

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Filing at a Glance

Company: Medicus Insurance Company

Product Name: IL 01/2012 Rate Manual

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI  
Combinations

Filing Type: Rate/Rule

SERFF Tr Num: MEIC-127992453 State: Illinois

SERFF Status: Closed-Filed

Co Tr Num: IL 01/2012

SCHEDCRED

Author: Jane Cundiff

Date Submitted: 01/31/2012

State Tr Num: MEIC-127992453

State Status:

Reviewer(s): Gayle Neuman

Disposition Date: 06/27/2012

Disposition Status: Filed

Effective Date Requested (New): 03/01/2012

Effective Date Requested (Renewal): 03/01/2012

Effective Date (New): 03/01/2012

Effective Date (Renewal):  
03/01/2012

State Filing Description:

## General Information

Project Name: IL RM 01/2012

Project Number: IL RM 01/2012

Reference Organization:

Reference Title:

Filing Status Changed: 06/27/2012

State Status Changed:

Created By: Jane Cundiff

Corresponding Filing Tracking Number:

Filing Description:

Please see our updated Illinois Rate/Rule manual for 2012. We have made revisions with the purpose of complying with Company Bulletin 2011-05, as well as updating our manual and rate structure to be in line with our national program. As part of these changes we have moved to a 22 class structure, identified specialties per our national program, and moved 4 counties to a different territory. Additionally, we updated claims free, part time, and per visit credits.

Lastly we have clarified the wording and format of our rate manual. Our base rate has not changed and our overall impact is -1.5%.

Please let us know if we can provide any further information.

Status of Filing in Domicile:

Domicile Status Comments:

Reference Number:

Advisory Org. Circular:

Deemer Date:

Submitted By: Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
 Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
 Company Tracking Number: IL 01/2012 SCHEDCRED  
 TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
 Product Name: IL 01/2012 Rate Manual  
 Project Name/Number: IL RM 01/2012/IL RM 01/2012

State Narrative:

## Company and Contact

### Filing Contact Information

Jane Cundiff, Regulatory Ccmpliance jcundiff@medicusins.com  
 Coordinator  
 4807 Spicewood Springs Road 512-879-5128 [Phone]  
 Bldg 4-100  
 Austin, TX 78759

### Filing Company Information

Medicus Insurance Company CoCode: 12754 State of Domicile: Texas  
 4807 Spicewood Springs Rd, Bldg. 4 1st Floor Group Code: 11 Company Type:  
 Austin, TX 78759 Group Name: Property and State ID Number:  
 Casualty  
 (866) 815-2023 ext. [Phone] FEIN Number: 20-5623491  
 -----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medicus Insurance Company	\$0.00		

## State Specific

Refer to our checklists prior to submitting filing

([http://www.idfpr.com/DOI/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)): OK

Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: OK

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABILITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : [http://www.idfpr.com/DOI/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm): OK

Medical Malpractice rates/rules may only be submitted in paper.: OK

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": OK

When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: OK

SERFF Tracking Number: MEIC-127992453

State: Illinois

Filing Company: Medicus Insurance Company

State Tracking Number: MEIC-127992453

Company Tracking Number: IL 01/2012 SCHEDCRED

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Product Name: IL 01/2012 Rate Manual

Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	06/27/2012	06/27/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Gayle Neuman	02/14/2012	02/14/2012	Jane Cundiff	02/14/2012	02/14/2012
Pending Industry Response	Gayle Neuman	02/14/2012	02/14/2012	Jane Cundiff	02/14/2012	02/14/2012
Pending Industry Response	Gayle Neuman	02/10/2012	02/10/2012	Jane Cundiff	02/10/2012	02/10/2012
Pending Industry Response	Gayle Neuman	02/09/2012	02/09/2012	Jane Cundiff	02/09/2012	02/09/2012
Pending Industry Response	Gayle Neuman	02/07/2012	02/07/2012	Jane Cundiff	02/09/2012	02/09/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
---------	-----------	------------	------------	----------------

*SERFF Tracking Number:*      *MEIC-127992453*                      *State:*                      *Illinois*  
*Filing Company:*              *Medicus Insurance Company*                      *State Tracking Number:*      *MEIC-127992453*  
*Company Tracking Number:*      *IL 01/2012 SCHEDCRED*  
*TOI:*                      *11.2 Med Mal-Claims Made Only*                      *Sub-TOI:*                      *11.2000 Med Mal Sub-TOI Combinations*  
*Product Name:*              *IL 01/2012 Rate Manual*  
*Project Name/Number:*      *IL RM 01/2012/IL RM 01/2012*

Effective Date	Note To Reviewer	Jane Cundiff	06/26/2012 06/26/2012
effective date	Note To Filer	Gayle Neuman	06/26/2012 06/26/2012
status	Note To Filer	Gayle Neuman	02/27/2012 02/27/2012
Follow up	Note To Reviewer	Jane Cundiff	02/27/2012 02/27/2012

SERFF Tracking Number: MEIC-127992453 State: Illinois  
 Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
 Company Tracking Number: IL 01/2012 SCHEDCRED  
 TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
 Product Name: IL 01/2012 Rate Manual  
 Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Disposition

Disposition Date: 06/27/2012  
 Effective Date (New): 03/01/2012  
 Effective Date (Renewal): 03/01/2012  
 Status: Filed  
 Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Medicus Insurance Company	-1.500%	2.120%	\$449,346	735	\$17,882,280	56.000%	-36.000%

SERFF Tracking Number: MEIC-127992453 State: Illinois  
 Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
 Company Tracking Number: IL 01/2012 SCHEDCRED  
 TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
 Product Name: IL 01/2012 Rate Manual  
 Project Name/Number: IL RM 01/2012/IL RM 01/2012

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document (revised)	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document (revised)	Certification		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Rate (revised)	IL Rate Manual 01/2012		Yes
Rate	IL Rate Manual 01/2012		Yes

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/14/2012  
Submitted Date 02/14/2012  
Respond By Date 02/21/2012

Dear Jane Cundiff,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

Sorry. As with EVERY med/mal rate filing, 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?

Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,  
Gayle Neuman

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/14/2012  
Submitted Date 02/14/2012

Dear Gayle Neuman,

### Comments:

Please see the response below.

### Response 1

Comments: 1. Medicus will maintain its own plan for statistical reporting of medical malpractice data.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let us know if we can provide any further information.

Thank you.

Sincerely,

Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/14/2012  
Submitted Date 02/14/2012  
Respond By Date 02/21/2012

Dear Jane Cundiff,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

One last question - On Section II - 2 under B. Vicarious Liability Charge, please explain how the company will decide the amount "up to 30%" for each physician not with the company.

Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,  
Gayle Neuman

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/14/2012  
Submitted Date 02/14/2012

Dear Gayle Neuman,

### Comments:

Please see the new language in Section II - 2 under B. Vicarious Liability Charge.

### Response 1

Comments: We have changed the language to state the following:

Vicarious Liability Charge: For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

### Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #
IL Rate Manual 01/2012		Replacement	
<b>Previous Version</b>			
IL Rate Manual 01/2012		Replacement	

Please let us know if we can provide any further information.

Thank you.

Sincerely,  
Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/10/2012  
Submitted Date 02/10/2012  
Respond By Date 02/14/2012

Dear Jane Cundiff,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

Let's try this one more time. I requested that the RF-3 entry be listed on line 15 (and indicate "medical malpractice"). If the overall rate impact is 2.120%, that should be the entry in column 3. Additionally, in the brief filing description, please add that this applies to physicians/surgeons and whoever else. Also please explain why the annual premium volume for Illinois does not match the written premium for this program listed on the rate/rule schedule tab.

Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,  
Gayle Neuman

SERFF Tracking Number: MEIC-127992453

State: Illinois

Filing Company: Medicus Insurance Company

State Tracking Number: MEIC-127992453

Company Tracking Number: IL 01/2012 SCHEDCRED

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Product Name: IL 01/2012 Rate Manual

Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/10/2012
Submitted Date	02/10/2012

Dear Gayle Neuman,

### Comments:

### Response 1

Comments: Please see the attached updated RF-3 form.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Form RF3 - (Summary Sheet)

Comment: Please see the attached.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We believe we have addressed the objections you had with our incorrectly filling out the RF-3 form. Please let us know if we can provide any further information.

Sincerely,  
Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/09/2012  
Submitted Date 02/09/2012  
Respond By Date 02/14/2012

Dear Jane Cundiff,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

The RF-3 attached is not complete.

Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,  
Gayle Neuman

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/09/2012  
Submitted Date 02/09/2012

Dear Gayle Neuman,

### Comments:

Please see the response below.

### Response 1

Comments: We have updated the RF-3 form.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Form RF3 - (Summary Sheet)

Comment: Please see the attached.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let us know if we can provide any further information.

Thank you.

Sincerely,

Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/07/2012  
Submitted Date 02/07/2012  
Respond By Date 02/21/2012

Dear Jane Cundiff,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

1. You will need to complete a RF-3 Summary Sheet for this filing.
2. On the Rate Information page, is the overall % rate impact 2.120% or -2.120%?
3. On the certification form, please change the filing number to "IL RM 01/2012" as that is the filing number used on the SERFF filing as submitted.
4. How many policies had schedule rating credits or debits over 25% as of January 1, 2012?

Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,  
Gayle Neuman

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/09/2012  
Submitted Date 02/09/2012

Dear Gayle Neuman,

### Comments:

Please see our responses below to the objections.

### Response 1

Comments: 1. Please see the attached and filled out RF-3 Summary Sheet.  
2. The overall % rate impact is positive 2.12%  
3. The filing number on the certification form has been changed to "IL RM 01/2012" per your request.  
4. The Schedule Credits are per insured. As of January 1, 2012 we had 183 insureds beyond the +/- 25%, affecting 94 policies.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Form RF3 - (Summary Sheet)

Comment: Please see the attached.

Satisfied -Name: Certification

Comment: Please see the attached signed Certification

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let us know if we can provide any further information.

Thank you.

Sincerely,

Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

**Note To Reviewer**

**Created By:**

Jane Cundiff on 06/26/2012 04:00 PM

**Last Edited By:**

Gayle Neuman

**Submitted On:**

06/27/2012 08:16 AM

**Subject:**

Effective Date

**Comments:**

Ms. Neuman,

Per your note regarding the effective date of this filing (MEIC - 127992453) we are using the effective date of 03/01/2012.

