, please feel free to contact me.

Michael O'Donohue
Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, August 23, 2011 6:23 AM
To: O'Donohue, Michael
Subject: The Doctors Company - Rate/Rule Filing #2011-IL-01

Mr. O'Donohue,

The Department of Insurance has now completed its review of the filing referenced above. Originally, Doctors Company requested the filing be effective July 1, 2011. Was the filing put in effect on July 1, 2011 or do you wish to have a different effective date?

Your prompt response is appreciated.

Gayle Neuman

Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE DESTROY IT AND NOTIFY US BY SENDING AN E-MAIL TO: GAYLE.NEUMAN@ILLINOIS.GOV.

Confidentiality Notice: This message and any attachments hereto may contain confidential and privileged communications or information and/or attorney client communications or work-product protected by law. The information contained herein is transmitted for the sole use of the intended recipient(s). If you are not the intended recipient or designated agent of the recipient of such information, you are hereby notified that

any use, dissemination, copying or retention of this e-mail or the information contained herein is strictly prohibited and may subject you to penalties under federal and/or state law. If you received this e-mail in error, please notify the sender immediately and permanently delete this e-mail.

Form (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective **July 1, 2011**

	(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1.	Automobile Liability		
	Private Passenger		
	Commercial		
2.	Automobile Physical Damage		
	Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other **Medical Malpractice** (Line of Insurance)	**$2,246, 836**	**-21.8%**

Does filing only apply to certain territory (territories) or certain classes? If so, specify:
Rate level impact varies by territory/class Physicians, Surgeons & Ancillary Healthcare

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
Rate and Rule Revision including but not limited to: (1) revised manual rates (including new and revised specialty classes and territories), (2) revised extended reporting period coverage rules, (3) revised separate and shared limit business entity coverage premium charges (4) new and revised deductible discounts, (5) revised increased limits factors, (6) revised claims-free discount, (7) revised Schedule Rating Plan and revised Imposed Surcharges, (8) new Experience Rating Plan and (9) elimination of group size discounts

* Adjusted to reflect all prior rate changes.
** Change in Company's premium level which will result from application of new rates.

FILING# 2011-IL-01

RECEIVED
JUN 17 2011
STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

The Doctors Company, an Interinsurance Exchange
Name of Company

Michael O'Donohue

Michael O'Donohue-Vice President
Official - Title

H29219D

Form (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective **July 1, 2011**

(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1. Automobile Liability		
Private Passenger		
Commercial		
2. Automobile Physical Damage		
Private Passenger		
Commercial		
3. Liability Other Than Auto		
4. Burglary and Theft		
5. Glass		
6. Fidelity		
7. Surety		
8. Boiler and Machinery		
9. Fire		
10. Extended Coverage		
11. Inland Marine		
12. Homeowners		
13. Commercial Multi-Peril		
14. Crop Hail		
15. Other **Medical Malpractice** Line of Insurance	**$2,246, 836**	**-21.6%**

Does filing only apply to certain territory (territories) or certain classes? If so, specify:
Rate level impact varies by territory/class Physicians, Surgeons & Ancillary Healthcare

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
Rate and Rule Revision including but not limited to: (1) revised manual rates (including new and revised specialty classes and territories), (2) revised extended reporting period coverage rules, (3) revised separate and shared limit business entity coverage premium charges (4) new and revised deductible discounts, (5) revised increased limits factors, (6) revised claims-free discount, (7) revised Schedule Rating Plan and revised Imposed Surcharges, (8) new Experience Rating Plan and (9) elimination of group size discounts

* Adjusted to reflect all prior rate changes.
** Change in Company's premium level which will result from application of new rates.

The Doctors Company, an Interinsurance Exchange
Name of Company

Michael O'Donohue

Michael O'Donohue-Vice President
Official - Title

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APR 19 2011
STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

H29219D

Form (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective **July 1, 2011**

(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1. Automobile Liability		
Private Passenger		
Commercial		
2. Automobile Physical Damage		
Private Passenger		
Commercial		
3. Liability Other Than Auto		
4. Burglary and Theft		
5. Glass		
6. Fidelity		
7. Surety		
8. Boiler and Machinery		
9. Fire		
10. Extended Coverage		
11. Inland Marine		
12. Homeowners		
13. Commercial Multi-Peril		
14. Crop Hail		
15. Other **Medical Malpractice** Line of Insurance	**$2,246, 836**	**-21.6%**

Does filing only apply to certain territory (territories) or certain classes? If so, specify:
Rate level impact varies by territory/class

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
Rate and Rule Revision

* Adjusted to reflect all prior rate changes.
** Change in Company's premium level which will result from application of new rates.

RECEIVED
MAR 14 2011
STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

The Doctors Company, an Interinsurance Exchange
Name of Company

Michael O'Donohue

Michael O'Donohue-Vice President
Official - Title

H29219D

THE DOCTORS COMPANY,
An Interinsurance Exchange

Certification

The Doctors Company has adopted the manual rates of American Physicians Assurance Corporation without any substantial changes. When the rates of American Physicians Assurance Corporation were last filed with the Department of Insurance, they were certified by Kevin Dyke FCAS, a qualified actuary and officer of American Physicians Assurance Corporation. Having completed a review of the analysis performed by Kevin Dyke, we certify that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. While the adoption of the rates of American Physicians Assurance Corporation results in a considerable overall rate reduction for insureds of The Doctors Company, we do not believe this to be an unreasonable outcome as the experience of American Physicians Assurance Corporation is far more voluminous than the limited experience of The Doctors Company, and as such, is believed to be more reliable for ratemaking purposes.

David Preimesberger
Treasurer

Dana Embree, F.C.A.S.
Actuary

THE DOCTORS COMPANY,
An Interinsurance Exchange

Certification

The Doctors Company has adopted the manual rates of American Physicians Assurance Corporation without any substantial changes. When the rates of American Physicians Assurance Corporation were last filed with the Department of Insurance, they were certified by Kevin Dyke FCAS, a qualified actuary and officer of American Physicians Assurance Corporation. At this time, we have assumed that these rates remain appropriate, but we have not yet performed our own review of the rates.

David Preimesberger.
Treasurer

Dana Embree, F.C.A.S.
Actuary

THE DOCTORS COMPANY,
An Interinsurance Exchange

Actuarial Certification

The Doctors Company has adopted the manual rates of American Physicians Assurance Corporation without any substantial changes. When the rates of American Physicians Assurance Corporation were last filed with the Department of Insurance, they were certified by Kevin Dyke FCAS, a qualified actuary and officer of American Physicians Assurance Corporation. At this time, we have assumed that these rates remain appropriate, but we have not yet performed our own review of the rates.

Dana Embree, F.C.A.S.
Assistant Vice President, Actuary

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only	
	a. Date the filing is received:	
	b. Analyst:	
	c. Disposition:	
	d. Date of disposition of the filing:	
	e. Effective date of filing:	
	New Business	
	Renewal Business	
	f. State Filing #:	
	g. SERFF Filing #:	
	h. Subject Codes	

3.	Group Name	Group NAIC #
	The Doctors Insurance Group	831

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	The Doctors Company, An Interinsurance Exchange	California	831-34495	95-3014772	

5.	Company Tracking Number	

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Michael O'Donohue 185 Greenwood Rd, Napa, CA 94558	Vice President	(800) 421-2368 Ext. 1318	707-226-0162	modonohue@thedoctors.com

7.	Signature of authorized filer	Michael O'Donohue
8.	Please print name of authorized filer	Michael O'Donohue

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	11.1 Medical Malpractice-Claims-Made Only			
10.	**Sub-Type of Insurance (Sub-TOI)**	11.1000 Medical Malpractice Sub-TOI Combinations			
11.	**State Specific Product code(s)**(if applicable)[See State Specific Requirements]	Commercial			
12.	**Company Program Title** (Marketing title)	Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program			
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☒ Rates/Rules ☐ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)			
14.	**Effective Date(s) Requested**	New:	July 1, 2011	Renewal:	July 1, 2011

Property & Casualty Transmittal Document---

15.	**Reference Filing?**	☐ Yes ☒ No
16.	**Reference Organization** (if applicable)	Not Applicable
17.	**Reference Organization # & Title**	Not Applicable
18.	**Company's Date of Filing**	March 11, 2011
19.	**Status of filing in domicile**	☒ Not Filed ☐ Pending ☐ Authorized ☐ Disapproved

20.	**This filing transmittal is part of Company Tracking #**	2011-IL-01

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
Rate and Rule Revision

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	2011-IL-01
2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	SERFF Filing No. DCTR-126981567 Company Filing No. 2011-IL-MPL01

☐ Rate Increase ☒ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
The Doctors Company	N/A	-21.6%	-$485,317	150	$2,246, 836	+6.5%	-78.4%

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a.	**Overall percentage rate indication (when applicable)**		
5b.	**Overall percentage rate impact for this filing**		
5c.	**Effect of Rate Filing – Written premium change for this program**		
5d.	**Effect of Rate Filing – Number of policyholders affected**		

6.	**Overall percentage of last rate revision**	+5.0%
7.	**Effective Date of last rate revision**	January 1, 2006- new March 1, 2006-renewal
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

9.	Rule # or Page # Submitted for Review	Replacement or Withdrawn?	Previous state filing number, if required by state
01	Rules and Rates Manual Pages 1-28 (3-06)	☐ New ☐ Replacement ☒ Withdrawn	2005-IL-01
02	Countrywide General Rules Pages Pages GR-1 to GR-13 (1-09)	☒ New ☐ Replacement ☐ Withdrawn	Not Applicable
03	Illinois General Rules Exception Pages Pages IL-E-1 to IL-E-8 (7-11)	☒ New ☐ Replacement ☐ Withdrawn	Not Applicable

04	Illinois Rate Pages Pages IL-R-1 to IL-R-3 (7-11)	☒ New ☐ Replacement ☐ Withdrawn	Not Applicable
05	Appendix-Illinois General Rules Exception Pages Pages IL-A-1 to IL-A-8 (7-11)	☒ New ☐ Replacement ☐ Withdrawn	Not Applicable

The Doctors Company, an Interinsurance Exchange
Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability

Explanatory Memorandum

This filing proposes the following changes to current Illinois rates and rules for physicians, surgeons and ancillary healthcare providers professional liability:

- adoption of $1,000,000/$4,000,000 manual rates (including territory definitions) filed and implemented by American Physicians Assurance Corporation (APAC) (a TDC subsidiary company) effective March 1, 2010 (See Section 3-Pages IL-R-1 to IL-R-3 of Countrywide Rules and Rates Manual). For purposes of display in the Rules and Rates Manual, these rates have been adjusted to a $1,000,000/$3,000,000 basis. Manual rates have been eliminated for all specialty classes where APAC currently writes no business.

- introduction of manual rates for Chiropractic, Podiatry (No Surgery) and Podiatry (Surgery) (See Section 3-Pages IL-R-1 to IL-R-3 of Countrywide Rules and Rates Manual)

  These rates are identical to the separate limit ancillary rates filed and implemented by APAC effective March 1, 2010.

- adoption of current APAC increased limits factors for limits lower than $1,000,000/$4,000,000 (See Section 3-Page IL-R-3 of Countrywide Rules and Rates Manual).

  Before adjusting to $1,000,000/$3,000,000 basis, these factors are identical to those filed and implemented by APAC effective March 1, 2010.

- separate and shared limit rate relativities for all ancillaries have been revised (See Section 2-Page IL-E-3 and Section 3-Page IL-R-3 of Countrywide Rules and Rates Manual). Ancillary premium charges for Chiropractors, Podiatrists and Psychologists have been eliminated.

  These relativities are identical to those filed and implemented by APAC effective March 1, 2010.

- ancillary premium charges for Purfusionists have been introduced (See Section 2-Page IL-E-3 and Section 3-Page IL-R-3 of Countrywide Rules and Rates Manual)

- extended reporting period coverage rules have been revised (See Section 1-Pages GR-4 and GR-5 and Section 2-Pages IL-E-1 and IL-E-2 of Countrywide Rules and Rates Manual). An appropriate state amendatory policy endorsement reflecting these changes has been submitted via SERFF in a separate filing.

  The premium for Extended Reporting Period (ERP) Coverage will now be based on the annual premium in effect on the termination date of the coverage. In

addition, the free ERP Coverage retirement benefit may now be exercised at any age if Named Insured has been continuously insured under a medical professional policy for 5 years and continuously insured by TDC for at least one year. Our previous rules allowed free retirement benefits at age 55 and required the Named Insured to be continuously insured by TDC for at least 5 years. We have also incorporated new rules addressing how the free ERP Coverage retirement benefit is impacted if the insured returns to the practice of medicine after retiring or being on permanent disability.

- "sizable risk rating" rule has been introduced (See Section 2-Page IL-E-2 of Countrywide Rules and Rates Manual)

- minimum premiums have been revised (See Section 2-Page IL-E-3 of Countrywide Rules and Rates Manual).

- "Slot" Position Rating has been introduced (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual). Appropriate optional policy endorsements reflecting this change have been submitted via SERFF in a separate filing.

- separate and shared limit business entity coverage premium charges have been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual)

  We have reduced the separate limit charge from 15% to 10%. We have also reduced the current 4% shared limit charge to an "up to 2%" charge. This change provides the Company with flexibility to apply a charge commensurate with the exposure presented by the individual entity.

- quarterly minimum premium of $750 for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual).

  This change was made based on underwriting judgment. The auxiliary physician product feature is used for rating physician exposure on an hourly basis. Without a minimum, the rating can result in a premium that is insufficient for the cost of issuance and maintenance. TDC currently writes no auxiliary healthcare professionals in Illinois.

- Prep ("new to practice") discounts have been revised for new business only. Where applicable, current prep discounts will be "grandfathered" for existing insureds (See Section 1-Page GR-11 of Countrywide Rules and Rates Manual).