Thank you,

Jane Cundiff

SERFF Tracking Number: MEIC-127992453 State: Illinois  
Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
Company Tracking Number: IL 01/2012 SCHEDCRED  
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
Product Name: IL 01/2012 Rate Manual  
Project Name/Number: IL RM 01/2012/IL RM 01/2012

**Note To Filer**

**Created By:**

Gayle Neuman on 06/26/2012 11:02 AM

**Last Edited By:**

Gayle Neuman

**Submitted On:**

06/27/2012 08:16 AM

**Subject:**

effective date

**Comments:**

The Department of Insurance has now completed its review of this filing. Originally, Medicus requested the filing be effective March 1, 2012. Was the filing put in effect on March 1, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

SERFF Tracking Number: MEIC-127992453

State: Illinois

Filing Company: Medicus Insurance Company

State Tracking Number: MEIC-127992453

Company Tracking Number: IL 01/2012 SCHEDCRED

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Product Name: IL 01/2012 Rate Manual

Project Name/Number: IL RM 01/2012/IL RM 01/2012

**Note To Filer**

**Created By:**

Gayle Neuman on 02/27/2012 01:19 PM

**Last Edited By:**

Gayle Neuman

**Submitted On:**

06/27/2012 08:16 AM

**Subject:**

status

**Comments:**

I have completed my review of this filing. It has now been routed on to the Actuarial Unit for review. They may be contacting you for any information that they need.

*SERFF Tracking Number:*      *MEIC-127992453*                      *State:*                      *Illinois*  
*Filing Company:*              *Medicus Insurance Company*                      *State Tracking Number:*      *MEIC-127992453*  
*Company Tracking Number:*      *IL 01/2012 SCHEDCRED*  
*TOI:*                      *11.2 Med Mal-Claims Made Only*                      *Sub-TOI:*                      *11.2000 Med Mal Sub-TOI Combinations*  
*Product Name:*              *IL 01/2012 Rate Manual*  
*Project Name/Number:*      *IL RM 01/2012/IL RM 01/2012*

**Note To Reviewer**

**Created By:**

Jane Cundiff on 02/27/2012 10:54 AM

**Last Edited By:**

Gayle Neuman

**Submitted On:**

06/27/2012 08:16 AM

**Subject:**

Follow up

**Comments:**

Ms. Neuman,

I just wanted to follow up to see if you need any further information from us regarding this filing.

Many thanks,

Jane

SERFF Tracking Number: MEIC-127992453

State: Illinois

Filing Company: Medicus Insurance Company

State Tracking Number: MEIC-127992453

Company Tracking Number: IL 01/2012 SCHEDCRED

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Product Name: IL 01/2012 Rate Manual

Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Rate Information

Rate data applies to filing.

### Filing Method:

Rate Change Type:

%

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

## Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Medicus Insurance Company	-1.500%	2.120%	\$449,346	735	\$17,882,280	56.000%	-36.000%

SERFF Tracking Number: MEIC-127992453

State: Illinois

Filing Company: Medicus Insurance Company

State Tracking Number: MEIC-127992453

Company Tracking Number: IL 01/2012 SCHEDCRED

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Product Name: IL 01/2012 Rate Manual

Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Rate/Rule Schedule

Schedule Item	Exhibit Name:	Rule # or Page	Rate Action	Previous State Filing Attachments
Status:		#:		Number:
	IL Rate Manual 01/2012		Replacement	IL Rate Manual 2012 01 26_Updated.pdf IL Rate Manual 2012 01 26 (CHANGES TRACKED1).pdf



## **MANUAL**

### **SECTION I**

#### **GENERAL RULES**

##### **I. PURPOSE OF MANUAL**

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

##### **II. POLICY TERM**

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

##### **III. LOCATION OF PRACTICE**

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

The Territory Definitions are:

1. Counties: Cook, Jackson, Madison, St. Clair and Will
2. Counties: Vermillion
3. Counties: Kane, Lake, McHenry and Winnebago
4. Counties: DuPage, Kankakee and Macon
5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph
6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

8. Remainder of State

**IV. PREMIUM COMPUTATION**

- A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.
- B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

**V. FACTORS OR MULTIPLIERS**

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

**VI. WHOLE DOLLAR RULE**

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

- A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and
- B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

**VII. ADDITIONAL PREMIUM CHARGES**

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

**VIII. RETURN PREMIUM FOR MID-TERM CHANGES**

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

## **IX. POLICY CANCELLATIONS**

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
  - 1. A policy is canceled at the Company's request.
  - 2. The Insured is leaving a group practice, or
  - 3. Death, disability or retirement of the Insured.
- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.

## **X. POLICY MINIMUM PREMIUM**

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

## **XI. PREMIUM PAYMENT PLAN**

The Company offers the Insured the choice to pay in full or the following premium payment options:

- A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.
- B. The quarterly payment plan requires a 25% down payment and three quarterly installments of 25%.
- C. Our Automated Clearing House (ACH) option allows the Insured to have 12 equal monthly installments.

There are no extra fees associated with any premium payment plan.

## **XII. COVERAGE**

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverage will be rated under Standard Claims-Made Rates.

**XIII. LIMITS OF LIABILITY**

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factor as applicable for the respective insureds and used to develop the applicable premium.

**Liability Limit Factors**

<b>Liability Limit</b>	<b>Physicians</b>	<b>Surgeons</b>
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

**XIV. PRIOR ACTS COVERAGE**

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the Insured, subject to underwriting.

**XV. EXTENDED REPORTING PERIOD COVERAGE**

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:
  - 1. The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

<u>Year</u>	<u>Factor</u>
1 <sup>st</sup>	3.30
2 <sup>nd</sup>	3.15
3 <sup>rd</sup>	2.40
4 <sup>th</sup>	2.00

2. For First Year Claims Made step, it is applied pro-rata.
  3. For Second Year and all years of maturity, it is applied to the last year's (365 days) annualized premium from the date of cancellation.
- D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.
- E. The length of the Extended Reporting Period will be indefinite.
- F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.
1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.
  2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.
  3. The Reporting Period is unlimited.

**- END OF SECTION I-**

## SECTION II

### MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

#### **I. DEFINITION**

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

Professional Corporations, Partnerships and Associations

- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;
2. Are organized as a legal entity;
3. Maintain common facilities (including multiple locations) and support personnel; and
4. Maintain medical/dental records of patients of the group as a historical record of patient care.

#### **II. PREMIUM COMPUTATION**

- A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

- B. Vicarious Liability Charge: For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

### III. PREMIUM MODIFICATIONS

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.

**- END OF SECTION II-**

## SECTION III

### MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

#### I. CLASSIFICATIONS

##### A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a rate class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
2. The rate classes are found in Section III of this Manual.

##### B. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

##### C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

##### D. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.
2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the

retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Company.

E. Per Patient Visit Rating

1. Per patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.
2. The premium for the per patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.
3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.
4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

<b>Specialty</b>	<b>Conversion Factor</b>
Urgent Care	.000160
Emergency Medicine	.000278

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per Patient Visit Rating

## II. PREMIUM COMPUTATION DETAILS

### A. Specialty Class Plan

The following classification plan shall be used to determine the appropriate rating class for each individual Insured.

#### PHYSICIANS & SURGEONS

<b>Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Abdominal Surgery	80166	17
Administrative Medicine	80240(a)	2
Aerospace Medicine	80133	2
Allergy/Immunology	80254	1
Anesthesiology- All Other	80183	6
Anesthesiology- Pain Management	80182	6
Broncho-Esophagology	80101	7
Cardiac Surgery	80141	19
Cardiothoracic Surgery	80150(a)	19
Cardiovascular Disease - Minor Surgery	80281	8
Cardiovascular Disease - No Surgery	80255	3
Cardiovascular Surgery	80150	19
Colon and Rectal Surgery	80115	11
Dentistry	80210	3
Dermatology - Minor Surgery	80297(a)	3
Dermatology - No Surgery	80297	2
Diabetes - Minor Surgery	80271	4
Diabetes - No Surgery	80237	3
Emergency Medicine - incl Major Surgery	80157	12
Emergency Medicine - No Major Surgery	80102	10
Endocrinology- Minor Surgery	80272	4
Endocrinology- No Surgery	80238	2
Endocrinology Surgery	80103	12
Family Practice or General Practice - Major Surgery & OB	80117(a)	18
Family Practice or General Practice - Surgery - limited OB	80117(b)	12
Family Practice or General Practitioners - Minor Surgery, No OB	80421	9
Family Practice or General Practitioners - No Surgery	80420	3
Forensic / Legal Medicine	80240	1
Gastroenterology - Minor Surgery	80274	8
Gastroenterology - No Surgery	80241	5
Gastroenterology - Surgery	80104	12
General Surgery	80143	15
Geriatrics - Minor Surgery	80276	7
Geriatrics - No Surgery	80243	3
Geriatrics - Surgery	80105	13

<b>Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Gynecology - Minor Surgery	80277	8
Gynecology - No Surgery	80244	4
Gynecology - Surgery	80167	12
Hand Surgery	80169	12
Head and Neck Surgery	80170	15
Head and Neck Surgery - No Plastic	80170(a)	12
Hematology - Minor Surgery	80278	7
Hematology - No Surgery	80245	3
Hospitalists - Including ER	80222(b)	11
Hospitalists - Invasive	80222(a)	9
Hospitalists - Non-Invasive	80222	5
Infectious Diseases - Minor Surgery	80279	8
Infectious Diseases - No Surgery	80246	4
Intensive Care Medicine	80283	8
Internal Medicine - Minor Surgery	80284	8
Internal Medicine - No Surgery	80257	6
Neonatal/Perinatal Medicine	80804	12
Neonatology - Major Surgery	80804(a)	16
Neoplastic - Surgery	80107	14
Neoplastic Diseases - Minor Surgery	80286	8
Neoplastic Diseases - No Surgery	80259	3
Nephrology - Minor Surgery	80287	6
Nephrology - No Surgery	80260	3
Nephrology - Surgery	80108	10
Neurology - Minor Surgery	80299(a)	8
Neurology - No Surgery	80299	4
Neurology - Surgery	80152	22
Nuclear Medicine	80262	2
Nutrition	80248	1
Obstetrics & Gynecology Surgery	80153	19
Obstetrics Surgery	80168	19
Occupational Medicine	80134	1
Oncology - Minor Surgery	80301	6
Oncology - No Surgery	80302	3
Oncology - Surgery	80164	14
Ophthalmology - Minor Surgery	80289	3
Ophthalmology - No Surgery	80263	2
Ophthalmology - Surgery	80114	3
Orthopedic Surgery Including Spine	80154(s)	20
Orthopedic Surgery Not Including Spine	80154	17
Orthopedics - Minor Surgery	80204	7
Orthopedics - No Surgery	80205(a)	4

<b>Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Otorhinolaryngology - Minor Surgery	80291	8
Otorhinolaryngology - No Surgery	80265	1
Otorhinolaryngology - Surgery - Incl Plastic	80155	16
Otorhinolaryngology - Surgery - No Plastic	80159(a)	10
Pain Management - Advanced Procedures	80182(d)	21
Pain Management - Basic Procedures	80182(b)	13
Pain Management - Intermediate Procedures	80182(c)	18
Pain Management - No Surgery	80182(a)	7
Pathology - Minor Surgery	80305	4
Pathology - No surgery	80307	2
Pediatrics - Minor Surgery	80293	8
Pediatrics - No Surgery	80267	2
Pediatrics - Surgery	80180	16
Perinatology	80153(a)	21
Pharmacology - Clinical	80234	2
Physiatry	80209(a)	3
Physical Medicine and Rehabilitation - All Other	80209	1
Physical Medicine and Rehabilitation - Pain Management	80208	7
Physician (NOC) - Minor Surgery	80294	8
Physician (NOC) - No Surgery	80268	2
Plastic Surgery	80156	16
Podiatry	80943	3
Preventive Medicine - No Surgery Undersea/Hyperbaric Medicine	80139	2
Psychiatry	80229	2
Public Health Medicine - No Surgery	80135	2
Pulmonary Diseases - No Surgery	80269	6
Radiation Oncology	80359(a)	3
Radiology - Diagnostic - Minor Surgery	80280	8
Radiology - Diagnostic - No Surgery	80253	6
Radiology - Interventional	80360	10
Radiology - Therapeutic - Minor Surgery	80358	8
Radiology - Therapeutic - No Surgery	80359	6
Rheumatology - No Surgery	80252	2
Sports Medicine - No Surgery	80205	4
Thoracic Surgery	80144	18
Traumatic Surgery	80171	19
Urgent Care	80102(a)	5
Urological - Surgery	80145	10
Urology - Minor Surgery	80120	8
Urology - No Surgery	80121	3
Vascular Surgery	80146	19

<b>Ancillary Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Acupuncturists	80966	X
Art, Music and Dance Therapists	80967	X
Audiologists	80968	X
Certified Registered Nurse Anesthetist	80960	C-1
Dental Hygienists	80712	X
Inhalation/Respiratory Therapists	80969	X
Massage Therapists	80970	X
Medical Technologists	80971	X
Nurse LPN	80963	X
Nurse Midwife	80962	N
Nurse Practitioner	80965	Z
Nurse RN	80964	Y
Nutritionists/Dieticians	80972	X
Occupational Therapists	80973	Y
Opticians	80937	X
Optometrist	80994	Y
Orthotists/Prosthetists	80974	Y
Pharmacists	59112	X
Physicians or Surgeons Assistants	80116	Z
Physiotherapists	80938	Y
Psychologists	80975	Z
X-Ray Technicians	80713	Y

B. Manual Rates

Standard Claims Made Program Step Factors

Step Factors:

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

**PHYSICIANS AND SURGEONS  
RATE TABLE**

Mature Rates (Claims-made)  
1M/3M

<b>Class</b>	<b>Territory 1</b>	<b>Territory 2</b>	<b>Territory 3</b>	<b>Territory 4</b>	<b>Territory 5</b>	<b>Territory 6</b>	<b>Territory 7</b>	<b>Territory 8</b>
1	\$15,401	\$13,938	\$13,214	\$11,751	\$11,027	\$9,564	\$7,377	\$8,101
2	\$20,632	\$18,672	\$17,702	\$15,742	\$14,772	\$12,812	\$9,883	\$10,852
3	\$29,059	\$26,298	\$24,933	\$22,172	\$20,806	\$18,046	\$13,919	\$15,285
4	\$31,965	\$28,928	\$27,426	\$24,389	\$22,887	\$19,850	\$15,311	\$16,814
5	\$33,418	\$30,243	\$28,673	\$25,498	\$23,927	\$20,752	\$16,007	\$17,578
6	\$35,161	\$31,821	\$30,168	\$26,828	\$25,176	\$21,835	\$16,842	\$18,495
7	\$38,648	\$34,977	\$33,160	\$29,489	\$27,672	\$24,001	\$18,513	\$20,329
8	\$42,426	\$38,396	\$36,402	\$32,371	\$30,377	\$26,347	\$20,322	\$22,316
9	\$46,204	\$41,814	\$39,643	\$35,254	\$33,082	\$28,693	\$22,132	\$24,303
10	\$49,981	\$45,233	\$42,884	\$38,136	\$35,787	\$31,038	\$23,941	\$26,290
11	\$54,922	\$49,704	\$47,123	\$41,905	\$39,324	\$34,106	\$26,307	\$28,889
12	\$61,314	\$55,490	\$52,608	\$46,783	\$43,901	\$38,076	\$29,370	\$32,251
13	\$67,417	\$61,012	\$57,844	\$51,439	\$48,270	\$41,866	\$32,293	\$35,461
14	\$73,519	\$66,535	\$63,080	\$56,095	\$52,640	\$45,655	\$35,216	\$38,671
15	\$80,784	\$73,110	\$69,313	\$61,638	\$57,841	\$50,167	\$38,696	\$42,492
16	\$88,049	\$79,684	\$75,546	\$67,181	\$63,043	\$54,678	\$42,175	\$46,314
17	\$97,638	\$88,363	\$83,774	\$74,498	\$69,909	\$60,633	\$46,769	\$51,358
18	\$109,843	\$99,408	\$94,245	\$83,810	\$78,648	\$68,213	\$52,615	\$57,777
19	\$124,663	\$112,820	\$106,961	\$95,118	\$89,259	\$77,416	\$59,714	\$65,573
20	\$134,253	\$121,499	\$115,189	\$102,435	\$96,125	\$83,371	\$64,307	\$70,617
21	\$165,927	\$150,164	\$142,365	\$126,602	\$118,804	\$103,041	\$79,479	\$87,278
22	\$205,738	\$186,193	\$176,523	\$156,978	\$147,308	\$127,763	\$98,548	\$108,218

**NON PHYSICIAN HEALTHCARE PROVIDERS  
RATE TABLE**

Mature Rates (Claims-made)  
1M/3M

<b>RATE CLASS</b>	<b>Separate limits</b>	<b>Shared limits</b>
<b>N</b>	<b>30% of Class 20</b>	<b>15% of Class 20</b>
<b>X</b>	<b>5% of Class 3</b>	<b>0% of Class 3</b>
<b>Y</b>	<b>15% of Class 3</b>	<b>0% of Class 3</b>
<b>Z</b>	<b>10% of Class 3</b>	<b>4% of Class 3</b>
<b>C-1</b>	<b>15% of Class 6</b>	<b>10% of Class 6</b>

### III. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

#### A. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week is considered a part time practitioner and is eligible for a reduction of 50% on the otherwise applicable rate for that specialty.
2. A Part Time Practitioner may include any practitioner in classes 1 through 10 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

#### B. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:
  - a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
  - b. Resident - Various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
  - c. Fellow - Follows completion of residency and is a higher level of training.
2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.
3. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program.
4. The credit is not applied to the Extended Reporting Period Coverage.
5. The physician-in-training credit is 50% for 1<sup>st</sup> Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

C. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A credit of 30% for first and second years and 20% for the third year will be applied. No other credits are to apply concurrent with this rule.

D. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the Insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program.
2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the Insured's teaching activities.
  - a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.
  - b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.
  - c. No other credits are to apply concurrent with this rule.
  - d. The applicable percentages are based upon hours, up to 50%.

E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the Insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the following schedule:

<u>Claim Free</u>	<u>Credit</u>
0	0
1	2%
2	4%
3	6%
4	8%
5	10%
6	12%
7	14%
8	16%
9	18%
10+	20%

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

G. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

**Schedule Rating: Modifications, subject to Underwriting:**

For Individuals and Groups, subject to Underwriting,

1. The Company will consider all insureds for credits/debits:

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the Insured(s) is greater/less than the expected experience for an Insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The Insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/- 25%	Characteristics of a particular Insured that differentiate the Insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the Insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the Insured.
8. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The Insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record Keeping Practices. +/- 10%	Degree to which Insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 25%
----------------------	-----------

H. Experience Rating

1. A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:
  - a. Premiums paid
  - b. Number of claims
  - c. Incurred losses
  - d. Cause of such losses
  - e. Nature of practice
2. Such credits/debits shall apply on a one year basis and will be subject to annual review.

I. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

J. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the Insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit.

<b>Indemnity Only Deductible Per Claim</b>		<b>Indemnity and ALAE Deductible Per Claim</b>	
\$5,000	2.5%	\$5,000	6.5%
\$10,000	4.5%	\$10,000	11.5%
\$15,000	6.0%	\$15,000	15.0%
\$20,000	8.0%	\$20,000	17.5%
\$25,000	9.0%	\$25,000	20.0%
\$50,000	15.0%	\$50,000	30.5%
\$100,000	25.0%	\$100,000	40.0%
\$200,000	37.5%	\$200,000	55.0%
\$250,000	42.0%	\$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

<b>Indemnity Only Per Claim/Aggregate</b>		<b>Indemnity &amp; ALAE Per Claim/Aggregate</b>	
\$5000/15,000	2.0%	\$5000/15,000	5.5%
\$10,000/30,000	4.0%	\$10,000/30,000	10.5%
\$25,000/75,000	8.5%	\$25,000/75,000	19.0%
\$50,000/150,000	14.0%	\$50,000/150,000	29.5%
\$100,000/300,000	24.0%	\$100,000/300,000	43.0%
\$200,000/600,000	36.0%	\$200,000/600,000	53.5%
\$250,000/750,000	40.0%	\$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each

insured involved in a claim. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to \$1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	\$10,500
10/30	.038	.035	.030	.024	\$21,000
25/75	.084	.079	.070	.058	\$52,500
50/150	.145	.139	.127	.109	\$105,000
100/300	.234	.228	.216	.196	\$120,000
200/600	.348	.346	.338	.321	\$420,000
250/750	.385	.385	.381	.368	\$525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
200/600	.396	.394	.385	.366	\$510,000
250/750	.467	.467	.462	.446	\$637,500

K. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

**-END OF SECTION III-**

## SECTION IV

### Medicus Secured Protection Program

#### I. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

- DEA License Suspension
- Professional Misconduct
- Successful Completion of Chemical Dependency Program
- Adverse Claims Experience (Severity and/or Frequency)
- Proctorship
- Medical Board Sanctions or Fines
- Unusual Practice Characteristics
- Physical or Mental Health Impairments
- Bare Exposure Period
- Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

#### II. APPLICANT REFERRAL CRITERIA:

##### A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

##### B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

### **III. LENGTH OF INSURED'S REHABILITATION**

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

### **IV. RATING APPROACH**

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

### **V. UNDERWRITING**

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.
2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).
3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.
4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

**VI. PHYSICIAN OR GROUP MANAGEMENT**

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurrence
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

**VII. INTERNAL LOGISTICS**

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

## VIII. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

### POINTS SCHEDULE A

#### Claims within the last 10 years from date of Report

- |   |                      |
|---|----------------------|
| A. Frequency and Severity Claims Schedule         | 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 with the past 5 years              | 75  |
| C. Currently in treatment for unresolved substance abuse  | 150 |
| D. Any relapse with in 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  |
| I. During the preceding 5 year, 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 a violation of a civil statute, per event.  |     |

#### Medically Related

- |   |     |
|---|-----|
| Within 5 years                                      | 100 |
| More than 5 years                                   | 50  |
| K. Medicare/Medicaid investigation                  | 40  |
| L. Loss of Medicare/Medicaid Privileges             | 50  |
| M. Loss of any health insurance provider privileges | 50  |

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

#### 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  |

POINTS SCHEDULE A (cont.)