- claims-free discount has been revised from 12.5% to 15% (See Section 2-Pages IL-E-3 and IL-E-4 of Countrywide Rules and Rates Manual)

- risk management discount rule has been introduced (See Section 2-Page IL-E-4 of Countrywide Rules and Rates Manual)

- current deductible discounts have been revised and additional deductible options introduced (See Section 2-Pages IL-E-4 and IL-E-5 of Countrywide Rules and Rates Manual).

  These deductible discounts are identical to those currently on file for American Physicians Assurance Corporation (APAC). No TDC Illinois insureds currently purchase any deductible option.

- Schedule Rating Plan has been revised (See Section 2-Pages IL-E-5 and IL-E-6 of Countrywide Rules and Rates Manual).

  The maximum schedule rating debit/credit available under the Plan has been reduced from +/-40% to +/-25%. Schedule rating credits/debits for Loss Control/Loss Management have been eliminated.

- 9-Pay Plan introduced as premium payment option (See Section 2-Page IL-E-7 of Countrywide Rules and Rates Manual)

- Experience Rating Plan has been introduced (See Section 2-Pages IL-E-7 and IL-E-8 of Countrywide Rules and Rates Manual).

- various point values for imposed surcharges have been revised (See Appendix-Illinois General Rules Exception Pages).

- group size discount rule has been eliminated

- All other rating rule changes are strictly of an editorial nature with no intended substantive change.

Mamoottile, Neetha

From: DOI.MedMal
Sent: Thursday, May 19, 2011 3:43 PM
To: 'O'Donohue, Michael'
Cc: Embree, Dana
Subject: RE: ILDOI - The Doctors Company - Rate Filing #2011-IL-01

Mr. O'Donohue,

Upon search of our records, we are unable to find a biographical affidavit for Mr. Preimesberger. Please submit a biographical affidavit for Mr. Preimesberger to the address listed below.

Ms. Amy Trader
Illinois Department of Insurance
320 W. Washington St,
Springfield, IL 62767

Thank You,
Neetha Mamoottile

From: O'Donohue, Michael [mailto:MODonohue@thedoctors.com]
Sent: Thursday, May 19, 2011 11:38 AM
To: DOI.MedMal
Cc: Embree, Dana
Subject: ILDOI - The Doctors Company - Rate Filing #2011-IL-01

In response to your May 13, 2011 letter regarding the captioned filing, enclosed is a revised certification. Proper biographical affidavit documentation for Mr. Preimesberger is on file with your Department.

If you have any additional questions, please feel free to contact me.

Michael O'Donohue
Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

From: DOI.MedMal [mailto:DOI.MedMal@Illinois.gov]
Sent: Friday, May 13, 2011 8:00 AM
To: O'Donohue, Michael
Subject: ILDOI - The Doctors Company - Rate Filing #2011-IL-01

Mr. O'Donohue,

Please refer to the attached document regarding the incomplete certification for The Doctors Company. We expect a response no later than May 20, 2011.

If you have any questions, you can email me at DOI.MedMal@illinois.gov or call at 217-557-1397.

Sincerely,

Neetha M. Mamoottile
Actuarial Analyst
Illinois Department of Insurance

DOI.MedMal@illinois.gov
217-557-1397

Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

May 13, 2011

Michael O'Donohue
The Doctors Company
185 Greenwood Road
P.O. Box 2900
Napa, CA
[Delivered via email to MODonohue@thedoctors.com]

Subject: ILDOI – The Doctors Company – Rate Filing #2011-IL-01

Mr. O'Donohue,

Ms. Dana Embree, has signed the certification accompanying the subject filing as both the Actuary and Assistant Vice President of The Doctors Company. The intent of the law is to have two separate people certify a rate filing.

According to Section 155.18(c)(3) of Illinois Insurance Code (215 ILCS 5/155.18(c)(3)), medical malpractice rate filings "shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience."

In addition, pursuant to Section 155.04(2) of the Illinois Insurance Code (215 ILCS 5/155.04(2)), all companies licensed to transact insurance business in Illinois must notify the Director within 30 days of the appointment or election of any new officers or directors. Section 915.40 of the Illinois Administrative Code (50 Ill. Adm. Code 915.40) further stipulates biographical affidavits of newly elected or appointed officers must be filed within 30 days after the person's election or appointment.

The subject filing is considered incomplete until the following requirements are met;

1. Two separate individuals certify the rate filing.
2. An authorized officer certify the rate filing with proper biographical affidavit documentation.

We expect to receive a response no later than May 20, 2011.

Sincerely,

Neetha M. Mamoottile
Illinois Department of Insurance
Casualty Actuarial Section
217-557-1397

Neuman, Gayle

From: O'Donohue, Michael [MODonohue@thedoctors.com]
Sent: Tuesday, April 19, 2011 4:20 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #2011-IL-01
Attachments: Summary Sheet (RF-3).pdf; ATT00001.txt

Dear Ms. Neuman:

Enclosed is a revised Summary Sheet (RF-3). We apologize for the inconvenience.

Michael O'Donohue
Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, April 19, 2011 12:08 PM
To: O'Donohue, Michael
Subject: RE: Rate/Rule Filing #2011-IL-01

Mr. O'Donohue,

I do not see a revised RF-3 attached to your response. Please forward at your earliest convenience.

Gayle Neuman
Illinois Department of Insurance
(217)524-6497

From: O'Donohue, Michael [mailto:MODonohue@thedoctors.com]
Sent: Tuesday, April 19, 2011 10:31 AM
To: Neuman, Gayle
Cc: Fleming, Bill; Embree, Dana; Edgington, Patty
Subject: Rate/Rule Filing #2011-IL-01

Dear Ms. Neuman:

In response to your April 8th and April 11th emails below regarding the captioned filing, we offer the following:

1) We have enclosed the required Actuarial Certification. It was inadvertently omitted from our original filing. We apologize for the inconvenience.

2) Effective January 1, 2008, The Doctors Company began reporting statistical data for its Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program to Insurance Services Office (ISO). Prior to this date, statistical data was reported to the National Independent Statistical Service (NISS).

3) We have enclosed a revised Summary Sheet (RF-3) which includes a more detailed description of our rate and rule revision. Approximately 600 policies with extended reporting period coverage are currently in effect.

4) The risk management "range of discount" approach used is consistent with the rule approved for American Physicians Assurance Corporation (APAC) in their rate and rule filing effective March 1, 2010. My understanding is your Department

requested that APAC eliminate any risk management impact from their Schedule Rating Plan and file a separate more objective risk management rule. We can discuss further if you like.

5) Extended reporting coverage, when issued, is for an unlimited duration whether the coverage was purchased or the premium waived in the event of death, disability or retirement. A condition of issuing extended reporting coverage in the event of retirement is the complete and permanent retirement from the practice of medicine. We have had physicians, particularly through the financial crisis, who came out of retirement and returned to work. In such situations, our previous rules required the physician to pay the full cost of extended reporting coverage. As an accommodation, we developed this rule to allow no charge if the return to practice was within two years, and a step down of premium for more than two years. The two year mark was selected because 1) maintenance of clinical competence/patient safety is assured, and 2) the largest portion of the tail exposure is eroded in the first two years and tapers off thereafter. We would prefer to maintain this rule in Illinois as we have the same rule in other states However, we could revert back to the prior rule if required.

6. The exposure presented by an entity varies based on the type of practice, number of employees, number of locations, and other factors. To reflect the proper premium commensurate with the exposure, we use a range of zero to two percent. For example, an anesthesia group with an entity covered on a shared basis presents no additional exposure to the company in covering the entity. Conversely, in a cosmetic practice with multiple employees, additional patients are being seen and procedures performed, resulting in increase in exposure to the entity. If those employees perform more invasive procedures, such as advanced lasers or chemical peels, the exposure is enhanced.

7) As set forth on Pages IL-E-4 and IL-E-5 of the Illinois General Rules Exception Pages, the deductible applies to damages and claims expenses. Once the deductible has been exhausted, all other claims expenses will be paid in addition to the limits of liability.

8) The Imposed Surcharges rule provides includes objective criteria for addressing a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard. Surcharges of up to 400% can be applied under this rule. Since Schedule Rating Plan debits are limited to 25%, less severe claim severity/frequency issues are typically addressed under Schedule Rating. Imposed surcharges do not apply when a particular account is subject to Experience Rating. In addition, the claims-free discount does not apply when imposed surcharges are used.

9) “Incident” basis and “demand” basis represent two different coverage triggers for our filed claims-made policy. "Incident" basis coverage is provided under our basic policy form (MPL001 (11-04)) previously approved by your Department. At the request of the insured, "demand" basis coverage may be added by attaching previously approved Endorsement MPL223 (11-04)-Asserted Claims Only ("Demand Trigger"). For reference purposes, enclosed is a copy of this endorsement.

10) The territory relativities are as follows:

Territory A – 1.000
Territory B – 0.930
Territory C – 0.820
Territory D – 0.620
Territory E – 0.730
Territory F – 0.505
Territory G – 0.470

If you have any additional questions, please feel free to contact me.

THE DOCTORS COMPANY

Michael O'Donohue
Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

Neuman, Gayle

From: O'Donohue, Michael [MODonohue@thedoctors.com]
Sent: Tuesday, April 19, 2011 10:31 AM
To: Neuman, Gayle
Cc: Fleming, Bill; Embree, Dana; Edgington, Patty
Subject: Rate/Rule Filing #2011-IL-01
Attachments: Actuarial Certification.pdf; MPL223 (11-04)-Asserted Claims Only (Demand Trigger).pdf; ATT00001.txt

Dear Ms. Neuman:

In response to your April 8th and April 11th emails below regarding the captioned filing, we offer the following:

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7) As set forth on Pages IL-E-4 and IL-E-5 of the Illinois General Rules Exception Pages, the deductible applies to damages and claims expenses. Once the deductible has been exhausted, all other claims expenses will be paid in addition to the limits of liability.

8) The Imposed Surcharges rule provides includes objective criteria for addressing a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard. Surcharges of up to 400% can be applied under this rule. Since Schedule Rating Plan debits are limited to 25%, less severe claim severity/frequency issues are typically addressed under Schedule Rating. Imposed surcharges do not apply when a particular account is subject to Experience Rating. In addition, the claims-free discount does not apply when imposed surcharges are used.

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Territory C – 0.820
Territory D – 0.620
Territory E – 0.730
Territory F – 0.505
Territory G – 0.470

If you have any additional questions, please feel free to contact me.

THE DOCTORS COMPANY
Michael O'Donohue
Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, April 11, 2011 5:39 AM
To: O'Donohue, Michael
Subject: RE: Rate/Rule Filing #2011-IL-01

Mr. O'Donohue,

To clarify question 7, if an insured has not chosen the Defense Within Limits of Liability Discount, would the insured's deductible apply to claim expenses (instead of just applying to damages)? Please explain.

Gayle Neuman
Illinois Department of Insurance
(217)524-6497

From: O'Donohue, Michael [mailto:MODonohue@thedoctors.com]
Sent: Friday, April 08, 2011 1:10 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #2011-IL-01

Dear Ms. Neuman:

I am receipt of your April 21, 2011 email below and a response will be submitted on or before April 20th At your convenience, please provide clarification with respect to Question 7.

If you have any additional questions, please feel free to contact me. Thanks.

THE DOCTORS COMPANY
Michael O'Donohue
Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, April 08, 2011 9:09 AM
To: O'Donohue, Michael
Subject: Rate/Rule Filing #2011-IL-01

Mr. O'Donohue,

I am in receipt of the above referenced filing submitted with your cover letter dated March 11, 2011. Please respond to the following questions/issues:

1. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This information is required in every rate/rule filing for medical malpractice.

2. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

3. The RF-3 Summary Sheet should include a description of the changes (added three territories, changes to scheduled rating, classifications) that affected the rates being charged. How many extended reporting period policies are currently in effect.

4. The extended reporting period is unlimited. Therefore, please explain why coverage for someone who returns to practice medicine from retirement within 2 years vs. within 2 years and a month would be handled differently.

5. Under III. Additional Coverages, B. Entities – please explain what causes the range of 0 to 2% for shared limits.

6. Under IV. Discounts/Surcharges, D. Risk Management Discount, please explain for each of 1 through 3 how it is determined if the discount is 0 or 2% or 5%.

7. If an insured has not chosen the Defense Within Limits of Liability Discount, would Medical Protective all the deductible discount for claim expenses? Please explain.

8. The Imposed Surcharges are to address extraordinary claims frequency or severity. Please explain how this varies from how it is addressed in the schedule rating plan, claims-free discount and the experience rating plan.

9. Are "incident" basis and "demand" basis suppose to represent claims-made and occurrence? Please explain.

10. I request the territory factors for the seven territories used.

I request receipt of your response by April 20, 2011.

Gayle Neuman

Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE DESTROY IT AND NOTIFY US BY SENDING AN E-MAIL TO: GAYLE.NEUMAN@ILLINOIS.GOV.

Confidentiality Notice: This message and any attachments hereto may contain confidential and privileged communications or information and/or attorney client communications or work-product protected by law. The information contained herein is transmitted for the sole use of the intended recipient(s). If you are not the intended recipient or designated agent of the recipient of such information, you are hereby notified that any use, dissemination, copying or retention of this e-mail or the information contained herein is strictly prohibited and may subject you to penalties under federal and/or state law. If you received this e-mail in error, please notify the sender immediately and permanently delete this e-mail.

THE DOCTORS COMPANY

THIS ENDORSEMENT CHANGES YOUR POLICY—PLEASE READ IT CAREFULLY.