**Medical Education**

- A. Attended more than one medical school or a residency program due to actual or planned disciplinary action 50
- B. Residency complete 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 event). 50
  - B. Privileges have been suspended in the past 10 years (per event). 100
  - C. Privileges have been revoked in the past 10 years (per event). 150
  - 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 physician or group procedures within his/her medical specialty 100

**Patient Safety / Physician or group Management**

- A. Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements. 100

B.	Mandatory patient safety/physician or group management previously recommended and Insured had initial compliance but no follow through.	75
	<b>Gaps in Medical Practice</b>	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	<b>Payment History</b>	
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
	<b>Other</b>	
A.	Uncooperative in Claims Handling	150
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 non-renewed).	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-physician or group 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#: \_\_\_\_\_  
(If Applicable)

Effective Date: \_\_\_\_\_

Review Date: \_\_\_\_\_

<b>Claims Without Indemnity</b>			
<b>ALAE</b>			
<b>From:</b>	<b>To:</b>	<b>Claim Score</b>	
\$5,001	\$25,000	1	
\$25,001	\$50,000	2	
\$50,001	\$100,000	3	
\$100,001	& up	4	
<b>Claims With Indemnity</b>			
<b>Indemnity + ALAE</b>			
<b>From:</b>	<b>To:</b>	<b>Claim Score</b>	
\$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	

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

Total: \_\_\_\_\_

Completed by: \_\_\_\_\_

Approved by: \_\_\_\_\_

**Frequency and Severity Claims Schedule (Continued)**

Total Claim Score	Low Frequency Specialties			
	No. of Years w/MIC			
	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/MIC			
	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, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

**Points Evaluation Worksheet**

Insured: \_\_\_\_\_

Policy#: \_\_\_\_\_

Effective Date: \_\_\_\_\_

(If Applicable)  
Review Date: \_\_\_\_\_

**Criteria**

**Points**

Claims Frequency	_____
Drug or Alcohol Impairment – Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges – Any State	_____
Procedures	_____
Physician or group Management	_____
Gaps in Coverage	_____
Other	_____
<b>Total Points:</b>	_____

**Ranges & Surcharges**

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by: \_\_\_\_\_

Approved by: \_\_\_\_\_

**-END OF MANUAL-**



**MANUAL**

**SECTION I**

**GENERAL RULES**

**SECTION I**

**MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS**

**I. APPLICATION PURPOSE OF MANUAL**

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

**II. APPLICATION OF GENERAL RULES**

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

**III. II. POLICY TERM**

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

**IV. III. LOCATION OF PRACTICE**

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

The Territory Definitions are:

- 1. Counties: Cook, Jackson, Madison, St. Clair and Will
- 2. Counties: Vermillion
- 3. Counties: Kane, Lake, McHenry and Winnebago
- 4. Counties: DuPage, Kankakee and Macon

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial

Formatted: Body Text FLI .5, bt

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Font: (Default) Arial, Font color: Black

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Body Text, Indent: First line: 0"

Formatted: Left, Indent: Left: 0", Hanging: 0.5"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph

6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

~~8. Remainder of State. However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.~~

Formatted: Font: (Default) Arial

#### ~~IV~~. PREMIUM COMPUTATION

~~A.~~ Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Heading 3

#### ~~V~~. PREMIUM COMPUTATION (Continued)

~~A.~~

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

Formatted: Left

#### ~~VI~~. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

#### ~~VII~~. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

#### ~~VIII~~. VII. ADDITIONAL PREMIUM CHARGES

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

Formatted: Left

**IX.VIII. RETURN PREMIUM FOR MID-TERM CHANGES**

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

Formatted: Left

Formatted: Body Text 2

**X.IX. POLICY CANCELLATIONS**

Formatted: Font: (Default) Arial

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
  1. A policy is canceled at the Company's request.
  2. The Insured is leaving a group practice, or
  3. Death, disability or retirement of the Insured.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Left

- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- 4. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.
- 2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

Formatted: Heading 3, Tab stops: Not at 1.5" + 2"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial, Font color: Black

Formatted: Font: (Default) Arial

Formatted: Heading 3, No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Heading 3

Formatted: Left

**X. POLICY CANCELLATIONS (Continued)**

- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**XI.X. POLICY MINIMUM PREMIUM**

The applicable minimum premium is ~~based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.~~

Formatted: Body Text, No bullets or numbering, Tab stops: Not at 1.5"

~~1. determined by the type of health care provider shown on the appropriate Rate Pages.~~

Formatted: Font: (Default) Arial

2- Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

### XII.XI. PREMIUM PAYMENT PLAN

Formatted: Font: (Default) Arial, Font color: Auto

The Company offers the ~~insured~~Insured the choice to pay in full or the following premium payment options:

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

A. ~~A.~~—The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Heading 3, Indent: Left: 0", First line: 0"

B. ~~B.~~—The quarterly payment plan requires a 25% down payment and three quarterly installments of 25%.

C. ~~C.~~—Our Automated Clearing House (ACH) option allows the ~~insured~~Insured to have 12 equal monthly installments.

Formatted: Font: (Default) Arial

There are no extra fees associated with ~~the any~~ premium payment plan.

Formatted: Left

#### ~~Q. Mandatory Quarterly Payment Option.~~

Formatted: No underline, Not Highlight

Formatted: Not Highlight

~~For medical liability insureds whose annual premiums total \$500 or more,~~

Formatted: Heading 3, Indent: Left: 0"

~~the plan must allow the option of quarterly payments.~~

Formatted: Left

Formatted: Left, Indent: Left: 1"

Formatted: Not Highlight

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

- An initial payment of no more than 40% of the estimated total premium due at policy inception;
- The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;
- No interest charges;
- Installation charges or fees of no more than the lesser of 1% of the total premium or \$25, whichever is less; and
- A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Formatted: Heading 4, No bullets or numbering

Non-Mandatory Quarterly Payment Option.

Formatted: Left

Formatted: Heading 3, Indent: Left: 0"

- For medical liability insureds whose annual premiums are less than \$500, insurers may, but are not required to, offer quarterly installment, installment, premium payment plans;
- For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans;
- If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.

Formatted: Heading 4, No bullets or numbering

Formatted: Not Highlight

Formatted: Not Highlight

Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

Formatted: Left

Formatted: Left, Indent: Left: 1"

The Company will offer the insured premium payment options, outlined in Section III 24.

Formatted: Body Text 2, No bullets or numbering

Formatted: Left

Formatted: Font: (Default) Arial

**XIII.XII. COVERAGE**

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. -The coverages will be rated under Standard Claims-Made Rates.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**XIV. BASIC LIMITS OF LIABILITY**

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

**XV.XIII. LIMITS OF LIABILITY**

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

**Liability Limit Factors**

Liability Limit	Limits	
	Physicians	Surgeons
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

**XVI.XIV. PRIOR ACTS COVERAGE**

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). -The retroactive date can be advanced only at the request or with the written acknowledgment of the insured/Insured, subject to underwriting.

**XVII.XV. EXTENDED REPORTING PERIOD COVERAGE**

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

**XVII. EXTENDED REPORTING PERIOD COVERAGE (Continued)**

B.

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Not Highlight

Formatted Table

Formatted

Formatted: Font: Bold, Not Highlight

Formatted: Centered

Formatted: Not Highlight

Formatted: Centered

Formatted

Formatted: Left, Space After: 0 pt

Formatted

Formatted

Formatted

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

Formatted

Formatted

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Heading 3

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

C. The premium for the Extended Reporting ~~Period Coverage~~ Endorsement shall be ~~the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:~~

1. The Extended Reporting Endorsement factor from the table below is ~~applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:~~

Year	Factor
<u>1<sup>st</sup></u>	<u>3.30</u>
<u>2<sup>nd</sup></u>	<u>3.15</u>
<u>3<sup>rd</sup></u>	<u>2.40</u>
<u>4<sup>th</sup></u>	<u>2.00</u>

2. For First Year Claims Made step, it is applied pro-rata.

3. For Second Year and all years of maturity, ~~it is applied to the expiring premium,~~ it is applied to the last year's (365 days) annualized premium from the date of cancellation.

C. ~~determined by applying the Extended Reporting Period Coverage rating factors shown in Section III-10.~~

D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.

E. The length of the Extended Reporting Period will be indefinite.

D. ~~in full within 30 days of the expiration of the policy.~~

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination

#### XVIII. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/-50
Healthcare Providers	+/-50

F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and

Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Font: (Default) Arial

Formatted: Heading 4, Indent: Left: 0", Pattern: Clear

Formatted: Font color: Auto

Formatted: Centered

Formatted: Heading 4

Formatted: Font color: Custom Color(RGB(192,80,77)), Strikethrough

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial, Font color: Auto, Not Strikethrough

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font color: Auto

Formatted: Font: (Default) Arial

Formatted: Heading 4, Indent: Left: 1"

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial

Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

Formatted: Font color: Red

Formatted: Font: (Default) Arial

- END OF SECTION I-

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL DEFINITION

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

4. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

- 1. Are comprised of 2 or more physicians;
2. Are organized as a legal entity;
3. Maintain common facilities (including multiple locations) and support personnel; and
4. Maintain medical/dental records of patients of the group as a historical record of patient care.

4.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

\$1,000,000 Per Claim
\$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

- Formatted: Font: (Default) Arial
Formatted: Left
Formatted: Left, Indent: Left: 1", No bullets or numbering
Formatted: Left
Formatted: Font: (Default) Arial, Font color: Auto
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial, Font color: Auto
Formatted: Font color: Auto
Formatted: Heading 3, No bullets or numbering, Tab stops: Not at 1.5"
Formatted: Font: (Default) Arial
Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"
Formatted: Left
Formatted: Left
Formatted: Font: (Default) Arial, Font color: Auto
Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"
Formatted: Font: (Default) Arial
Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial, 11 pt
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial
Formatted: Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial

**III. PREMIUM COMPUTATION (Continued)**

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

**B. Vicarious Liability Charge:** ~~For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage. For each employed physician and ancillary staff not individually insured by the Company, a premium charge will be made at the same separate corporate percentage rate calculated above, to the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.~~

**B.**

~~For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.~~

**III. CLASSIFICATIONS PREMIUM MODIFICATIONS**

~~The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.~~

~~The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.~~

Formatted: Font: (Default) Arial

Formatted: Normal, Indent: Left: 1"

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial

Formatted Table

Formatted: Font: (Default) Arial

Formatted: Heading 3

Formatted: Font: (Default) Arial, No underline

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Formatted Table

Formatted: Font: Not Bold

Formatted: Indent: Left: 0"

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.

**IV.**

**A. Corporations, Partnerships and Associations**

Formatted: Body Text FLI .5, bt, No bullets or numbering

Formatted: Font: (Default) Arial

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

Formatted: Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

2. Not otherwise identified as a Miscellaneous Entity.

**B. Miscellaneous Entities**

Formatted: Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

- a. Urgent Care Center
- b. Surgi Center
- c. MRI Center
- d. Renal Dialysis Center
- e. Peritoneal Dialysis Center

**V. PREMIUM MODIFICATIONS**

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

The following premium modifications are applicable to all filed programs.

**A. Schedule Rating**

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III-22.

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

~~B. Manual Rates~~

~~1. Corporations, Partnerships & Associations Rating Factors~~

~~As referenced in III in Section II-2:~~

~~See Table in Section II-2. Separate Corporate Limits~~

~~0% Shared Corporate Limits~~

~~2. Miscellaneous Entities~~

~~Not eligible under this Filing.~~

~~C. Policy Writing Minimum Premium~~

~~The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.~~

~~D. Premium Modifications~~

~~1. Schedule Rating Partnerships & Corporations~~

<del>Physician &amp; Surgeons</del>	<del>+/- 50%</del>
<del>Health Care Providers</del>	<del>+/- 50%</del>

~~2. Self-Insured Retention Credits See Section III.V.B~~

**- END OF SECTION II-**

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Font: (Default) Arial

**Formatted:** Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph

**Formatted:** Font: (Default) Arial

**Formatted:** Font: (Default) Arial

**Formatted:** Font: (Default) Arial

### SECTION III

## MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

Formatted: Top: 1", Bottom: 1", Footer distance from edge: 0.06"

### VI. CLASSIFICATIONS

#### A. Physicians/Surgeons and Non Physician Health Care Providers

- Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
- The Rate Classes are found in Section III -10 to Section III-15 of this Manual.

Formatted: Left

#### B. Locum Tenens Physician

- Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
- The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
- Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

Formatted: Left

#### C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

Formatted: Heading 3

Formatted: Heading 4, Indent: Left: 1"

Formatted: Font: (Default) Arial

Formatted: No underline

Formatted: No underline

#### D. Slot Rating

- Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are

Formatted: Left

Formatted: Font: (Default) Arial

covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Company.

E. Per Patient Visit Rating

1. Per patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.

2. The premium for the per patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.

3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.

4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

<u>Specialty</u>	<u>Conversion Factor</u>
<u>Urgent Care</u>	<u>.000160</u>
<u>Emergency Medicine</u>	<u>.000278</u>

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per Patient Visit Rating

Formatted: Font: (Default) Arial

Formatted: Left, Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5", Tab stops: Not at 1.5"

Formatted: Left, Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

Formatted: Font: (Default) Arial, Underline

Formatted: Left, Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25", Tab stops: Not at 1.25"

Formatted: Font: (Default) Arial









Fourth Year: 90%  
Fifth Year (Mature): 100%

Formatted: Font: (Default) Arial



C-1

15% of Class 6

10% of Class 6

**III. PREMIUM MODIFICATIONS**

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

B.A. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be is considered a part time practitioner and may be is eligible for a reduction of 50% o in the otherwise applicable rate for that specialty. -The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.
2. A Part Time Practitioner may include any practitioner in classes 1 through &10 only, except for Anesthesia and Emergency Medicine as identified in the class

B. Part Time Physicians (Continued)

2. plan. -The hours reported to the Company for rating purposes are subject to audit. -at the Company's discretion.
3. The part time credit is not applied to the Extended Reporting Period Coverage.
4. No other credits are to apply concurrent with this rule.

C.B. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. -For rating purposes, they are defined as follows:
  - a. a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
  - b. b. Resident - Various lengths of time depending upon medical specialty; 3 years average. -Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
  - c. c. Fellow - Follows completion of residency and is a higher level of training.

Formatted: Font: (Default) Arial, 11 pt, Bold, Font color: Auto

Formatted: Font color: Auto

Formatted: Font: (Default) Arial, 11 pt, Bold, Font color: Auto

Formatted: Font color: Auto

Formatted: No Spacing, Don't keep with next, Don't keep lines together

Formatted: Left

Formatted: Heading 4, Tab stops: 1.5", Left + 3.44", Left

Formatted: Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

Formatted: Left

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Heading 5, Indent: First line: 0", Space After: 6 pt

Formatted: Font: (Default) Arial, Font color: Auto

Formatted: Font: (Default) Arial, Font color: Auto

Formatted: Font: (Default) Arial

2. Coverage is available for activities directly related to a physician's training program. -The coverage will not apply to any professional services rendered after the training is complete.
3. a. \_\_\_\_\_ Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III-20.
- 3-4. The credit is not applied to the Extended Reporting Period Coverage.
- 4-5. The physician-in-training credit is 50% for 1<sup>st</sup> Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

Formatted: Font: (Default) Arial, Font color: Auto

Formatted: Left, Indent: Left: 0", First line: 0"

Formatted: Left

Formatted: Font color: Auto

Formatted: Heading 4, Indent: Left: 0", First line: 0"

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

Formatted: Left

D. Locum Tenens Physician (Continued)

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

Formatted: Left

E.C. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A reduced rate credit of 30% for first and second years and 20% for the third year will be applied. will be applied in accordance with the credits shown presented in Section III-20. No other credits are to apply concurrent with this rule.

Formatted: Left

Formatted: Left, Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25", Tab stops: Not at 1.75"

Formatted: Font color: Auto

Formatted: Left

Formatted: Font color: Auto

Formatted: Not Highlight

Formatted: Not Highlight

F.D. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for

Formatted: Left

Formatted: Font: (Default) Arial

coverage valid only for teaching activities related to an accredited training program.

a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III-20 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. -The coverage will not apply to any aspect of the insured's teaching activities.

a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

F. Physician Teaching Specialists  
(Continued)

b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

b.

c. No other credits are to apply concurrent with this rule.

e.

d. The applicable percentages are based upon hours, up to 50% are presented on presented in Section III-20.

G-E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

**Formatted:** Left, Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25", Tab stops: Not at 1.75"

**Formatted:** Font color: Auto

**Formatted:** No underline

**Formatted:** Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25"

**Formatted:** No underline

**Formatted:** Font color: Auto

**Formatted:** Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25", Tab stops: Not at 1.75"

**Formatted:** Font color: Auto

**Formatted:** Font color: Auto

**Formatted:** Left

**Formatted:** Font: (Default) Arial

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval. The credit to be applied to the applicable rate is presented in Section III-20.

F. ~~E.~~ Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free, the following schedule:

<u>Claim Free</u>	<u>Credit</u>
<u>0</u>	<u>0</u>
<u>1</u>	<u>2%</u>
<u>2</u>	<u>4%</u>
<u>3</u>	<u>6%</u>
<u>4</u>	<u>8%</u>
<u>5</u>	<u>10%</u>
<u>6</u>	<u>12%</u>
<u>7</u>	<u>14%</u>
<u>8</u>	<u>16%</u>
<u>9</u>	<u>18%</u>
<u>10+</u>	<u>20%</u>

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

A schedule is provided in Section III-20.

G. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

- Formatted: Underline
- Formatted: Font: (Default) Arial, Underline
- Formatted: Heading 3
- Formatted: Left
- Formatted: Body Text, Indent: Left: 1", Pattern: Clear
- Formatted: Underline
- Formatted: Centered
- Formatted Table
- Formatted: Centered
- Formatted: Left

- Formatted: Font: (Default) Arial

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

M. Schedule Rating (not to be used in conjunction with Loss Rating)

**Schedule Rating: Modifications, subject to Underwriting:**

For Individuals and Groups, subject to Underwriting,

1. The Company will consider all insureds for credits/debits:

1. <u>Historical Loss Experience</u>  +/- 25%	The frequency or severity of claims for the insured Insured(s) is greater/less than the expected experience for an insured Insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. <u>Cumulative Years of Patient Experience.</u>  +/- 10%	The insured Insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. <u>Classification Anomalies.</u>  +/- 25%	Characteristics of a particular insured Insured that differentiate the insured Insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. <u>Claim Anomalies</u>  +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. <u>Management Control Procedures.</u>  +/- 10%	Specific operational activities undertaken by the insured Insured to reduce the frequency and/or severity of claims.
6. <u>Number /Type of Patient Exposures.</u>  +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. <u>Organizational Size / Structure.</u>  +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured Insured.
8. <u>Medical Standards, Quality &amp; Claim Review.</u>	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice. (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide

- Formatted: Left
- Formatted: Font: 11 pt
- Formatted: Font: 11 pt
- Formatted: Centered, Indent: Left: 0"
- Formatted: Indent: Left: 1"
- Formatted: Heading 4, Indent: Left: 0", Pattern: Clear
- Formatted: Font: (Default) Arial
- Formatted Table

- Formatted: Font: (Default) Arial

+/- 10%	<u>consistent review of claims/incidents that have occurred and to develop corrective action.</u>
<u>9. Other Risk Management Practices and Procedures.</u>	<u>Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.</u>
+/- 10%	
<u>10. Training, Accreditation &amp; Credentialing.</u>	<u>The insured Insured(s) exhibits greater/less than normal participation and support of such activities.</u>
+/- 10%	
<u>11. Record –Keeping Practices.</u>	<u>Degree to which insured Insured incorporates methods to maintain quality patient records, referrals, and test results.</u>
+/- 10%	
<u>12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures</u>	<u>Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.</u>
+/- 10%	
<u>Maximum Modification</u>	<u>+ / - 5025%</u>

A.H. Experience Rating

1. A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

- a. Premiums paid
- b. Number of claims
- c. Incurred losses
- d. Cause of such losses
- e. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review.

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

- Formatted: Font: 8 pt
- Formatted Table
- Formatted: Font: (Default) Arial, Underline
- Formatted: Left, Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1", Tab stops: Not at 0"
- Formatted: Font: (Default) Arial
- Formatted: Heading 4
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial
- Formatted: Heading 5, Indent: Left: 2"
- Formatted: Font: (Default) Arial
- Formatted: Heading 5, Indent: Left: 2", Space After: 12 pt
- Formatted: Font: (Default) Arial
- Formatted: Heading 4
- Formatted: Font: (Default) Arial
- Formatted: Heading 3, Indent: Left: 1"
- Formatted: Font: (Default) Arial

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least \$100,000 in estimated annual premium.