First Named Insured:	
Policy Number:	
Additional Premium:	Return Premium:
Endorsement Effective Date:	Date Issued:

ASSERTED CLAIMS ONLY
("DEMAND TRIGGER")

In consideration of the premium charged, **your** Policy is amended as follows:

1. Policy **Section III: When This Policy Will Respond**, is deleted and replaced with the following:

Claims are covered under this Policy only if and when:

1. The *Claim* arises from a *Professional Services Incident or Review Incident* that takes place:

   i. in the *Covered Territory;* and

   ii. entirely on or after the *Retroactive Date;* and

   iii. prior to the termination date of this Policy; and

2. **We** receive a *Claim Report* from **you** during this *Policy Period.*

This Policy will respond only once to a *Claim* on behalf of each Protected Party. If **we** receive a *Claim Report* during this *Policy Period*, then all subsequent related *Claims*, at any time, of any nature, by anyone, are related back to and deemed part of the first *Claim* reported to **us**.

If **we** receive a *Claim Report* during this *Policy Period* from one Protected Party, this Policy will not respond on behalf of any other Protected Party unless **we** also receive a *Claim Report* from such other Protected Party during this *Policy Period.*

2. Policy **Section VI: Exclusions, item b**, is deleted and replaced with the following:

b. Liability for any:

1. *Claim* made against **you** prior to the Effective Date of this Policy;

2. *Claim* or *Probable Claim Event* of which **we** or any other insurer were informed prior to the Effective Date of this Policy; or

3. act, omission, Incident, circumstance, or *Probable Claim Event* that does not meet the definition of *Claim.*

3. Policy **Section VII: Definitions, items a** and **b**, are deleted and replaced with the following:

   a. ***Claim*** means a written demand for payment of damages or for services, or *Suit* seeking damages, arising from a *Professional Services Incident* or *Review Incident* that is not otherwise excluded by the terms and conditions of this Policy.

   b. ***Claim Report*** means **your** written communication received at **our** offices that notifies **us** of **your** receipt of a *Claim* made against **you** by or on behalf of a party alleging injury or damages.

ALL OTHER TERMS, CONDITIONS, AND LIMITATIONS CONTAINED IN YOUR POLICY REMAIN THE SAME.

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

APPENDIX-ILLINOIS GENERAL RULES EXCEPTION PAGES

IV. DISCOUNTS/SURCHARGES

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

Eligibility-New Business

In lieu of declining a risk, the following surcharges may be applied for a risk that does not meet the minimum underwriting guidelines established for the Company.

Eligibility-Renewal Business

In lieu of nonrenewing a risk, the following surcharges may be applied for:

1. a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. a risk for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established for the Company

Subject to the point ranges set forth on the Points Evaluation Worksheet, surcharges of 20% to 400% will be applied as a percentage of premium. With the exception of part-time and claims-free discounts, all rating discounts apply. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

All $2 million/$5 million rates will be surcharged by an additional 5.5%. Limits above $2 million/$5 million are not available.

POINTS SCHEDULE

CLAIMS WITHIN THE LAST 10 YEARS FROM DATE OF REPORT

	Points
A. Frequency and Severity Claims Schedule	Total Points From Schedule
B. No claims reported in the past five full years.	-100
DRUG OR ALCOHOL IMPAIRMENT – HEALTH	
A. Has experienced drug, alcohol, or mental illness problems more than 5 years ago.	50
B. Has experienced drug, alcohol, or mental illness problems within the past 5 years.	75

C. Currently in treatment for unresolved substance abuse.	150
D. Any relapse within the past 5 years.	150
E. Physical or mental impairment that impacted physician's ability to practice medicine safely.	100

GOVERNMENT AGENCY ACTIONS

A. Medical license in any state has been revoked.	150
B. Medical license in any state has been suspended.	100
C. Medical license has been placed on probation with restrictions on the type of services he or she can provide.	75
D. Medical license has been placed on probation for more than 5 years.	75
E. Medical license has been placed on probation for 1 to 5 years.	50
F. Medical license is under investigation.	40
G. Public letter of reprimand, fine, citation, etc.	50
H. Failure to report license investigation as required by affirmative duty language in policy	50

Note: Items A, B, C, D, E, F, G and H – only applies per occurrence – i.e., highest point value.

I. During the preceding 5 years, DEA license has been revoked suspended, or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician.	100
J. Has been convicted or indicted of a criminal act, or has been found to be in violation of a civil statute, per occurrence.	
Medically related:	
Within 5 years	100
More than 5 years	50
Not medically related:	
Within 5 years	50
More than 5 years	25
K. Medicare/MediCal/Medicaid investigation	40
L. Loss of Medicare/MediCal/Medicaid privileges	50
M. Loss of any health insurance provider privileges	50

INAPPROPRIATE PATIENT CONTACT

A. Proven with a single patient.	75
B. Proven with more than one patient.	150
C. Alleged with one or more patients.	50

MEDICAL EDUCATION

A. Attended more than one medical school or a residency program due to actual or planned disciplinary action.	50
B. Residency completed at two or more facilities.	50
C. Started, but did not complete, a full residency program.	50
D. Did not begin a residency.	50
E. Has never received board certification	50

MEDICAL RECORDS

A. Records alterations with material change and intent.	150
B. Records alterations not a material change to records, just cleaning up.	25
C. Generally poor record keeping.	50

INFORMED CONSENT

A. Incomplete consent obtained.	25
B. Lack of Informed Consent.	50

PRIVILEGES - ANY STATE
(Hospital, Surgery Center, etc.)

A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per occurrence).	50
B. Privileges have been suspended in the past 10 year s (per occurrence).	100
C. Privileges have been revoked in the past 10 years (per occurrence).	150
D. Has unexplained changes in privileges (per occurrence).	25
E. Has been notified by facility of its intent to:	
Restrict privileges	30
Suspend privileges	50
Revoke privileges	100
Note: Only applies per occurrence-i.e. highest point value	
F. No privileges at any facility.	100

G. Currently undergoing peer review.	75
H. Notice of peer review received.	50

PROCEDURES

A. Is performing a medical procedure that is considered experimental but not directly dangerous.	15
B. Is performing a medical procedure that is in violation of policy exclusions.	50
C. Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E. Is performing a procedure(s) outside his/her medical specialty.	100
F. Is performing high risk procedures within his/her medical specialty	100

PATIENT SAFETY/RISK MANAGEMENT

A. Mandatory patient safety/risk management previously recommended and insured did not comply.	100
B. Mandatory patient safety/risk management previously recommended and insured had initial compliance but no follow through.	75

GAPS IN MEDICAL PRACTICE

A. Gaps in medical practice of 3-6 months' duration.	50
B. Gaps in medical practice of 6-8 months' duration.	100
C. Gaps in medical practice greater than 8 months	150

PAYMENT HISTORY

A. Two or more late payments within the last three years.	100
B. Two or more cancellations for non-payment of premium within the last three years.	150

OTHER

A. Uncooperative in Claims Handling	75
B. Patient Load:	
For Surgeons, 61-99 patients per week	50
For Surgeons, 100 or more patients per week	100
For all others, 101-149 patients per week	50
For all others, 150 or more patients per week	100

C. Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio	25
D. Uses collection agency that can file suit without insured's written consent.	25
E. Previous insurance history (bare, insolvent prior insurer or nonrenewed).	100
F. Claim experience of Associates, Partners or Corporation:	
If one member with claim(s)	75
If more than one member with claim(s)	100
Favorable experience of group as a whole	-150
G. For each claim or suit in which the physician breached the standard of care:	
Mixed Reviews	50
All Negative Reviews	100
Admitted or Clear Liability	100
H. For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I. Claim is too early in discovery period:	
Surgical Class	-100
Non-Surgical Class	-50
J. For each claim or suit in which expert reviewers state the insured met the standard of care:	
Surgical Class	-150
Non-Surgical Class	-100
K. High risk surgical patient selection.	150
L. Reinstatement of nonrenewal due to company election	150
M. Loss Ratio in excess of 500%.	150
N. Loss Ratio less than 100%.	-100
O. Discrepancies between application answers/documents and verification	150

Frequency and Severity Claims Schedule

Insured: _____ **Policy #:** _____

Effective Date: _____ **Review Date:** _____

Claims Without Indemnity

ALAE From:	ALAE To:	Claim Score
$ 5,001	$ 25,000	1
$ 25,001	$ 50,000	2
$ 50,001	$ 100,000	3
$ 100,001	& up	4

Claims <u>With</u> Indemnity

Indemnity + ALAE From:	Indemnity + ALAE To:	Claim Score
$ 1	$ 25,000	4
$ 25,001	$ 50,000	5
$ 50,001	$ 100,000	6
$ 100,001	$ 250,000	7
$ 250,001	$ 500,000	8
$ 500,001	$750,000	9
$ 750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$	$	
Claim # 2		/ /	$	$	$	
Claim # 3		/ /	$	$	$	
Claim # 4		/ /	$	$	$	
Claim # 5		/ /	$	$	$	
Claim # 6		/ /	$	$	$	
Claim # 7		/ /	$	$	$	
Claim # 8		/ /	$	$	$	
Claim # 9		/ /	$	$	$	
Claim # 10		/ /	$	$	$	

Total:

Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties No. of Years w/TDC (1) (2) 0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties * No. of Years w/TDC (1) (2) 0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for <u>each</u> Total Claim Score above 15.

*** Emergency Medicine, General Surgery, Gynecology, Neurosurgery, Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology**

Points Evaluation Worksheet

Insured:_____ Policy #:_____

Renewal Date:_____ Evaluation Date:_____

Criteria	Points
Claims	_____
Drug or Alcohol Impairment - Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges - Any State	_____
Procedures	_____
Risk Management	_____
Gaps In Coverage	_____
Other	_____
TOTAL POINTS	_____

Ranges & Surcharges

0 to 50 points-No surcharge	51 to 90 points-20% surcharge	91 to 130 points-30% surcharge
131 to 170 points-40% surcharge	171 to 210 points-50% surcharge	211 to 250 points-60% surcharge
251 to 280 points-70% surcharge	281 to 300 points-80% surcharge	301 to 325 points-90% surcharge
326 to 350 points-100% surcharge	351 to 370 points-125% surcharge	371 to 390 points-150% surcharge
391 to 410 points-175% surcharge	411 to 430 points-200% surcharge	431 to 450 points-225% surcharge
451 to 470 points-250% surcharge	471 to 490 points-275% surcharge	491 to 510 points-300% surcharge
511 to 530 points-325% surcharge	531 to 550 points-350% surcharge	551 to 570 points-375% surcharge
571 to 590 points-400% surcharge	591 or more points-Nonrenew	

Comments:_____

_____

_____

_____

Completed by:_____ Approved by:_____

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

SECTION 2-ILLINOIS GENERAL RULES EXCEPTION PAGES

I. GENERAL GUIDELINES

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph with the following:

In the event of termination of the policy or a Named Insured's coverage under the policy because of cancellation or non-renewal, Extended Reporting Period Coverage may be purchased in order to cover claims reported after the termination date of the coverage, which are based on incidents which happened on or after the retroactive date and prior to the termination date of the coverage. Extended Reporting Period Coverage provides an unlimited extended reporting period.

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing 1. Premium Calculation and Payment with the following:

1. Premium Calculation and Payment

   The premium for the Extended Reporting Period Coverage is calculated as follows:

   a. If the retroactive date is five or more years before the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the annual premium in effect on the termination date of the coverage.

   b. If the retroactive date is less than five years, but more than nine months prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve months factored pro rata with regard to maturity.

   c. If the retroactive date is nine months or less prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:

      i. One to 30 days .090
      ii. 31-91 days .276
      iii. 92-182 days .520
      iv. 182-273 days .760

   d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date of the coverage.

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement. At the option of the insured, the following three payment plans will be available with no interest or installment charges:

- 1 single payment
- 2 payments billed 12 months apart
- 8 quarterly payments over 2 years

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph of 2. Retirement with the following:

The Company may waive the premium for Extended Reporting Period Coverage if a Named Insured:

a. has permanently and completely retired from the practice of medicine; and

b. has been continuously insured under a medical professional liability policy for the five years immediately preceding the date of retirement; and

c. has been continuously insured with the Company or one of its subsidiaries for at least one year immediately preceding the date of retirement.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must file the rate for this risk with the Illinois Department of Insurance on or before the effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

Rule C. Rating Factors is revised by deleting and replacing 2. Increased Limits Factors with the following:

2. Increased Limits Factors

For all specialties except Chiropractic, the Company offers the following limits of liability: 0.1M/0.4M, 0.25M/1.0M, 0.3M/1.2M, 0.5M/2M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

For Chiropractic only, the Company offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M, 0.25M/0.75M, 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

The applicable increased limits factors are shown on the State Rate Pages.

Rule C. Rating Factors is amended by adding the following to 3. Claims-Made Maturity Year:

NOTE: "Incident" Basis Coverage: This form of claims-made coverage provides coverage for a written demand made against the insured, and allows the policy to be triggered by the report to the Company of an incident that the insured believes may later give rise to a claim.

"Demand" Basis Coverage: This form of claims-made coverage is more restrictive than incident basis coverage, because the policy only responds when the insured reports a written demand for damages or a suit to, and provides no coverage for reported incidents.

Rule D. Minimum Premium-Surgicenters is deleted and replaced with the following:

D. Minimum Premium

Healthcare facility policies are subject to a minimum premium of $2,500. All other policies are subject to a minimum premium of $500.

III. ADDITIONAL COVERAGES

Rule A. Ancillary Healthcare Professionals is deleted and replaced with the following:

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists and Psychologists. These ancillaries share limits of liability with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist
Perfusionist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 50% less than the separate limits of liability rate.

Rule F. Punitive Damages Coverage is deleted.

IV. DISCOUNTS/SURCHARGES

Rule A. Claims-Free Discount is deleted and replaced with the following:

A. Claims-Free Discount

A 15% claims-free discount shall be applied on the effective date of the policy for each Named Insured meeting all of the following criteria:

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective date of the policy.