Formatted: Heading 3, Indent: Left: 1"

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at \$250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

Credibility x Adjusted Actual Loss Ratio - Adjusted Expected Loss Ratio = Experience Mod.

Adjusted Expected Loss Ratio

D. Experience Rating (Continued)

Formatted: No underline

Formatted: Left, Indent: Left: 1"

Formatted: Heading 3, Indent: Left: 1"

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

Formatted: Font: (Default) Arial, Underline

Formatted: Heading 3, Left, Indent: First line: 0", Space After: 0 pt, Pattern: Clear

Formatted: Font: (Default) Arial, 11 pt

I. Risk Management

Formatted: Font: (Default) Arial

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

~~VII. APPLICATION OF MANUAL~~

~~This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non-physician health care providers.~~

~~VIII. BASIC LIMITS OF LIABILITY~~

~~Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:~~

~~Claims Made Coverage~~

~~\$1,000,000 Per Claim~~

~~\$3,000,000 Aggregate~~

~~IX. PREMIUM COMPUTATION~~

~~The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown in Section III 17 to Section III 20, in accordance with each individual's medical classification and class plan designation.~~

~~X. CLASSIFICATIONS~~

~~A. Physicians/Surgeons and Non-Physician Health Care Providers~~

~~1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.~~

~~2. The Rate Classes are found in Section III 10 to Section III 15 of this Manual.~~

~~B. Part Time Physicians~~

~~1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.~~

~~2. A Part Time Practitioner may include any practitioner in classes 1 through 8 only, except for Anesthesia and Emergency Medicine as identified in the class~~

~~B. Part Time Physicians (Continued)~~

~~plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

~~3. The part time credit is not applied to the Extended Reporting Period Coverage.~~

~~4. No other credits are to apply concurrent with this rule.~~

~~C. Physicians in Training~~

~~1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:~~

~~a. First Year Resident (or Intern) 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.~~

~~b. Resident various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.~~

~~c. Fellow Follows completion of residency and is in a higher level of training.~~

~~2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.~~

~~a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III 20.~~

~~3. The credit is not applied to the Extended Reporting Period Coverage.~~

~~4. No other credits are to apply concurrent with this rule.~~

~~D. Locum Tenens Physician~~

Formatted: Font: (Default) Arial

Formatted: Normal, Indent: Left: 1", Space After: 0 pt

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", First line: 0"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5" + 3.44"

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", Tab stops: Not at 1.5" + 2" + 3.44"

Formatted: Normal, Tab stops: Not at 1.5" + 3.44"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted ...

Formatted ...

Formatted ...

Formatted ...

Formatted: Normal, Indent: Left: 1"

Formatted: Font: (Default) Arial

~~1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Normal, Indent: Left: 1"

~~D. Locum Tenens Physician (Continued)~~

~~2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.~~

Formatted: Normal, Indent: Left: 1", Tab stops: Not at 1.5"

~~3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~E. New Physician~~

~~1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full-time practice for the first time:~~

Formatted: Normal, Indent: Left: 1"

~~e. Residency;~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~f. Fellowship program in their medical specialty;~~

~~g. Fulfillment of a military obligation in remuneration for medical school tuition;~~

Formatted: Normal, Indent: Left: 1", Space After: 0 pt, No bullets or numbering

~~h. Medical school or specialty training program.~~

~~2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~3. A reduced rate will be applied in accordance with the credits shown presented in Section III 20. No other credits are to apply concurrent with this rule.~~

~~F. Physician Teaching Specialists~~

Formatted: Normal, Indent: Left: 1"

~~1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~b. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III 20 to determine the applicable credit.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering

~~2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.~~

Formatted: Normal, Indent: Left: 1"

~~e. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

~~F. Physician Teaching Specialists (Continued)~~

~~f. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering

~~g. No other credits are to apply concurrent with this rule.~~

Formatted: Normal, Indent: Left: 1"

~~h. The applicable percentages are presented on presented in Section III 20.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~G. Physician's Leave of Absence~~

Formatted: Font: (Default) Arial

~~1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.~~

Formatted: Font: (Default) Arial

~~2. This will apply retroactively to the first day of disability or leave of absence.~~

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

~~3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.~~

~~4. The credit to be applied to the applicable rate is presented in Section III 20.~~

~~XI. PREMIUM MODIFICATIONS~~

~~The following premium modifications are applicable to all filed programs:~~

~~A. Schedule Rating~~

~~The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.~~

~~The premium for a risk may be modified in accordance with a maximum modification indicated in Section III 22, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III 22.~~

~~B. Risk Management~~

~~1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.~~

~~C.J. Deductible Credits~~

~~Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). -Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). -Deductibles are subject to approval by the Company based on financial statements to be submitted by the insuredInsured, and financial guarantees are required. -The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Indent: Left: 1", Space After: 0 pt, Pattern: Clear

Formatted: Normal, Indent: Left: 1"

Formatted: Left, Space After: 0 pt, Pattern: Clear

Formatted: Font: (Default) Arial

Formatted: Heading 3, Indent: Left: 0"

Formatted: Heading 3

Formatted: Left, Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Left

Formatted: Font: (Default) Arial





**C. Deductible Credits (Continued)**

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
<del>200/600</del>	<del>.396</del>	<del>.394</del>	<del>.385</del>	<del>.366</del>	<del>\$510,000</del>
<del>250/750</del>	<del>.467</del>	<del>.467</del>	<del>.462</del>	<del>.446</del>	<del>\$637,500</del>
<del>200/600</del>	<del>.396</del>	<del>.394</del>	<del>.385</del>	<del>.366</del>	<del>510,000</del>
<del>250/750</del>	<del>.467</del>	<del>.467</del>	<del>.462</del>	<del>.446</del>	<del>637,500</del>

**D. Experience Rating**

~~This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.~~

~~On an optional basis, large risks with sufficiently credible loss experience may be loss rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least \$100,000 in estimated annual premium.~~

~~The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.~~

~~Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at \$250,000 per loss.~~

- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1"
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial, 11 pt, Bold
- Formatted Table
- Formatted: Font: (Default) Arial, 11 pt, Bold
- Formatted: Centered
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Centered
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted Table
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial
- Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"
- Formatted: Font: (Default) Arial

~~The experience period does not include the 12 month period immediately prior to the effective date of the experience modification.~~

~~The experience rating modification is calculated using the following formula:~~

$$\frac{\text{Credibility} \times \text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} \times \text{Experience Mod.}$$

#### ~~D. Experience Rating (Continued)~~

~~Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.~~

#### ~~E. Claim Free Credit Program~~

~~If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided in Section III 20.~~

#### ~~K. F. Individual Risk Rating~~

~~\_\_\_\_\_ A risk may be individually rated by submitting a filing to the Illinois Department of \_\_\_\_\_ Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. \_\_\_\_\_ The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual \_\_\_\_\_ experience, location or dispersion of exposure, and \_\_\_\_\_ shall apply to all risks under the same or substantially the same circumstances or \_\_\_\_\_ conditions. -We must list the standards by which variations in hazards or expense \_\_\_\_\_ provisions are measured, in order -to determine that a specific risk is so different in \_\_\_\_\_ hazard/expense that it warrants individual rating.~~

### ~~XII. MODIFIED PREMIUM COMPUTATION~~

#### ~~A. Slot Rating~~

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial, Underline

Formatted: Heading 3

Formatted: Font: (Default) Arial

Formatted: Left, Indent: Left: 1"

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Left, Indent: Left: 1"

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Font: (Default) Arial

- ~~1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.~~
- ~~2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.~~
- ~~3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.~~

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

~~B. Requirements for Waiver of Premium for Extended Reporting Period Coverage:~~

- ~~1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.~~
- ~~2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.~~
- ~~3. The Reporting Period is unlimited.~~

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

~~C. Blending Rates~~

~~A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his~~

**Formatted:** Space After: 12 pt

~~new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until~~

**Formatted:** Font: (Default) Arial

~~the full GYN rate is achieved at the start of the fourth year.~~

~~D. Per Patient Visit Rating~~

- ~~1. Standard Claims Made coverage for group practices is available, at the Company's option, on a per patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.~~
- ~~2. The number of patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.~~
- ~~3. The applicable medical specialty rate is divided by the equivalent patient visits resulting in the patient visit rate to be applied to the visits projected for the policy period. The product of the patient visit rate and the projected visits results in the indicated manual premium.~~
- ~~4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~
- ~~5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.~~

**XIII. PREMIUM COMPUTATION DETAILS**

**A. Classifications**

- ~~1. Applicable to Standard Claims Made Programs.~~
- ~~2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.~~

**PHYSICIANS & SURGEONS**

**CLASS 1**

- ~~Allergy/Immunology~~
- ~~Forensic Medicine~~
- ~~Occupational Medicine~~
- ~~Otorhinolaryngology-NMRP, NS~~
- ~~Physical Med. & Rehab.~~

~~Public Health & Preventative Med~~

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 2**

Dermatology

Formatted: Font: (Default) Arial

Endocrinology

Formatted: Font: (Default) Arial

Geriatrics

Formatted: Font: (Default) Arial

Ophthalmology-NS

Formatted: Font: (Default) Arial

Pathology

Formatted: Font: (Default) Arial

Pediatrics, No Surgery

Formatted: Font: (Default) Arial

Psychiatry

Formatted: Font: (Default) Arial

Rheumatology

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 3**

Formatted: Font: (Default) Arial

Pediatrics-NMRP

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 4**

Diabetes

Formatted: Font: (Default) Arial

Family Practice-NMRP, NS

Formatted: Font: (Default) Arial

General Practice-NMRP, NS

Formatted: Font: (Default) Arial

General Surgery-NMRP

Formatted: Font: (Default) Arial

Hematology

Formatted: Font: (Default) Arial

Industrial Medicine

Formatted: Font: (Default) Arial

Neurosurgery-NMRP, NMajS

Formatted: Font: (Default) Arial

Nuclear Medicine

Formatted: Font: (Default) Arial

Oncology

Formatted: Font: (Default) Arial

Ophthalmic Surgery

Formatted: Font: (Default) Arial

Oral/Maxillofacial Surgery

Formatted: Font: (Default) Arial

Orthopaedics-NMRP, NS

Formatted: Font: (Default) Arial

Radiation Oncology

Formatted: Font: (Default) Arial

Thoracic Surgery-NMRP, NS

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 5**

- Cardiovascular Disease-NMRP, NS
- Infectious Disease
- Nephrology-NMRP
- Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 6**