2. Cumulative outstanding claims reserves (indemnity and allocated loss adjustment expenses) less than $20,000.

3. Cumulative claim payments (indemnity and allocated loss adjustment expenses) less than $10,000 in the last three full years immediately preceding the effective dates of the policy.

If the Named Insured is an insured with the Company less than three full years, the claims-free discount shall also be available if the insured has cumulative outstanding claim reserves less than $20,000 (including no outstanding claims reserves with previous carriers) and cumulative claim payments less than $10,000 in the last three full years immediately preceding the effective date of the policy. In order to receive the discount, the insured must submit acceptable documentation of "claims-free" experience from its previous insurance carriers.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (Physician Assistants, Surgeon Assistants, Certified Nurse Practitioners, etc.) that share limits of liability
- healthcare facilities

Rule D. Risk Management Discount is deleted and replaced with the following:

D. <u>Risk Management Discount</u>

1. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.

2. A risk management discount of up to 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.

3. A risk management discount of up to 10% shall be applied for all Named Insureds that participate in any other risk management program approved by the Company.

Rule E. Deductible Discount is deleted and replaced with the following:

A Named Insured can elect that a deductible apply on a per claim basis. The deductible options are:

a. $5,000 deductible per claim-3% premium discount
b. $10,000 deductible per claim-5% premium discount
c. $25,000 deductible per claim-12% premium discount
d. $50,000 deductible per claim-19% premium discount
e. $100,000 deductible per claim-30% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the $1,000,000/$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. Once the deductible has been exhausted, all

other claims expenses will be paid in addition to the limits of liability. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

Rule F. Defense Within Limits of Liability Discount is deleted.

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

See Appendix-Illinois General Rules Exception Pages

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

Modification Factors	Range of Modifications–Credit/Debit
1) Accreditation/Credentialing	-10% to +10%
2) Laboratory/Radiological Services	0% to +5%
3) Collection Procedural Services	-10% to +10%
4) Pharmacy/Optical Supply Unit	0% to +5%
5) Unusual Risk Characteristics	-25% to +25%
Maximum Credit/Debit for all factors:	**-25% to +25%**

Purpose

This schedule rating plan is intended to allow flexibility in computing premiums for upcoming policy periods where there is a solid underwriting justification for deviating from published rates. The following factors appear in the Company's schedule rating plan and are described briefly to suggest underwriting philosophy and information required for consideration.

1) Accreditation/Credentialing

How does the Named Insured select/credential employees?

What is the overall level of training and experience of the Named Insured's employees?

Is the Named Insured a member of a national organization such as MGMA or AGPA?

Is the entity certified or accredited by AAAHC, ARC, CAP, JCAHO or another recognized credentialing body?

Does the Named Insured have an active medical standards committee, peer review and/or claims review committee?

Does the Named Insured have privileges at a reputable hospital?

2) Laboratory/Radiological Services

Does the Named Insured have these exposures?

Is the equipment up-to-date and well maintained?

Are there appropriately trained ancillary personnel to staff these services?

3) Collection Procedures

Does the Named Insured use a collection service?

Does the service require the signature of the Named Insured before sending a patient to collection?

4) Pharmacy/Optical Supply Unit

Does the Named Insured provide laboratory, radiological, pharmacy, optical services, etc.?

Is the equipment up-to-date and well maintained?

Are there appropriately trained ancillary personnel to staff these services?

5) Unusual Risk Characteristics

Does the Named Insured own, control or staff any medically related enterprise?

Is the paramedical/physician ratio acceptable?

What is the historical attrition rate?

Is the Named Insured subject to any contractual, vicarious or contingent liability exposures?

Is there an arbitration plan in place?

Do any factors exist which minimize direct patient care exposure (e.g. Are all patients seen on a referral basis with other primary care physicians continuing an active involvement?)?

Is there a university affiliation that is likely to benefit the medical knowledge of the Named Insured?

Are the Named Insured and paramedical personnel engaged in continuing medical education?

Note: The Company must maintain complete files of how and why it applied specific Schedule Rating Plan credits/debits and make these files available to the Illinois Department of Insurance upon request. Specific documentation must be included at the inception of new business and upon each anniversary or renewal date of a policy.

The following additional rules are added:

Premium Payment Plans

Full or appropriate partial payment of the annual policy premium is due on or before the effective date of the policy.

At the option of the insured, the following payment plans with no interest or installment charges will be available:

- 1 single payment due on or before the effective date of the policy
- 4 quarterly installment payments of approximately 25% of the annual premium. The initial installment payment is due on or before the effective date of the policy. Additional installment payments are due 3, 6 and 9 months after the effective date of the policy.
- "9-Pay Plan"-15% down payment is due on or before the effective date of the policy. Additional equal installment payments are due 2, 3, 4, 5, 6, 7, 8 and 9 months after the effective date of the policy.

Any additional premium resulting from changes during the policy period must be spread equally over the remaining installment payments. If there are no remaining installment payments, additional premium resulting from changes during the policy period may be billed separately.

Experience Rating Plan

Eligibility

A group of physicians/surgeons is eligible for experience rating subject to a review of the exposure characteristics, a pre-designated minimum manual premium requirement and verification of reliable prior carrier loss and exposure data.

Experience Base

The experience modification is determined from the latest available six report years. If the experience for the full six years is not available, then the total available experience is used subject to a minimum requirement of one complete report year.

The experience period used in generating the modification must end with the year prior to the year in which the experience modification calculation is performed. Loss experience from other companies or self-insurance experience may be used if it is reliable.

Experience Modification Factor

The Experience Modification Factor is calculated in two steps. First, the Expected Loss Based on Experience is credibility-weighted with the Expected Loss Based on Manual Premium to arrive at the Credibility-Weighted Expected Loss. Then the Credibility-Weighted Expected Loss is divided by the Expected Loss Based on Manual Premium to arrive at the Experience Modification Factor.

The Expected Loss Based on Experience is a loss forecast based on the account's own experience. It is calculated by first limiting individual claim indemnities to the basic limit and ALAE on a pro-rata basis, and then trending and developing them to an ultimate, current cost level basis. The total experience period basic limit loss is then divided by the number of Experience Period Exposure Units (base class equivalent) to arrive at a Pure Premium estimate:

Pure Premium = Ultimate Trended Basic Limit Loss / Experience Period Exposure Units.

Losses are trended to six months beyond the policy effective date. The Expected Loss Based on Experience is then found by multiplying the Pure Premium estimate by the Current Exposure Units and an increased limit factor:

Expected Loss Based on Experience = Pure Premium x Current Exposure Units x Increased Limit Factor.

The Expected Loss Based on Manual Premium is determined by calculating the account's manual premium and then multiplying by the Permissible Loss Ratio. The Permissible Loss Ratio is the loss ratio underlying our manual rates. The Credibility-Weighted Expected Loss is then calculated using the following formula:

Credibility-Weighted Expected Loss = [Expected Loss Based on Experience x Credibility Factor] + [Expected Loss Based on Manual Premium x (100% - Credibility Factor)].

Finally, the Experience Modification Factor is calculated using the following formula:

Experience Modification Factor = Credibility-Weighted Expected Loss / Expected Loss Based on Manual Premium -1.00.

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

APPENDIX-ILLINOIS GENERAL RULES EXCEPTION PAGES

IV. DISCOUNTS/SURCHARGES

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

Eligibility-New Business

In lieu of declining a risk, the following surcharges may be applied for a risk that does not meet the minimum underwriting guidelines established for the Company.

Eligibility-Renewal Business

In lieu of nonrenewing a risk, the following surcharges may be applied for:

1. a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. a risk for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established for the Company

Subject to the point ranges set forth on the Points Evaluation Worksheet, surcharges of 20% to 400% will be applied as a percentage of premium. With the exception of part-time and claims-free discounts, all rating discounts apply. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

~~All $2 million/$5 million rates will be surcharged by an additional 5.5%.~~ Limits above $2 million/$5 million are not available.

POINTS SCHEDULE

CLAIMS WITHIN THE LAST 10 YEARS FROM DATE OF REPORT

	Points
A. Frequency and Severity Claims Schedule	Total Points From Schedule
B. No claims reported in the past five full years.	-100
DRUG OR ALCOHOL IMPAIRMENT – HEALTH	
A. Has experienced drug, alcohol, or mental illness problems more than 5 years ago.	50
B. Has experienced drug, alcohol, or mental illness problems within the past 5 years.	75

C. Currently in treatment for ~~unresolved~~ substance abuse. 150

D. Any relapse within the past 5 years. 150

E. Physical or mental impairment that impacted physician's ability to practice medicine safely. 100

GOVERNMENT AGENCY ACTIONS

A. Medical license in any state has been revoked. 150

B. Medical license in any state has been suspended. 100

C. Medical license has been placed on probation with restrictions on the type of services he or she can provide. 100~~75~~

D. Medical license has been placed on probation for more than 5 years. 100~~75~~

E. Medical license has been placed on probation for 1 to 5 years. 75

F. Medical license is under investigation. 50

G. Reprimand, fine, citation, etc. ~~40~~

1) Public letter of reprimand, fine, citation, etc. 50
2) Public letter of reprimand with restrictions and/or mandated courses 100

H. Petition to revoke probation filed 100

I. Failure to report license investigation as required by affirmative duty language in policy 50

Note: Items A, B, C, D, E, F, G, H and I ~~H~~ – only applies per occurrence – i.e., highest point value.

J. During the preceding 5 years, DEA license has been revoked suspended, or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician. 100

K. Has been convicted or indicted of a criminal act, or has been found to be in violation of a civil statute, per occurrence.

1) Medically related:

Within 5 years	100
More than 5 years	50

2) Not medically related:

Within 5 years	50
More than 5 years	25

L. Medicare/MediCal/Medicaid investigation 40

M. Loss of Medicare/MediCal/Medicaid privileges 50

N. Loss of, or current investigation of, ~~any health~~ insurance provider privileges 50

O. Investigation by U.S. Government (Qui Tam, Ricoh, etc.) 50

INAPPROPRIATE PATIENT CONTACT

A. Proven with a single patient. 75

B. Proven with more than one patient. 150

C. Alleged with one or more patients. 50

MEDICAL EDUCATION

A. Attended more than one medical school or a residency program due to actual or planned disciplinary action. 50

B. Residency completed at two or more facilities. 50

C. Started, but did not complete, a full residency program. 50

D. Did not begin a residency. 50

E. Has never received board certification 50

MEDICAL RECORDS

A. Records alterations with material change and intent. 150

B. Records alterations not a material change to records, just cleaning up. 25

C. Generally poor record keeping. 50

INFORMED CONSENT

A. Incomplete consent obtained. 25

B. Lack of Informed Consent. 50

PRIVILEGES - ANY STATE
(Hospital, Surgery Center, etc.)

A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per occurrence). 50

B. Privileges have been suspended in the past 10 years (per occurrence). 100

C. Privileges have been revoked in the past 10 years (per occurrence). 150

D. Has unexplained changes in privileges (per occurrence). 25

E. Has been notified by facility of its intent to:

1) Restrict privileges	30
2) Suspend privileges	50
3) Revoke privileges	100
4) Failure to report changes in privileges	100

Note: Only applies per occurrence-i.e. highest point value

F. No privileges at any facility.	100
G. Currently undergoing peer review.	75
H. Notice of peer review received.	50

PROCEDURES

A. Is performing a medical procedure that is considered experimental but not directly dangerous.	15
B. Is performing a medical procedure that is in violation of policy exclusions.	50
C. Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E. Is performing a procedure(s) outside his/her medical specialty.	100
F. Is performing high risk procedures within his/her medical specialty	100

PATIENT SAFETY/RISK MANAGEMENT

A. Mandatory patient safety/risk management previously recommended and insured did not comply.	100
B. Mandatory patient safety/risk management previously recommended and insured had initial compliance but no follow through.	75

GAPS IN MEDICAL PRACTICE

A. Gaps in medical practice of 3-6 months' duration.	50
B. Gaps in medical practice of 6-8 months' duration.	100
C. Gaps in medical practice greater than 8 months	150

PAYMENT HISTORY

A. Two or more late payments within the last three years.	100
B. Two or more cancellations for non-payment of premium within the last three years.	150

OTHER

A. Uncooperative in Claims Handling	75

B. Patient Load:

1) ~~For~~ Surgeons~~,~~ 61-99 patients per week 50
2) ~~For~~ Surgeons~~,~~ 100 or more patients per week 100
3) All ~~For all~~ others except Surgeons~~,~~ 101-149 patients per week
4) All ~~For all~~ others except Surgeons~~,~~ 150 or more patients per week 50
100

C. Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio 25

D. Uses collection agency that can file suit without insured's written consent. 25

E. Previous insurance history (bare, insolvent prior insurer or nonrenewed). 100

F. Claim experience of Associates, Partners or Corporation:

1) If one member with claim(s) 75
2) If more than one member with claim(s) 100
3) Favorable experience of group as a whole -150

G. For each claim or suit in which the physician breached the standard of care:

1) Mixed Reviews 50
2) All Negative Reviews 100
3) Admitted or Clear Liability 100

H. For two or more claims, suits or incidents arising out of the same or similar procedures or treatments. 50

I. Claim is too early in discovery period:

1) Surgical Class -100
2) Non-Surgical Class -50

J. For each claim or suit in which expert reviewers state the insured met the standard of care:

1) Surgical Class -150
2) Non-Surgical Class -100

K. High risk surgical patient selection. 150

L. Reinstatement of nonrenewal due to company election 150

M. Loss Ratio in excess of 500%. 150

N. Loss Ratio less than 100%. -100

O. Discrepancies between application answers/documents and verification 150

P. Action by specialty association or society (AANS, ACS, etc.) 75

Q. Poor witness capabilities 150

Frequency and Severity Claims Schedule

Insured: _____ **Policy #:** _____

Effective Date: _____ **Review Date:** _____

Claims Without Indemnity

ALAE From:	ALAE To:	Claim Score
$ 5,001	$ 25,000	1
$ 25,001	$ 50,000	2
$ 50,001	$ 100,000	3
$ 100,001	& up	4

Claims With Indemnity

Indemnity + ALAE From:	Indemnity + ALAE To:	Claim Score
$ 1	$ 25,000	4
$ 25,001	$ 50,000	5
$ 50,001	$ 100,000	6
$ 100,001	$ 250,000	7
$ 250,001	$ 500,000	8
$ 500,001	$750,000	9
$ 750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$	$	
Claim # 2		/ /	$	$	$	
Claim # 3		/ /	$	$	$	
Claim # 4		/ /	$	$	$	
Claim # 5		/ /	$	$	$	
Claim # 6		/ /	$	$	$	
Claim # 7		/ /	$	$	$	
Claim # 8		/ /	$	$	$	
Claim # 9		/ /	$	$	$	
Claim # 10		/ /	$	$	$	

Total:

Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties No. of Years w/TDC (1) (2) 0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties * No. of Years w/TDC (1) (2) 0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for each Total Claim Score above 15.

*** Emergency Medicine, General Surgery, ~~Gynecology,~~ Neurosurgery, Obstetrics & Gynecology, Oral Surgeons, Orthopedic Surgery, Otolaryngology (Major with Facial Plastic), Plastic Surgery, Thoracic Surgery and Urology**

Points Evaluation Worksheet

Insured:_____ Policy #:_____

Renewal Date:_____ Evaluation Date:_____

Criteria	**Points**
Claims	_____
Drug or Alcohol Impairment~~- Health~~	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges - Any State	_____
Procedures	_____
Patient Safety/Risk Management	_____
Gaps In Medical Practice	_____
Payment History~~Coverage~~	_____
Other	_____
TOTAL POINTS	_____

Ranges & Surcharges

0 to 50 points-No surcharge	51 to 90 points-20% surcharge	91 to 130 points-30% surcharge
131 to 170 points-40% surcharge	171 to 210 points-50% surcharge	211 to 250 points-60% surcharge
251 to 280 points-70% surcharge	281 to 300 points-80% surcharge	301 to 325 points-90% surcharge
326 to 350 points-100% surcharge	351 to 370 points-125% surcharge	371 to 390 points-150% surcharge
391 to 410 points-175% surcharge	411 to 430 points-200% surcharge	431 to 450 points-225% surcharge
451 to 470 points-250% surcharge	471 to 490 points-275% surcharge	491 to 510 points-300% surcharge
511 to 530 points-325% surcharge	531 to 550 points-350% surcharge	551 to 570 points-375% surcharge
571 to 590 points-400% surcharge	591 or more points-NON-RENEW~~Nonrenew~~	

Comments:_____

_____

_____

_____

Completed by:_____ Approved by:_____

FILED

JUL 01 2011

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

COUNTRYWIDE RULES AND RATES MANUAL

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SECTION 2 STATE GENERAL RULES EXCEPTION PAGES

General Rules modified in accordance with state requirements.

SECTION 3 STATE RATE PAGES

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JUL 01 2011

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

SECTION 1- GENERAL RULES

I. GENERAL GUIDELINES

A. Application of Manual

This manual provides the rates, rules, classifications and territories for writing Healthcare Professional Liability Insurance for The Doctors Company ("the Company").

B. Application of General Rules

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the State General Rules Exception Pages in Section 2 of this manual.

C. Prior Acts Coverage

Prior Acts Coverage (retroactive/nose coverage) provides coverage for those claims arising from incidents that take place after the retroactive date and prior to the date the insured's policy became effective with the Company. The initial retroactive date will impact the rating of a policy based on the years of claims-made policy maturity. Once established the retroactive coverage date can only be advanced at the request or written knowledge of the insured.

If the limits of liability on policies carried by an applicant in the Prior Acts Coverage period are lower than those the applicant requests from the Company, then the policy will be endorsed to provide the lower limits of liability for Prior Acts Coverage. The premium is computed using the Blended Rate methodology (See I. General Guidelines, E. Policy Changes).

D. Suspension of Insurance

An insured may request temporary suspension of insurance, due to a disability, military duty, pregnancy, family leave, or sabbatical leave for training. Suspension allows for cessation of practice without the need to purchase Extended Reporting Period coverage, and then restart the claims-made maturation process when practice is resumed. The insured may report claims during the period of suspension which arise from incidents that take place after the retroactive date, but not incidents that take place during the period of suspension.

1. No premium is charged during the period of suspension. When the period of suspension commences for a policy covering only one Named Insured, any unearned premium will be refunded to the Named Insured on a pro-rata basis. For group policies, any unearned premium for the applicable suspended Named Insured will be credited on a pro-rata basis toward the group premium.

2. Normal maturation of the policy continues during the period of suspension.

3. If a insured's coverage is suspended because of temporary disability, and he or she does not return to the practice of medicine due to permanent and total disability, the Company will waive the premium for Extended Reporting Period Coverage (as described in part G of this Section), issued retroactively to the first day of the period of suspension. Cancellation will be on the same date of the suspension if cancellation is at the insured's request. If the Company cancels the policy, the

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Company will send advance notice of cancellation or nonrenewal in accordance with state requirements.

4. If a insured's coverage is suspended for reasons other than disability, and he or she does not return to the practice of medicine after the period of suspension, the Company will cancel the policy, and calculate the premium for the Extended Reporting Period Endorsement effective on the first day of the period of suspension. Premium is calculated based on the rates and rules in effect on the inception date listed in the Coverage Summary. Cancellation will be on the same date of the suspension if cancellation is at the insured's request. If the Company cancels the policy, the Company will send advance notice of cancellation or nonrenewal in accordance with state requirements.

E. Policy Changes

1. Changes in Territory

   If a Named Insured moves to a different territory, the premium adjustment (if appropriate) is billed or refunded effective the date of the change. This change is computed as a Blended Rate as discussed below.

2. Changes in Limits of Liability

   The Company requires a written request for changes in limits of liability and a "no known loss" disclaimer signed by each Named Insured under the policy. Increases in limits of liability are made at renewal and are not backdated. Decreases in limits of liability are made effective immediately.

3. Changes in Specialty/Rate

   Changes in specialty occur when a physician adds or drops certain procedures, such as obstetrics. Changes in rate occur when the status of the physician changes, such as from full-time to part-time.

   The new premium after a change in specialty/rate is computed at either the standard rate of the new coverage (a "Straight Change") or a mixed rate that is partially based on the specialty/rate of the previous coverage (a "Blended Rate").

   a. Straight Change

      A straight change is made:

      1. If the period of coverage preceding the change is six months or less (eighteen months or less for a "Prep" physician).

      2. If the change is by Company election, such as a general rate change for a specialty, the change is only done at the renewal date with required notification, if any.

      3. If the insured has been continuously insured by the Company for at least five complete years and the change is based on semi-retirement.

      In all other cases, the territory and specialty/rate changes are Blended Rates.

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b. Blended Rate

When an insured is reclassified as a result of a territory, specialty/rate or other change, a "blended rate" computation is done to cover the previous exposure.

In the computation of a Blended Rate, the following variables are used:

1. The rate for each previous and new scope of coverage.

2. The effective date, the retroactive date, and the effective date of each subsequent change.

3. The period of coverage to be considered (usually over a five-year period).

Computing a Blended Rate involves:

1. Determining the mature claims-made annual premium for the "old" and "new" classifications.

2. Application of a pro-rata factor to compute how much "old" premium and "new" premium applies within each calendar year considered.

3. After the Blended Rate has been computed, any additional charges or discounts on the policy are applied.

F. Cancellation/Nonrenewal

The policy can be cancelled by written request of the First Named Insured and stating a prospective effective date of cancellation. Any unearned premium will be refunded, less the customary short rate fee.

The Company may cancel or nonrenew a policy in accordance with state requirements. A pro-rata refund is made of any unearned premium.

G. Extended Reporting Period Coverage

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

1. Premium Calculation and Payment

The premium for the Extended Reporting Period Coverage is calculated as follows:

a. If the retroactive date is five or more years before the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage.

b. If the retroactive date is less than five years, but more than nine months prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve months factored pro rata with regard to maturity.

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c. If the retroactive date is nine months or less prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:

i. One to 30 days	.090
ii. 31-91 days	.276
iii. 92-182 days	.520
iv. 182-273 days	.760

d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date of the coverage.

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement.

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

2. Retirement

The Company will waive the premium for Extended Reporting Period Coverage if a Named Insured:

a. has permanently and completely retired from the practice of medicine; and

b. has been continuously insured with the Company or one of its subsidiaries for at least five years.

If the Named Insured returns to the practice of medicine, he or she may reapply to the Company. If the Company agrees to offer coverage, the premium for the Extended Reporting Period Coverage is reinstated and due in full. However, if such return is within two years of the date of retirement, coverage will be retroactively suspended, Extended Reporting Period Coverage canceled and active coverage reinstated without additional charge, subject to underwriting of the risk.

If the Named Insured returns to the practice of medicine more than two years after the date of retirement, the Named Insured will pay a prorated Extended Reporting Period Coverage premium based on the length of time since the date of retirement. However, such Named Insureds are not eligible for a second waiver of Extended Reporting Period Coverage premium upon subsequent retirement from the practice medicine.

If the Named Insured returns to the practice of medicine more than one year after the date of retirement, and purchases active coverage from another company, the premium will be prorated based on the length of time since the date of retirement.

3. Death or Disability

The Company will waive the premium for Extended Reporting Period Coverage in the event of:

a. the death of the Named Insured while his/her policy is in force; or

b. the total and permanent disability of the Named Insured when the disability commences while the policy is in force.

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If the Named Insured returns to the practice of medicine after disability, he or she may reapply to the Company. If the Company agrees to offer coverage, the premium for the Extended Reporting Period Coverage is reinstated and due in full. However, if such return is within two years of the date of disability, coverage will be retroactively suspended, Extended Reporting Period Coverage canceled and active coverage reinstated without additional charge, subject to underwriting of the risk.

If the Named Insured returns to the practice of medicine more than two years after the date of disability, the Named Insured will pay a prorated Extended Reporting Period Coverage premium based on the length of time since the date of disability. However, such Named Insured is not eligible for a second waiver of Extended Reporting Period Coverage premium upon subsequent disability or retirement from the practice medicine.

If the Named Insured returns to the practice of medicine more than one year after the date of disability, and purchases active coverage from another company, the premium will be prorated based on the length of time since the date of disability.

If a Named Insured dies during the Extended Reporting Period, any remaining premium is waived.

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II. RATING GUIDELINES

A. Premium Calculation

Premium is calculated in consideration of the following:

1. State and territory in which the insured practices,
2. Medical specialty,
3. Limits of liability,
4. Policy maturation based on the retroactive date.

All changes requiring additional premium or return premium are computed on a prorated basis. Premium calculations are rounded to the nearest dollar.

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must maintain complete files of how it modified the applicable rates, rules and coverages for the risk and make these files available to the Department of Insurance upon request.

C. Rating Factors

Policies are rated under the following calculation using the factors detailed below.

Manual Base Premium = Manual Base Rate x Increased Limit Factor x Claims-Made Maturity Year Factor

The manual base premium may be adjusted to reflect applicable discounts/surcharges set forth in this manual.

1. Manual Base Rate

   The manual base rate is the 1M/3M claims-made mature rate based on specialty. See State Rate Pages for applicable manual base rates.

2. Increased Limits Factors

   For all specialties except Chiropractic, the Company offers the following limits of liability: 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

   For Chiropractic only, the Company also offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M and 0.25M/0.75M.

   The applicable increased limits factors are shown on the State Rate Pages.

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3. Claims-Made Maturity Year

Claims-made maturation is the process of the policy aging. The policy attains maturity through premium increases occurring on the anniversary of the retroactive date. The policy is mature upon the completion of five consecutive years of claims-made coverage.

The claims-made maturity factors are as follows:

Claims-Made Maturity Year	"Incident" Basis Factor	"Demand" Basis Factor
Year 1	0.35	0.21
Year 2	0.60	0.45
Year 3	0.80	0.72
Year 4	0.92	0.88
Year 5	1.00	1.00

D. Minimum Premium-Surgicenters

Surgicenters are rated on a per procedure basis and are subject to a minimum premium of $10,000. See State Rate Pages for applicable manual base rates.

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III. ADDITIONAL COVERAGES

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists, Perfusionists and Psychologists. These ancillaries share limits of liability with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 25% less than the separate limits of liability rate. The supervising physician/surgeon may purchase vicariously liability only coverage for 10% of the applicable physician's/surgeon's premium.

B. Entities

Entity coverage is available when a group of two or more physicians have formed a business organization. The entity coverage also covers nonratable employees of the entity. Shared or separate limits of liability coverage may be provided to the entity:

Separate Limits of Liability Coverage = 10% of each physician's/surgeon's premium

Shared Limits of Liability Coverage = up to 2% of each physician's/surgeon's premium. The shared limits of liability charge is dependent upon the exposure presented by the entity.

C. Slot Positions

Slotting of coverage allows for the adding and deleting of healthcare professionals in the same specialty without the need to purchase Extended Reporting Period (ERP) Coverage. Healthcare professionals are insured one at a time under the slot position rather than adding each new healthcare professional as a Named Insured and canceling each deleted healthcare professional with the option to purchase ERP Coverage. Since the slot is continuous, the ERP Coverage for any deleted healthcare professionals is "built-in". The slot matures based on the effective date of coverage of the first healthcare professional in the position. A slot will be active and billed premium even when not occupied by a healthcare professional. Only one active healthcare professional at a time can occupy a slot. Slot occupants share the Limits of Liability of the slot.

Slots when unoccupied are designated as "open slots". When the group cancels a slot, payment of the ERP Coverage premium provides ERP coverage for all the occupants of that slot position. The ERP Coverage premium for a canceled slot position is calculated in the same manner as any canceled coverage.