- Gynecology-NMRP, NS
- Internal Medicine-NMRP
- Certified Registered Nurse Anesthetist
- Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 7**

- Anesthesiology
- Nephrology-MRP
- Podiatry, Surgery
- Pulmonary Diseases
- Radiology-NMRP
- Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 8**

- Cardiac Surgery-MRP, NMajS
- Cardiovascular Disease-Spec. MRP
- Gastroenterology
- General Surgery-MRP, NMajS
- Hand Surgery-MRP, NMajS
- Internal Medicine-MRP
- Neurology
- Orthopaedics-MRP, NMajS
- Otorhinolaryngology-MRP, NMajS
- Pediatrics-MRP
- Radiology-MRP
- Urology-MRP, NMajS
- Vascular Surgery-MRP, NMajS

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 9**

Family Practice-MRP, NMajS

General Practice-MRP, NMajS

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 10**

Neurosurgery-MRP, NMajS

Urological Surgery

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 11**

Cardiovascular Disease-MRP

Colon Surgery

Formatted: Font: (Default) Arial

Emergency Medicine-NMajS, prim

Formatted: Font: (Default) Arial

Gynecology/Obstetrics-MRP, Nmaj

Formatted: Font: (Default) Arial

Otorhinolaryngology; No Elective  
Plastic

Formatted: Font: (Default) Arial

Radiology-MajRP

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 12**

Emergency Medicine-MajS

Formatted: Font: (Default) Arial

Family Practice-not primarily MajS

Formatted: Font: (Default) Arial

General Practice-NMajS, prim

Formatted: Font: (Default) Arial

Gynecological Surgery

Formatted: Font: (Default) Arial

Hand Surgery

Formatted: Font: (Default) Arial

Head/Neck Surgery

Formatted: Font: (Default) Arial

Otorhinolaryngology; Head/Neck

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 13**

Formatted: Font: (Default) Arial

General Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 14**

Neonatology  
Otorhinolaryngology; Other Than  
Head/Neck  
Plastic Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 15**

Orthopaedic Surgery s/o Spine  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 16**

Cardiac Surgery  
Thoracic Surgery  
Vascular Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 17**

Obstetrical/Gynecological Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 18**

Neurosurgery-No Intracranial Surgery  
Orthopaedic Surgery w/Spine  
Other, Specialty NOC

Formatted: Font: (Default) Arial

**CLASS 19**

Neurosurgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

**MEDICAL PROCEDURE DEFINITIONS**

**~~NMRP: — NOMINAL MINOR RISK PROCEDURE~~**

**~~NS: — NO SURGERY~~**

**~~NOC: — NOT OTHERWISE CLASSIFIED~~**

**~~NMAJS: — NO MAJOR SURGERY~~**

**~~MRP: — MINOR RISK PROCEDURES~~**

**~~MAJRP: — MAJOR RISK PROCEDURES~~**

**~~NON PHYSICIAN HEALTH CARE PROVIDERS~~**

**Class X**

~~Follow, Intern, Optician, Resident, Social Worker~~

**Class Y**

~~Optometrist, Physical Therapist, X-Ray and Lab Technicians~~

**Class Z**

~~Nurse Practitioner — Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care~~

~~Physician Assistant — Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care~~

~~Psychologist — Class 4~~

~~Certified Registered Nurse Anesthetist~~

~~Shared Limits — 20% times Anesthesiologist rate~~

~~Separate Limits — 25% times Anesthesiologist rate~~

~~Certified Nurse Midwife — No complicated OB or surgery~~

~~Shared Limits — Not available~~

~~Separate Limits — 50% of OB/GYN rate~~

**B. Territory Definitions**

Formatted: Font: (Default) Arial

**TERRITORY 1 COUNTIES**

Cook, Jackson, Madison, St. Clair and Will

**TERRITORY 2 COUNTIES**

Lake, Vermillion

**TERRITORY 3 COUNTIES**

Kane, McHenry, Winnebago

**TERRITORY 4 COUNTIES**

DuPage, Kankakee, Macon

**TERRITORY 5 COUNTIES**

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

**TERRITORY 6 COUNTIES**

Grundy, Sangamon

**TERRITORY 7 COUNTIES**

Peoria

**TERRITORY 8 COUNTIES**

Remainder of State

C. Standard Claims Made Program Step Factors

First Year: \_\_\_\_\_ 25%  
Second Year: \_\_\_\_\_ 50%  
Third Year: \_\_\_\_\_ 78%  
Fourth Year: \_\_\_\_\_ 90%  
Fifth Year (Mature): \_\_\_\_\_ 100%

Mature Rates for Physicians and Surgeons (Claims made):

\_\_\_\_\_ **\$1,000,000 / 3,000,000**

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,594	9,295	7,354	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,594	9,295	7,354	7,999

Formatted: Font: (Default) Arial







Formatted: Font: (Default) Arial

D. Mature Rates for non-Physician Health Care Providers

Class X equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 10% of Class 4 rate for separate limits.

Class Y equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 15% of the Class 4 rate for separate limits.

Class Z equals 10% of the Class 1 Physician/Surgeon rate for shared limits; 25% of Class 1 Physician/Surgeon rate for separate limits.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 11 rate.

E. Liability Limits Factors:

	Limits	
	Physicians	Surgeons
<del>500/1.0</del>	<del>.719</del>	<del>.719</del>
<del>1M/3M</del>	<del>1.0</del>	<del>1.0</del>
<del>2M/4M</del>	<del>1.36</del>	<del>1.55</del>
<del>3M/5M</del>	<del>1.52</del>	<del>1.73</del>

Formatted: Font: (Default) Arial

F. Extended Reporting Period Coverage Factors:

1. The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Formatted: Font: (Default) Arial

<u>Year</u>	<u>Factor</u>
1 <sup>st</sup>	3.30
2 <sup>nd</sup>	3.15
3 <sup>rd</sup>	2.40
4 <sup>th</sup>	2.00

2. For First Year Claims Made step, the corresponding factor above is applied pro-rata. For Second Year and all years of maturity, the corresponding factor above is applied to the expiring premium.

F. Extended Reporting Period Coverage Factors (Continued):

3. The Reporting Period is unlimited.

G. Shared Limits Modification:  
Not available.

H. Policy Writing Minimum Premium:  
Physicians & Surgeons — \$500.

I. Policy Writing Minimum Premium:  
Non-Physician Healthcare Providers — \$500

J. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:  
Class X: 20% of Class 1  
Class Y: 25% of Class 1  
Class Z: 35% of Class 1

K. Premium Modifications

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons — 30%
2. Physicians in Training — 4<sup>th</sup> Year Resident 50%; Resident 40%; Fellow 30%.
3. Locum Tenens — no premium, subject to prior underwriting approval
4. New Physicians & Surgeons — 30% for the first two years of practice
5. Physician Teaching Specialists — Non-surgical 50%; Surgical 40%.
6. Physician's Leave of Absence — full suspension of insurance and premium for up to one year, subject to underwriting approval

L. Claim Free Credit Program

Formatted: Font: (Default) Arial  
Formatted: Font: (Default) Arial  
Formatted: Font: (Default) Arial  
Formatted: Font: (Default) Arial  
Formatted: Font: (Default) Arial

~~If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:~~

- ~~1. If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date. [indented over]~~
- ~~2. If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.~~
- ~~3. If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.~~
- ~~4. If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.~~

~~A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.~~

Formatted: Font: (Default) Arial

M. Schedule Rating (not to be used in conjunction with Loss Rating)

<del>1. Historical Loss Experience +/- 25%</del>	<del>The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.</del>
<del>2. Cumulative Years of Patient Experience. +/- 10%</del>	<del>The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.</del>
<del>3. Classification Anomalies. +/- 25%</del>	<del>Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.</del>
<del>4. Claim Anomalies +/- 25%</del>	<del>Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).</del>
<del>5. Management Control Procedures. +/- 10%</del>	<del>Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.</del>
<del>6. Number /Type of Patient Exposures +/- 10%</del>	<del>Size and/or demographics of the patient population which influences the frequency and/or severity of claims.</del>
<del>7. Organizational Size / Structure +/- 10%</del>	<del>The organization's size and processes are such that economies of scale are achieved while servicing the insured.</del>
<del>8. Medical Standards, Quality &amp; Claim Review. +/- 10%</del>	<del>Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.</del>
<del>9. Other Risk Management Practices and Procedures. +/- 10%</del>	<del>Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.</del>
<del>10. Training, Accreditation &amp; Credentialing. +/- 10%</del>	<del>The insured(s) exhibits greater/less than normal participation and support of such activities.</del>
<del>11. Record Keeping Practices. +/- 10%</del>	<del>Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.</del>
<del>12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%</del>	<del>Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.</del>
<del>Maximum Modification</del>	<del>+ / - 50%</del>

Formatted: Font: (Default) Arial

~~N~~ [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

~~Q. Mandatory Quarterly Payment Option.~~

~~For medical liability insureds whose annual premiums total \$500 or more, the plan must allow the option of quarterly payments.~~

- ~~6. An initial payment of no more than 40% of the estimated total premium due at policy inception.~~
- ~~7. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively.~~
- ~~8. No interest charges.~~
- ~~9. Installment charges or fees of no more than the lesser of 1% of the total premium or \$25, whichever is less; and~~
- ~~10. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.~~

~~Non-Mandatory Quarterly Payment Option.~~

- ~~4. For medical liability insureds whose annual premiums are less than \$500, insurers may, but are not required to, offer quarterly installment, premium payment plans.~~
- ~~5. For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.~~
- ~~6. If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.~~

~~Quarterly installment premium payment plans subject to (F) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may~~

Formatted: Font: (Default) Arial, Highlight

Formatted: Font: (Default) Arial

but need not re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

Formatted: Font: (Default) Arial

**-END OF SECTION III-**

Formatted: Font: (Default) Arial

**SECTION IV**

**Medicus Secured Protection Program**

**I. OVERVIEW**

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

- DEA License Suspension
- Professional Misconduct
- Successful Completion of Chemical Dependency Program
- Adverse Claims Experience (Severity and/or Frequency)
- Proctorship
- Medical Board Sanctions or Fines
- Unusual Practice Characteristics
- Physical or Mental Health Impairments
- Bare Exposure Period
- Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

**II. APPLICANT REFERRAL CRITERIA:**

**A. Eligibility-New Business**

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

**B. Eligibility-Renewal Business**

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

- Formatted: Heading 1, Left, Widow/Orphan control
- Formatted: Left: 1", Right: 1"
- Formatted: Font: (Default) Arial, Bold
- Formatted: Font: (Default) Arial
- Formatted: Heading 2, Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial

- Formatted: Heading 2, Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial, Not Bold, Underline
- Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial, Not Bold, Underline
- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1"
- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1", Space After: 12 pt
- Formatted: Font: (Default) Arial, Not Bold, Underline
- Formatted: Heading 3, Indent: Left: 0", Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1"

~~1.~~ ~~4.~~ A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

Formatted: Heading 4, Indent: Left: 0", First line: 0", Widow/Orphan control, Hyphenate

~~2.~~ ~~2.~~ A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

Formatted: Indent: Left: 0.75"

Formatted: Heading 4, Indent: Left: 0", First line: 0", Widow/Orphan control, Hyphenate

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

Formatted: Indent: Left: 0.75"

Formatted: Indent: Left: 1"

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

Formatted: Indent: Left: 0.25"

Formatted: Indent: Left: 1"

**III. 3. LENGTH OF INSURED'S REHABILITATION**

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

**IV. 4. RATING APPROACH**

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the ~~insured~~ ~~insured~~ has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial

**V. 5. UNDERWRITING**

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0.5"

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

Formatted: Indent: Left: 0.31"

Formatted: Indent: Left: 0.31"

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial, Underline

Formatted: Font: (Default) Arial, Not Bold, Underline

A. Coverage Modifications

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial, Not Bold, Underline

1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial

2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).