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D. Auxiliary Healthcare Professional Coverage

Auxiliary Healthcare Professional Coverage is available for certain types of risks and is rated on an hourly basis. This coverage is subject to a minimum premium of $750 per quarter.

Hourly Rate: 0.0625% of the rate based on the medical specialty of the Auxiliary healthcare professional. See State Rate Pages for applicable manual base rates.

E. MediGuard Coverage

Basic Limits Coverage – Included as part of the medical professional liability premium - $25,000 Per Disciplinary Proceeding/$25,000 Annual Maximum for all Disciplinary Proceedings/$1,000 Deductible Per Disciplinary Proceeding.

Optional Excess Limits Coverage – Basic limits coverage of $25,000/$25,000 may be optionally increased to either: $50,000/$50,000, $75,000/$75,000, or $100,000/$100,000 for the following additional charges:

$50,000/$50,000 Excess:	$300 per person
$75,000/$75,000 Excess:	$550 per person
$100,000/$100,000 Excess:	$800 per person

These optional excess limits may also be purchased by an entity at the applicable per person charge provided that the limits for the entity do not exceed the lowest limits purchased by any one person insured under the endorsement.

Group Aggregate Limits for Medicare/Medicaid only – This applies to groups only. Depending on the group size (number of Named Insureds) and the total limits selected, i.e., basic limit plus optional excess for the lowest total limits amount selected among all of the group members, the following Maximum Aggregate Limit automatically applies with respect to the group as a whole for Medicare/Medicaid only:

Group Size	Selected Limits	Maximum Group Aggregate Limit for All Medicare/Medicaid Proceedings
2 - 4	$ 25,000/$ 25,000	$50,000
	$ 50,000/$ 50,000	$100,000
	$ 75,000/$ 75,000	$125,000
	$100,000/$100,000	$175,000
5 - 9	$ 25,000/$ 25,000	$100,000
	$ 50,000/$ 50,000	$150,000
	$ 75,000/$ 75,000	$175,000
	$100,000/$100,000	$225,000
10 - 25	$ 25,000/$ 25,000	$150,000
	$ 50,000/$ 50,000	$250,000
	$ 75,000/$ 75,000	$375,000
	$100,000/$100,000	$500,000
26+	$ 25,000/$ 25,000	$250,000
	$ 50,000/$ 50,000	$500,000
	$ 75,000/$ 75,000	$750,000
	$100,000/$100,000	$1,000,000

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If a group has mixed limits of liability, the lowest limits of the group drive the Group Coverage Aggregate Limit available. For example, in a group of 5-9 Named Insureds with mixed limits of liability, such as four with the basic limits of $25,000/$25,000, three with $50,000/$50,000, and two with $100,000/$100,000, the Group coverage Aggregate Limit available will be that associated with the $25,000/$25,000 limits, or $100,000.

F. Punitive Damages Coverage

A Named Insured may elect to include punitive damages coverage. When a Named Insured makes such an election, a 5% additional charge shall be applied to the Named Insured's premium.

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IV. DISCOUNTS/SURCHARGES

A. Claims-Free Discount

A 17.5% or 12.5% claims-free discount shall be applied on the effective date of the policy for each Named Insured meeting all of the following criteria:

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective date of the policy.

2. Cumulative outstanding claims reserves (indemnity and allocated loss adjustment expenses) less than $20,000.

3. Cumulative claim payments (indemnity and allocated loss adjustment expenses) less than $10,000 in the last three full years immediately preceding the effective dates of the policy.

If the Named Insured is an insured with the Company less than three full years, the claims-free discount shall also be available if the insured has cumulative outstanding claim reserves less than $20,000 (including no outstanding claims reserves with previous carriers) and cumulative claim payments less than $10,000 in the last three full years immediately preceding the effective date of the policy. In order to receive the discount, the insured must submit acceptable documentation of "claims-free" experience from its previous insurance carriers.

A 17.5% claims-free discount applies for General Surgery (All Other), General Surgery (Bariatric), Neurosurgery, Obstetrics & Gynecology, Orthopedic Surgery (No Spinal), Orthopedic Surgery (With Spinal), Plastic Surgery, and Thoracic/Cardiovascular Surgery.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistant, Certified Nurse Practitioner, etc.) that share limits with any Named Insured
- healthcare professionals rated on a "per procedure" basis

B. Prep Discount

A "prep" or new to practice discount may be requested by an insured who purchases a claims-made policy and is entering private practice for the first time within two years of completing his/her: internship, residency program, military service, HMO or Veteran Administration employment, volunteer/county/government work, or teaching position. Prep rate may also apply to a physician who decided to change his or her specialty by completing a new residency training program. No additional discounts will apply.

First year	50%
Second year	25%
Third year	0%

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C. Part Time/Quarter Time Discount

A part time discount is available for non-surgical medical specialties based upon hours worked per week or days worked per year subject to underwriting. No additional discounts will apply.

1. Part Time: 50%

   20 hours or less per week or who work 26 weeks or less per year. Anesthesiologists must work 20 hours or less per week (15 billable hours and five hours administrative).

2. Quarter Time: 75%

   10 hours or less per week and have been in practice for at least three years with loss history of no more than one claim with no severity.

D. Risk Management Discount

1. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.

2. A risk management discount of up to 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.

3. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in any other risk management program approved by the Company.

E. Deductible Discount

A Named Insured can elect that a deductible apply on a per claim basis. The two deductible options are:

a. $5,000 deductible per claim-4% premium discount
b. $10,000 deductible per claim-7.5% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the $1,000,000/$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

F. Defense Within Limits of Liability Discount

A Named Insured may elect coverage that includes payment of defense expenses within the limits of liability. A 4.5% discount shall be applied to the Named Insured's premium.

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G. Waiver of Consent to Settle Discount

A Named Insured may elect to waive his or her right to consent to settle a claim and give the Company the sole right to investigate, negotiate and settle. A 5% discount shall be applied the Named Insured's premium.

H. Imposed Surcharges

Surcharges represent an alternative to cancellation/nonrenewal/declination and are accepted as such by an insured. Surcharges are imposed as a percentage of premium. The primary purpose of a surcharge is to address extraordinary claims frequency or claims severity. Only a small percentage of insureds have surcharges at any given time.

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

Modification Factors	Range of Modifications–Credit/Debit
1) Claims Management • Internal Review Procedures • Commitment to Loss Prevention • Incident/Claim Reporting Procedures • Other Claims Management Characteristics	40% to 40%
2) Risk Management • Credentialing/Peer Review • Medical Record/Consent Form Documentation • Quality Assurance Procedures • Employee Selection, Training and Supervision • Participation in Risk Management Programs (other than those approved by the Company) • Other Risk Management Characteristics	40% to 40%
3) General Factors • Geographic Location • Loss Experience/History • Hospital Staff Privileges • Managed Care Network Participation • Practice Profile • Other Factors	40% to 40%
Maximum Credit/Debit for all factors:	**40% to 40%**

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THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

SECTION 2-ILLINOIS GENERAL RULES EXCEPTION PAGES

I. GENERAL GUIDELINES

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph with the following:

In the event of termination of the policy or a Named Insured's coverage under the policy because of cancellation or non-renewal, Extended Reporting Period Coverage may be purchased in order to cover claims reported after the termination date of the coverage, which are based on incidents which happened on or after the retroactive date and prior to the termination date of the coverage. Extended Reporting Period Coverage provides an unlimited extended reporting period.

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing 1. Premium Calculation and Payment with the following:

1. Premium Calculation and Payment

The premium for the Extended Reporting Period Coverage is calculated as follows:

a. If the retroactive date is five or more years before the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the annual premium in effect on the termination date of the coverage.

b. If the retroactive date is less than five years, but more than nine months prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve months factored pro rata with regard to maturity.

c. If the retroactive date is nine months or less prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:

i. One to 30 days	.090
ii. 31-91 days	.276
iii. 92-182 days	.520
iv. 182-273 days	.760

d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date of the coverage.

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement. At the option of the insured, the following three payment plans will be available with no interest or installment charges:

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- 1 single payment
- 2 payments billed 12 months apart
- 8 quarterly payments over 2 years

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph of 2. Retirement with the following:

The Company may waive the premium for Extended Reporting Period Coverage if a Named Insured:

a. has permanently and completely retired from the practice of medicine; and

b. has been continuously insured under a medical professional liability policy for the five years immediately preceding the date of retirement; and

c. has been continuously insured with the Company or one of its subsidiaries for at least one year immediately preceding the date of retirement.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must file the rate for this risk with the Illinois Department of Insurance on or before the effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

Rule C. Rating Factors is revised by deleting and replacing 2. Increased Limits Factors with the following:

2. Increased Limits Factors

For all specialties except Chiropractic, the Company offers the following limits of liability: 0.1M/0.4M, 0.25M/1.0M, 0.3M/1.2M, 0.5M/2M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

For Chiropractic only, the Company offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M, 0.25M/0.75M, 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

The applicable increased limits factors are shown on the State Rate Pages.

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Rule C. Rating Factors is amended by adding the following to 3. Claims-Made Maturity Year:

NOTE: "Incident" Basis Coverage: This form of claims-made coverage provides coverage for a written demand made against the insured, and allows the policy to be triggered by the report to the Company of an incident that the insured believes may later give rise to a claim.

"Demand" Basis Coverage: This form of claims-made coverage is more restrictive than incident basis coverage, because the policy only responds when the insured reports a written demand for damages or a suit to, and provides no coverage for reported incidents.

Rule D. Minimum Premium-Surgicenters is deleted and replaced with the following:

D. Minimum Premium

Healthcare facility policies are subject to a minimum premium of $2,500. All other policies are subject to a minimum premium of $500.

III. ADDITIONAL COVERAGES

Rule A. Ancillary Healthcare Professionals is deleted and replaced with the following:

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists and Psychologists. These ancillaries share limits of liability with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist
Perfusionist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 50% less than the separate limits of liability rate.

Rule B. Entities is revised by deleting and replacing the last paragraph with the following:

Shared Limits of Liability Coverage = 2% of each physician's/surgeon's premium

Rule F. Punitive Damages Coverage is deleted.

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IV. DISCOUNTS/SURCHARGES

Rule A. Claims-Free Discount is deleted and replaced with the following:

A. Claims-Free Discount

A 15% claims-free discount shall be applied on the effective date of the policy for each Named Insured meeting all of the following criteria:

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective date of the policy.

2. Cumulative outstanding claims reserves (indemnity and allocated loss adjustment expenses) less than $20,000.

3. Cumulative claim payments (indemnity and allocated loss adjustment expenses) less than $10,000 in the last three full years immediately preceding the effective dates of the policy.

If the Named Insured is an insured with the Company less than three full years, the claims-free discount shall also be available if the insured has cumulative outstanding claim reserves less than $20,000 (including no outstanding claims reserves with previous carriers) and cumulative claim payments less than $10,000 in the last three full years immediately preceding the effective date of the policy. In order to receive the discount, the insured must submit acceptable documentation of "claims-free" experience from its previous insurance carriers.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (Physician Assistants, Surgeon Assistants, Certified Nurse Practitioners, etc.) that share limits of liability
- healthcare facilities

Rule D. Risk Management Discount is deleted and replaced with the following:

D. Risk Management Discount

1. A risk management discount of 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.

2. A risk management discount of 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.

3. A risk management discount of 10% shall be applied for all insureds that participate in an onsite risk management analysis conducted by a Company representative.

4. A risk management discount of 5% shall be applied for all insureds that complete five or more topical sections within the Company's Patient Safety Interactive Guide.

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Rule E. Deductible Discount is deleted and replaced with the following:

E. Deductible Discount

A Named Insured can elect that a deductible apply on a per claim basis. The deductible options are:

a. $5,000 deductible per claim-3% premium discount
b. $10,000 deductible per claim-5% premium discount
c. $25,000 deductible per claim-12% premium discount
d. $50,000 deductible per claim-19% premium discount
e. $100,000 deductible per claim-30% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the $1,000,000/$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. Once the deductible has been exhausted, all other claims expenses will be paid in addition to the limits of liability. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

Rule F. Defense Within Limits of Liability Discount is deleted.

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

See Appendix-Illinois General Rules Exception Pages

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks and is intended to allow flexibility in determining final premiums where there is a solid underwriting justification for deviating from filed manual rates. The following risk characteristics will be used in determining overall schedule rating plan credits/debits:

Risk Characteristics	Range of Modifications–Credit/Debit
1) Practice Profile	**-15% to +15%**

- Protocols in place for screening, hiring, training, credentialing, supervision and ongoing continuing education of staff.
- Medical record keeping systems including policies and procedures to provide control for advising patients of diagnostic studies, consultation and appointments.
- Degree to which record keeping practices incorporate methods to maintain quality records, referrals and test results.
- Hospital affiliations and privileges are geographically proximate and reflect professional expertise of the office practice.
- Implementation of an electronic record system and degree to which insured incorporates methods to maintain quality records, referrals and test results.
- Entity is certified or accredited by AAAHC, ARC, CAP, TJC or another recognized credentialing body. (**Up to -15% only**)

- Medical license has been revoked, suspended, under investigation, probation action taken, or public letter or reprimand, fine or citation has been issued. (**Up to +15% only**)

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2) Loss Control Activities **-10% to +10%**

- Operational activities reflect consent, referral and discharge processes.
- Quality assurance process exists which reviews patient treatment and unexpected results and integrates solutions into the office practice.
- Participation in a Company approved or CME accredited patient safety educational program other than those set forth in the Risk Management Discount rule. (Up to -10% only)
- Presence of medical review committee and/or claim review committee that meet on a regular basis to review office protocols and procedures. (**Up to -10% only**)
- Full time dedicated manager primarily engaged in risk management and/or loss prevention activities. (**Up to -10% only**)
- Demonstrated evidence of cooperation with Company on claims management and resolution procedures. (**Up to -10% only**)

3) Patient Rapport **-10% to +10%**

- Patient volume is adequate in relationship to group size and patient distribution. Resources are provided to patients for availability of healthcare during weekends and evenings.
- Patient surveys and complaints are analyzed and integrated into the office practice protocol.
- Displays significant length of time insured with the Company and and/or contribution to the community. (**Up to -10% only**)
- Demonstrates an established, longstanding practice and/or significant degree of experience in their current area of medicine. (**Up to -10% only**)

4) Other Risk Characteristics **-15% to +15%**

- Procedures performed differentiate from physicians of the same class, type, and location of risk. The characteristics differentiate the insured from other members of the same class, or recognition of recent developments with a classification or jurisdiction that are anticipated to impact future loss experience.
- The frequency or severity of claims is greater/less than the expected experience for an insured of the same classification/size or recognition of unusual circumstances of claims in the loss experience. **NOTE:** Does not apply to risks eligible for imposed surcharges and Experience Rating Plan.
- Additional activities undertaken with the specific intention of reducing the frequency or severity of claims. (**Up to -15% only**)
- Demonstrates the willingness to expend the time and capital to include the latest advances in medical treatments and equipment into the practice. (**Up to -15% only**)
- Laboratory, radiological, pharmacy, or optical equipment is up-to-date and well maintained. (**Up to -15% only**)
- Adverse payment history within the last three years. (**Up to +15% only**)

Maximum Credit/Debit for risk characteristics: **-25% to +25%**

Note: The Company must maintain complete files of how and why it applied specific Schedule Rating Plan credits/debits and make these files available to the Illinois Department of Insurance upon request. Specific documentation must be included at the inception of new business and upon each anniversary or renewal date of a policy.

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The following additional rules are added:

Premium Payment Plans

Full or appropriate partial payment of the annual policy premium is due on or before the effective date of the policy.

At the option of the insured, the following payment plans with no interest or installment charges will be available:

- 1 single payment due on or before the effective date of the policy
- 4 quarterly installment payments of approximately 25% of the annual premium. The initial installment payment is due on or before the effective date of the policy. Additional installment payments are due 3, 6 and 9 months after the effective date of the policy.
- "9-Pay Plan"-15% down payment is due on or before the effective date of the policy. Additional equal installment payments are due 2, 3, 4, 5, 6, 7, 8 and 9 months after the effective date of the policy.

Any additional premium resulting from changes during the policy period must be spread equally over the remaining installment payments. If there are no remaining installment payments, additional premium resulting from changes during the policy period may be billed separately.

Experience Rating Plan

Eligibility

If a group of physicians/surgeons, before the application of any filed credits/debits, develops an annual premium of at least $250,000 at $1,000,000/$3,000,000 limits, such group will be eligible for experience rating subject to a review of its exposure characteristics and verification of reliable prior carrier loss and exposure data.

Experience Base

The experience modification is determined from the latest available six report years. If the experience for the full six years is not available, then the total available experience is used subject to a minimum requirement of one complete report year.

The experience period used in generating the modification must end with the year prior to the year in which the experience modification calculation is performed. Loss experience from other companies or self-insurance experience may be used if it is reliable.

Experience Modification Factor

The Experience Modification Factor is calculated in two steps. First, the Expected Loss Based on Experience is credibility-weighted with the Expected Loss Based on Manual Premium to arrive at the Credibility-Weighted Expected Loss. Then the Credibility-Weighted Expected Loss is divided by the Expected Loss Based on Manual Premium to arrive at the Experience Modification Factor.

The Expected Loss Based on Experience is a loss forecast based on the account's own experience. It is calculated by first limiting individual claim indemnities to the basic limit and ALAE on a pro-rata basis, and then trending and developing them to an ultimate, current cost level basis. The total experience period basic limit loss is then divided by the number of Experience Period Exposure Units (base class equivalent) to arrive at a Pure Premium estimate:

Pure Premium = Ultimate Trended Basic Limit Loss / Experience Period Exposure Units.

Losses are trended to six months beyond the policy effective date. The Expected Loss Based on Experience is then found by multiplying the Pure Premium estimate by the Current Exposure Units and an increased limit factor:

Expected Loss Based on Experience = Pure Premium x Current Exposure Units x Increased Limit Factor.

The Expected Loss Based on Manual Premium is determined by calculating the account's manual premium and then multiplying by the Permissible Loss Ratio. The Permissible Loss Ratio is the loss ratio underlying our manual rates. The Credibility-Weighted Expected Loss is then calculated using the following formula:

Credibility-Weighted Expected Loss = [Expected Loss Based on Experience x Credibility Factor] + [Expected Loss Based on Manual Premium x (100% - Credibility Factor)].

Finally, the Experience Modification Factor is calculated using the following formula:

Experience Modification Factor = Credibility-Weighted Expected Loss / Expected Loss Based on Manual Premium -1.00.

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THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

APPENDIX-ILLINOIS GENERAL RULES EXCEPTION PAGES

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IV. DISCOUNTS/SURCHARGES

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

Eligibility-New Business

In lieu of declining a risk, the following surcharges may be applied for a risk that does not meet the minimum underwriting guidelines established for the Company.

Eligibility-Renewal Business

In lieu of nonrenewing a risk, the following surcharges may be applied for:

1. a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. a risk for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established for the Company

Subject to the point ranges set forth on the Points Evaluation Worksheet, surcharges of 20% to 400% will be applied as a percentage of premium. With the exception of part-time and claims-free discounts, all rating discounts apply. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

Limits above $2 million/$5 million are not available.

POINTS SCHEDULE

CLAIMS WITHIN THE LAST 10 YEARS FROM DATE OF REPORT

		Points
A.	Frequency and Severity Claims Schedule	Total Points From Schedule
B.	No claims reported in the past five full years.	-100

DRUG OR ALCOHOL IMPAIRMENT

A.	Has experienced drug, alcohol, or mental illness problems more than 5 years ago.	50
B.	Has experienced drug, alcohol, or mental illness problems within the past 5 years.	75
C.	Currently in treatment for substance abuse.	150

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	Points
D. Any relapse within the past 5 years.	150
E. Physical or mental impairment that impacted physician's ability to practice medicine safely.	100

GOVERNMENT AGENCY ACTIONS

A. Medical license in any state has been revoked.	150
B. Medical license in any state has been suspended.	150
C. Medical license has been placed on probation with restrictions on the type of services he or she can provide.	100
D. Medical license has been placed on probation for more than 5 years.	100
E. Medical license has been placed on probation for 1 to 5 years.	75
F. Medical license is under investigation.	50
G. Reprimand, fine, citation, etc.	
1. Public letter of reprimand, fine, citation, etc.	50
2. Public letter of reprimand with restrictions and/or mandated courses	100
H. Petition to revoke probation filed.	100
I. Failure to report license investigation as required by affirmative duty language in policy.	50

Note: Items A, B, C, D, E, F, G, H and I – only applies per occurrence – i.e., highest point value.

J. During the preceding 5 years, DEA license has been revoked suspended, or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician.	100

K. Has been arrested, indicted or convicted or indicted of a criminal act, or has been found to be in violation
of a civil statute, per occurrence.

1) Medically related:	Within 5 years	100
	More than 5 years	50
2) Not medically related:	Within 5 years	50
	More than 5 years	25

L. Medicare/MediCal/Medicaid investigation	40
M. Loss of Medicare/MediCal/Medicaid privileges	50

	Points
N. Loss of, or current investigation of, insurance provider privileges	50
O. Investigation by U.S. Government (Qui Tam, Ricoh, etc.)	50

INAPPROPRIATE PATIENT CONTACT

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A. Proven with a single patient.	75
B. Proven with more than one patient.	150
C. Alleged with one or more patients.	50

MEDICAL EDUCATION

A. Attended more than one medical school or a residency program due to actual or planned disciplinary action.	50
B. Residency completed at two or more facilities.	50
C. Started, but did not complete, a full residency program.	50
D. Did not begin a residency.	50
E. Has never received board certification.	50

MEDICAL RECORDS

A. Records alterations with material change and intent.	150
B. Records alterations not a material change to records, just cleaning up.	25
C. Generally poor record keeping.	50

INFORMED CONSENT

A. Incomplete consent obtained.	25
B. Lack of Informed Consent.	50

PRIVILEGES - ANY STATE
(Hospital, Surgery Center, etc.)

A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per occurrence).	50
B. Privileges have been suspended in the past 10 years (per occurrence).	100
C. Privileges have been revoked in the past 10 years (per occurrence).	150
D. Has unexplained changes in privileges (per occurrence).	25

Points

E. Has been notified by facility of its intent to:

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1) Restrict privileges	30
2) Suspend privileges	50
3) Revoke privileges	100
4) Failure to report changes in privileges	100

Note: Only applies per occurrence-i.e. highest point value

F. No privileges at any facility.	100
G. Currently undergoing peer review.	75
H. Notice of peer review received.	50

PROCEDURES

A. Is performing a medical procedure that is considered experimental but not directly dangerous.	15
B. Is performing a medical procedure that is in violation of policy exclusions.	50
C. Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E. Is performing a procedure(s) outside his/her medical specialty.	100
F. Is performing high risk procedures within his/her medical specialty.	100

PATIENT SAFETY/RISK MANAGEMENT

A. Mandatory patient safety/risk management previously recommended and insured did not comply.	100
B. Mandatory patient safety/risk management previously recommended and insured had initial compliance but no follow through.	75

GAPS IN MEDICAL PRACTICE

A. Gaps in medical practice of 3-6 months' duration.	50
B. Gaps in medical practice of 6-8 months' duration.	100
C. Gaps in medical practice greater than 8 months.	150

PAYMENT HISTORY

	Points
A. Two or more late payments within the last three years.	100
B. Two or more cancellations for non-payment of premium within the last three years.	150

OTHER

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A. Uncooperative in claims handling.	75
B. Patient Load:	
1) Surgeons-61-99 patients per week	50
2) Surgeons-100 or more patients per week	100
3) All others except Surgeons-101-149 patients per week	50
4) All others except Surgeons-150 or more patients per week	100
C. If insured advertises his/her services on TV, newspapers, billboards or radio.	25
D. Uses collection agency that can file suit without insured's written consent.	25
E. Previous insurance history (bare, insolvent prior insurer or nonrenewed).	100
F. Claim experience of Associates, Partners or Corporation:	
1) If one member with claim(s)	75
2) If more than one member with claim(s)	100
3) Favorable experience of group as a whole	-150
G. For each claim or suit in which the physician breached the standard of care:	
1) Mixed Reviews	50
2) All Negative Reviews	100
3) Admitted or Clear Liability	100
H. For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I. Claim is too early in discovery period:	
1) Surgical Class	-100
2) Non-Surgical Class	-50
J. For each claim or suit in which expert reviewers state the insured met the standard of care:	
1) Surgical Class	-150
2) Non-Surgical Class	-100

	Points
K. High risk surgical patient selection.	150
L. Reinstatement of nonrenewal due to company election.	150
M. Loss Ratio in excess of 500%.	150
N. Loss Ratio less than 100%.	-100
O. Discrepancies between application answers/documents and verification.	150
P. Action by specialty association or society (AANS, ACS, etc.).	75
Q. Poor witness capabilities.	150

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Frequency and Severity Claims Schedule

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Insured: _____ **Policy #:** _____

Effective Date: _____ **Review Date:** _____

Claims Without Indemnity

ALAE From:	ALAE To:	Claim Score
$ 5,001	$ 25,000	1
$ 25,001	$ 50,000	2
$ 50,001	$ 100,000	3
$ 100,001	& up	4

Claims With Indemnity

Indemnity + ALAE From:	Indemnity + ALAE To:	Claim Score
$ 1	$ 25,000	4
$ 25,001	$ 50,000	5
$ 50,001	$ 100,000	6
$ 100,001	$ 250,000	7
$ 250,001	$ 500,000	8
$ 500,001	$750,000	9
$ 750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$	$	
Claim # 2		/ /	$	$	$	
Claim # 3		/ /	$	$	$	
Claim # 4		/ /	$	$	$	
Claim # 5		/ /	$	$	$	
Claim # 6		/ /	$	$	$	
Claim # 7		/ /	$	$	$	
Claim # 8		/ /	$	$	$	
Claim # 9		/ /	$	$	$	
Claim # 10		/ /	$	$	$	

Total:

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Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties			
	No. of Years w/TDC (1) (2)			
	0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties *			
	No. of Years w/TDC (1) (2)			
	0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for <u>each</u> Total Claim Score above 15.

*** Emergency Medicine, General Surgery, Neurosurgery, Obstetrics & Gynecology, Oral Surgeons, Orthopedic Surgery, Otolaryngology (Major with Facial Plastic), Plastic Surgery, Thoracic Surgery and Urology**

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Points Evaluation Worksheet

Insured:_____ Policy #:_____

Renewal Date:_____ Evaluation Date:_____

Criteria	Points
Claims	_____
Drug or Alcohol Impairment	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges - Any State	_____
Procedures	_____
Patient Safety/Risk Management	_____
Gaps In Medical Practice	_____
Payment History	_____
Other	_____
TOTAL POINTS	_____

Ranges & Surcharges

0 to 50 points-No surcharge	51 to 90 points-20% surcharge	91 to 130 points-30% surcharge
131 to 170 points-40% surcharge	171 to 210 points-50% surcharge	211 to 250 points-60% surcharge
251 to 280 points-70% surcharge	281 to 300 points-80% surcharge	301 to 325 points-90% surcharge
326 to 350 points-100% surcharge	351 to 370 points-125% surcharge	371 to 390 points-150% surcharge
391 to 410 points-175% surcharge	411 to 430 points-200% surcharge	431 to 450 points-225% surcharge
451 to 470 points-250% surcharge	471 to 490 points-275% surcharge	491 to 510 points-300% surcharge
511 to 530 points-325% surcharge	531 to 550 points-350% surcharge	551 to 570 points-375% surcharge
571 to 590 points-400% surcharge	591 or more points-NON-RENEW	

Comments:_____

_____

_____

_____

Completed by:_____ Approved by:_____

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

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SECTION 3- ILLINOIS RATE PAGES

A. MANUAL BASE RATES

TERRITORIES

Territory A = Cook, Madison and St. Clair Counties
Territory B = Jackson, Vermilion and Will Counties
Territory C = Kane, Lake and McHenry Counties
Territory D = Champaign, Macon and Sangamon Counties
Territory E = Bureau, Coles, DeKalb, DuPage, Kankakee, LaSalle, Ogle, Randolph and Winnebago Counties
Territory F = Remainder of State
Territory G = Adams, Knox, Peoria and Rock Island Counties

$1M/$3M LIMITS OF LIABILITY MATURE CLAIMS-MADE COVERAGE

	Territory						
Healthcare Professional Specialty	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Abdominal Surgery	98,655	91,748	80,897	61,166	72,018	49,821	46,367
Acupuncturist	43,527	40,481	35,693	26,987	31,775	21,981	20,458
Addictionology	18,610	17,306	15,260	11,538	13,585	9,398	8,746
Allergy/Immunology	17,263	16,055	14,155	10,702	12,602	8,717	8,113
Anesthesiology	41,323	38,431	33,886	25,621	30,166	20,869	19,422
Anesthesiology-Pain Management	41,323	38,431	33,886	25,621	30,166	20,869	19,422
Cardiac Surgery	153,590	142,839	125,943	95,226	112,120	77,563	72,187
Cardiovascular Disease (No Surgery)	28,489	26,495	23,361	17,663	20,797	14,387	13,390
Cardiovascular Disease (Minor Surgery)	59,362	55,207	48,677	36,805	43,334	29,978	27,900
Cardiovascular Disease (Major Surgery)	140,366	130,540	115,100	87,027	102,467	70,885	65,972
Chiropractic	6,960	6,473	5,707	4,315	5,081	3,515	3,271
Colon and Rectal Surgery	66,021	61,399	54,137	40,932	48,195	33,340	31,030
Dermatology (No Surgery)	20,687	19,238	16,963	12,826	15,100	10,447	9,722
Dermatology (Minor Surgery)	37,310	34,700	30,595	23,132	27,237	18,842	17,536
Dermatology (Major Surgery)	50,717	47,167	41,589	31,445	37,024	25,613	23,838
Diagnostic Radiology (No Surgery)	43,053	40,039	35,303	26,693	31,429	21,741	20,235
Diagnostic Radiology (Minor Surgery)	65,509	60,923	53,717	40,616	47,822	33,083	30,789
Emergency Medicine (No Major Surgery)	98,832	91,913	81,042	61,276	72,147	49,910	46,451
Endocrinology (No Surgery)	25,550	23,761	20,951	15,841	18,652	12,902	12,008
Endocrinology (Minor Surgery)	37,756	35,113	30,960	23,409	27,562	19,067	17,745
Endocrinology (Major Surgery)	43,724	40,664	35,854	27,108	31,918	22,081	20,550
Family General Practice (No Surgery)	34,799	32,363	28,535	21,575	25,403	17,573	16,355
Family General Practice (Minor Surgery-No Obstetrics)	46,460	43,208	38,098	28,805	33,915	23,463	21,836
Family General Practice (Minor Surgery-1 to 24 deliveries)	47,196	43,893	38,701	29,262	34,454	23,834	22,182
Family General Practice (Major Surgery-No Obstetrics)	64,243	59,746	52,680	39,831	46,898	32,443	30,194
Forensic/Legal Medicine	16,879	15,697	13,840	10,465	12,321	8,523	7,932
Gastroenterology (No Surgery)	42,991	39,982	35,253	26,655	31,384	21,710	20,206
Gastroenterology (Minor Surgery)	45,847	42,637	37,594	28,425	33,468	23,152	21,547
General Preventive Medicine (No Surgery)	15,854	14,743	13,000	9,829	11,573	8,006	7,451
General Surgery	96,189	89,456	78,876	59,638	70,218	48,575	45,209
Geriatrics	27,245	25,337	22,340	16,892	19,889	13,758	12,805
Gynecology (No Surgery)	26,430	24,580	21,673	16,386	19,294	13,347	12,422
Gynecology (Minor Surgery)	42,377	39,411	34,749	26,274	30,935	21,401	19,917
Gynecology (Major Surgery)	71,067	66,092	58,275	44,062	51,879	35,889	33,401
Hand Surgery	64,093	59,606	52,556	39,737	46,787	32,367	30,123
Hematology (No Surgery)	34,799	32,363	28,535	21,575	25,403	17,573	16,355
Hematology (Minor Surgery)	49,356	45,901	40,472	30,601	36,030	24,924	23,197

Healthcare Professional Specialty (Continued)	Territory A	B	C	D	E	F	G
Hospitalist	38,579	35,879	31,635	23,919	28,163	19,483	18,132
Infectious Disease	50,459	46,926	41,376	31,285	36,835	25,482	23,715
Intensive Care Medicine	38,579	35,879	31,635	23,919	28,163	19,483	18,132
Internal Medicine (No Surgery)	40,862	38,001	33,506	25,334	29,829	20,635	19,205
Internal Medicine (Minor Surgery)	53,198	49,474	43,622	32,983	38,835	26,865	25,003
Laryngology Surgery	58,747	54,635	48,172	36,423	42,886	29,668	27,611
Manipulative Medicine	17,363	16,147	14,238	10,765	12,675	8,768	8,160
Neonatology	60,266	56,047	49,418	37,365	43,994	30,434	28,324
Nephrology (No Surgery)	31,319	29,127	25,682	19,418	22,864	15,816	14,720
Nephrology (Minor Surgery)	46,284	43,044	37,953	28,697	33,787	23,373	21,753
Neurology (No Surgery)	41,895	38,962	34,354	25,975	30,583	21,157	19,691
Neurology (Minor Surgery)	49,740	46,259	40,787	30,839	36,310	25,118	23,378
Neurosurgery	243,204	226,179	199,427	150,786	177,538	122,818	114,305
Nuclear Medicine	25,454	23,672	20,872	15,781	18,581	12,854	11,963
Nutritionist	14,947	13,900	12,257	9,267	10,911	7,548	7,025
Obstetrics	127,748	118,806	104,753	79,204	93,256	64,512	60,042
Obstetrics/Gynecology	127,748	118,806	104,753	79,204	93,256	64,512	60,042
Obstetrics/Gynecology-1 to 49 deliveries	102,204	95,050	83,807	63,366	74,609	51,613	48,036
Obstetrics/Gynecology-50 to 69 deliveries	105,392	98,015	86,421	65,343	76,936	53,223	49,534
Obstetrics/Gynecology-70 to 89 deliveries	108,584	100,983	89,039	67,322	79,267	54,835	51,035
Obstetrics/Gynecology-90 to 109 deliveries	114,973	106,925	94,278	71,284	83,930	58,062	54,038
Obstetrics/Gynecology-110 to 129 deliveries	121,363	112,868	99,517	75,245	88,595	61,289	57,041
Obstetrics/Gynecology-130 to 149 deliveries	127,748	118,806	104,753	79,204	93,256	64,512	60,042
Obstetrics/Gynecology-150 to 169 deliveries	140,523	130,687	115,229	87,124	102,582	70,964	66,046
Obstetrics/Gynecology-170 deliveries and above	153,299	142,567	125,704	95,045	111,907	77,416	72,050
Occupational Medicine	20,092	18,686	16,475	12,457	14,667	10,146	9,443
Oncology (No Surgery)	35,346	32,872	28,984	21,914	25,803	17,850	16,613
Oncology (Minor Surgery)	43,527	40,481	35,693	26,987	31,775	21,981	20,458
Ophthalmology (No Surgery)	23,645	21,989	19,388	14,660	17,261	11,940	11,112
Ophthalmology (Minor Surgery)	25,695	23,897	21,070	15,930	18,757	12,976	12,077
Ophthalmology (Major Surgery)	45,525	42,339	37,331	28,226	33,234	22,990	21,397
Ophthalmology (Major Surgery-Plastic)	59,568	55,398	48,846	36,932	43,485	30,082	27,997
Orthopedic Surgery (No Spinal)	97,905	91,053	80,283	60,701	71,472	49,443	46,016
Orthopedic Surgery (With Spinal)	132,868	123,567	108,951	82,378	96,993	67,099	62,448
Otolaryngology (Major With No Facial Cosmetic Plastic Surgery)	58,747	54,635	48,172	36,423	42,886	29,668	27,611
Otolaryngology (Major With Facial Cosmetic Plastic Surgery)	89,223	82,977	73,162	55,318	65,132	45,058	41,934
Otorhinolaryngology (No Surgery)	19,198	17,854	15,742	11,902	14,015	9,695	9,023
Otorhinolaryngology (Minor Surgery)	42,930	39,925	35,203	26,617	31,339	21,680	20,177
Pathology	28,838	26,820	23,648	17,880	21,052	14,563	13,554
Pediatrics (No Surgery)	27,560	25,631	22,600	17,088	20,119	13,918	12,953
Pediatrics (Minor Surgery)	41,024	38,152	33,639	25,435	29,947	20,716	19,281
Physical Medicine and Rehabilitation	17,363	16,147	14,238	10,765	12,675	8,768	8,160
Physicians (No Major Surgery-Sclerotherapy)	47,435	44,114	38,897	29,410	34,628	23,955	22,295
Physicians-Not Otherwise Classified (No Surgery)	27,900	25,946	22,878	17,298	20,366	14,090	13,112
Physicians-Not Otherwise Classified (Minor Surgery)	43,527	40,481	35,693	26,987	31,775	21,981	20,458
Plastic Surgery	94,221	87,625	77,261	58,417	68,781	47,581	44,284
Podiatry (No Surgery)	22,967	21,360	18,833	14,240	16,766	11,598	10,794
Podiatry (Surgery)	40,399	37,572	33,128	25,048	29,492	20,402	18,988
Psychiatry	19,480	18,116	15,973	12,078	14,220	9,837	9,155
Public Health	16,879	15,697	13,840	10,465	12,321	8,523	7,932
Pulmonary Diseases (No Surgery)	37,837	35,189	31,027	23,459	27,621	19,107	17,783
Pulmonary Diseases (Minor Surgery)	64,518	60,002	52,905	40,001	47,099	32,582	30,323
Rheumatology	26,105	24,279	21,407	16,186	19,058	13,183	12,270
Therapeutic Radiology	48,667	45,260	39,906	30,173	35,526	24,576	22,874
Thoracic Surgery	128,559	119,560	105,419	79,706	93,849	64,922	60,423
Urgent Care Medicine	34,799	32,363	28,535	21,575	25,403	17,573	16,355
Urology (Minor Surgery)	34,933	32,489	28,646	21,659	25,501	17,642	16,419
Urology (Major Surgery)	53,744	49,982	44,070	33,321	39,233	27,140	25,260
Vascular Surgery	145,979	135,760	119,702	90,507	106,565	73,719	68,610

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Healthcare Facilities	Territory A	B	C	D	E	F	G
Surgery Centers (Per procedure)	28.19	26.22	23.11	17.47	20.58	14.24	13.24
Dental							
Dentist (No Surgery)	7,693	7,154	6,308	4,769	5,616	3,885	3,616
Dentist (Minor Surgery)	19,233	17,887	15,770	11,924	14,040	9,712	9,039
Oral Maxillofacial Surgeon	38,463	35,770	31,539	23,847	28,078	19,424	18,078

B. LIMITS OF LIABILITY

All Specialties Except Chiropractic		Chiropractic	
Per Claim/Aggregate Limits of Liability	Factor	Per Claim/Aggregate Limits of Liability	Factor
.1M/.3M	Not Available	.1M/.3M	0.526
.1M/.4M	0.482	.1M/.4M	Not Available
.2M/.6M	Not Available	.2M/.6M	0.684
.25M/.75M	Not Available	.25M/.75M	0.737
.25M/1M	0.668	.25M/1M	Not Available
.3M/1.2M	0.704	.3M/1.2M	Not Available
.5M/1.5M	Not Available	.5M/1.5M	0.842
.5M/2M	0.794	.5M/2M	Not Available
1M/3M	1.000	1M/3M	1.000
2M/5M	1.350	2M/5M	1.350
3M/6M	1.554	3M/6M	1.554
4M/7M	1.673	4M/7M	1.673
5M/8M	1.742	5M/8M	1.742
6M/9M	1.798	6M/9M	1.798
7M/10M	1.843	7M/10M	1.843
8M/11M	1.884	8M/11M	1.884
9M/12M	1.916	9M/12M	1.916
10M/13M	1.946	10M/13M	1.946
11M/14M	1.976	11M/14M	1.976

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For each $1,000,000 increase in the annual aggregate limit, add 0.005 to the applicable increased limits factor.

For each $1,000,000 decrease in the annual aggregate limit, subtract 0.005 from the appropriate increased limits factor.

C. ANCILLARY HEALTHCARE PROFESSIONALS

Ancillary Healthcare Professional	Separate Limits Rate
Physician Assistant	6% of Family General Practice (No Surgery) rate
Surgeon Assistant	6% of Family General Practice (No Surgery) rate
Certified Nurse Practitioner	6% of Family General Practice (No Surgery) rate
Certified Nurse Midwife	20% of Obstetrics/Gynecology rate
Certified Registered Nurse Anesthetist	6% of Anesthesiology rate
Optometrist	5% of Ophthalmology (No Surgery) rate
Perfusionist	6% of Family General Practice (No Surgery) rate