Formatted: Heading 4, No bullets or numbering, Widow/Orphan control, Hyphenate, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Heading 4, Widow/Orphan control, Hyphenate

3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.

Formatted: Heading 4, No bullets or numbering, Widow/Orphan control, Hyphenate, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Heading 4, Widow/Orphan control, Hyphenate

4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.

Formatted: Heading 4, No bullets or numbering, Widow/Orphan control, Hyphenate, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Font: (Default) Arial, Not Bold, Underline

B. Consent to Settle

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.5"

Formatted: Font: (Default) Arial, Not Bold, Underline

C. Impaired Physicians

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.5"

#### D. ~~D.~~ Prior Acts

Formatted: Font: (Default) Arial, Not Bold, Underline

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.5"

#### E. ~~E.~~ Imposed Deductibles

Formatted: Font: (Default) Arial

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

Formatted: Font: (Default) Arial, Not Bold, Underline

Formatted: Heading 3, Indent: Left: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.25"

### VI. ~~6.~~ PHYSICIAN OR GROUP MANAGEMENT

Formatted: Indent: Left: 0.5"

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III ~~(K)~~ Premium Modifications.

Formatted: Font: (Default) Arial

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0"

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurance
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

Formatted: Indent: Left: 0.38"

**VII. ~~7.~~ INTERNAL LOGISTICS**

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

Formatted: Font: (Default) Arial, Not Bold

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Heading 2, Widow/Orphan control











Points Evaluation Worksheet

Insured: \_\_\_\_\_ Policy#: \_\_\_\_\_  
 (If Applicable)  
 Effective Date: \_\_\_\_\_ Review Date: \_\_\_\_\_

Criteria	Points
Claims Frequency	_____
Drug or Alcohol Impairment – Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges – Any State	_____
Procedures	_____
Physician or group Management	_____
Gaps in Coverage	_____
Other	_____
Total Points:	_____

Formatted: Font: (Default) Arial

Ranges & Surcharges

Point Range	Surcharge	Point Range	Surcharge	Point Range	Surcharge
0 – 100	0%	301 – 325	90%	471 – 490	275%
101-130	40%	326 – 350	100%	491 – 510	300%
131 – 160	45%	351 – 370	125%	511 – 530	325%
161 – 190	50%	371 – 390	150%	531 – 550	350%
191 – 210	55%	391 – 410	175%	551 – 570	375%
211 – 250	60%	411 – 430	200%	571 – 590	400%
251 – 280	70%	431 – 450	225%	591+	Nonrenew
281 – 300	80%	451 – 470	250%		

Formatted: Font: (Default) Arial

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by: \_\_\_\_\_ Approved by: \_\_\_\_\_

**-END OF MANUAL-**

SERFF Tracking Number: MEIC-127992453

State: Illinois

Filing Company: Medicus Insurance Company

State Tracking Number: MEIC-127992453

Company Tracking Number: IL 01/2012 SCHEDCRED

TOI: 11.2 Med Mal-Claims Made Only

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations

Product Name: IL 01/2012 Rate Manual

Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Explanatory Memorandum

**Comments:**

Please see the attached Explanatory Memorandum for the Illinois Rate Manual 01/2012.

**Attachment:**

Explanatory Memo Rate Filing IL 3-1-12.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Form RF3 - (Summary Sheet)

**Comments:**

Please see the attached.

**Attachment:**

RF-3\_2012\_1.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Certification

**Comments:**

Please see the attached signed Certification

**Attachment:**

IL Cert Med Mal Rates 2012 (Signed1).pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Manual

**Comments:**

Due to the modifications throughout the manual, we thought it necessary to send the entire manual. The final version and changes tracked version are attached to the Rate/Rule Schedule tab.

MEDICUS INSURANCE COMPANY  
ILLINOIS PHYSICIANS AND SURGEONS  
MARCH 1, 2012 RATE FILING  
EXPLANATORY MEMORANDUM

The following documentation, including accompanying exhibits, supports the requested change for the Illinois professional liability rates of Medicus Insurance Company. The proposed rates are requested to become effective for new and renewal business on March 1, 2011.

#### MEDICUS EXPERIENCE

Medicus entered Illinois Physician and Surgeon's Medical Professional liability market in 2006. Through December, 2011, Medicus inception to date gross earned premium in Illinois has totaled \$66.4 million.

Exhibit 1 presents the results of a review of Medicus' experience in Illinois and the indicated and proposed overall rate changes.

On Exhibit 1, Sheet 2, Medicus' historical experience is developed to an ultimate basis, adjusted for historical rate changes in Illinois and trended to the prospective policy period. Please note that there have been no rate changes with material impact on the rate level since Medicus entered the market.

Exhibit 1, Sheet 1, presents the derivation of the +1.6% rate indication based on Medicus' experience. The selected policy year 2012 loss ratio from Exhibit 1, Sheet 2, is credibility weighted with the permissible loss ratio. The credibility weighted loss ratio is compared to the permissible loss ratio to generate the indication.

Exhibit 2 shows the projected expenses and the calculation of the permissible loss ratio. Exhibit 3 shows the return on equity calculation that is included to provide an after tax return on equity. Exhibit 4 shows the payment pattern assumed for including investment income in Exhibit 3.

#### RATE LEVEL CHANGE

Medicus is proposing to implement various changes with an overall impact of -1.5%. The proposed changes include:

- Revisions to the territory plan
- Revisions to the specialty class plan
- Revised part-time discount, including increasing the maximum from -30% to -50%
- Revisions to the Claims-Free Discount
- Capping the Schedule Rating at +-25% per Illinois DOI directions
- Extracting the Experience Rating component from Schedule Rating

Component	Rate Impact
Base Rate	0.0%
Territory Plan Changes	-0.2%
Specialty Class Plan Changes	-0.2%
Claims Free Discount Changes	-1.1%
Schedule/Experience/Part-Time Rating Plans	0.0%
<b>Total</b>	<b>-1.5%</b>

Medicus, as a recent start-up insurance company, does not have sufficient data available for an experience based review of their Illinois class or territory plans, and will likely not have sufficient data for several years. Therefore, Medicus relies on industry data and underwriting judgment.

Based on a review of competitor territorial plans, Medicus has shifted four counties between territories. Specifically, Lake County has moved to Territory 3 and Knox, Adams and Rock Island Counties have moved to Territory 7. This review is shown on Exhibit 5. The overall impact is -0.2%.

Medicus has revised the class plan used in Illinois to more closely align with that used by Medicus in other states and to better reflect evolving views of the risk posed by various specialties as well as revisions in other major carriers' specialty class plans. For the specialties where Medicus has the highest risk count in Illinois, proposed changes are presented in Exhibit 6. We believe the proposed changes are reasonable and consistent with the market. The overall impact is -0.2%.

The Claims Free Discount is being revised to be consistent with the discount offered by Medicus in other states. The expected impact is -1.1%.

At the direction of the Illinois Department, we have revised the Schedule Rating Plan to reflect a maximum surcharge/discount of +-25%. Concurrently, we are extracting the Experience Rating Plan components from Schedule Rating and expanding the maximum part-time discount from 30% to 50%. By itself, the overall impact of the revised Schedule Rating Plan would have been +2.52%; however, in combination we are projecting no overall impact.

The rate impact of these changes was calculated by re-rating Medicus' in force book of business using the new factors.

**Section 754.EXHIBIT A Summary Sheet (Form RF-3)**

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 03/01/2012.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger	0	
	Commercial	0	
2.	Automobile Physical Damag Private Passenger	0	
	Commercial	0	
3.	Liability Other Than Auto	0	
4.	Burglary and Theft	0	
5.	Glass	0	
6.	Fidelity	0	
7.	Surety	0	
8.	Boiler and Machinery	0	
9.	Fire	0	
10.	Extended Coverage	0	
11.	Inland Marine	0	
12.	Homeowners	0	
13.	Commercial Multi-Peril	0	
14.	Crop Hail	0	
15.	Other Medical Malpractice	\$17,882,280	2.120%
	Life of Insurance		

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: Applies to all Illinois territories, classes and insureds.

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): We are revising our class/specialty plan, territories, part-time credit, as well as our scheduled credit plan per state mandate which will apply across all Illinois territories and insureds (physicians, surgeons, ancillaries and entities).

\*Adjusted to reflect all prior rate changes.

\*\*Change in Company's premium level which will result from application of new rates.

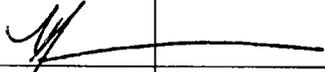
Medicus Insurance Company  
 Name of Company  
Mark Johnson - Vice President and CFO  
 Official – Title

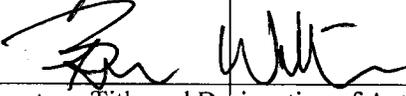
# ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates 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.

I, Mark Johnson, a duly authorized officer of Medicus Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Bruce Williams, a duly authorized actuary of NORCAL Mutual Insurance Company, am authorized to certify on behalf of Medicus Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

 CFO  
\_\_\_\_\_  
Signature and Title of Authorized Insurance Company Officer 01/31/2012  
Date

 ANP Actuarial ACAS MAAA  
\_\_\_\_\_  
Signature, Title and Designation of Authorized Actuary 01/31/2012  
Date

Insurance Company FEIN 20-5623491 Filing Number IL RM 01/2012

Insurer's Address 4807 Spicewood Springs, Bldg 4-100

City Austin State TX Zip Code 78759

Contact Person's:  
Name and E-mail Jane M. Cundiff (jcundiff@medicusins.com)

Direct Telephone and Fax Number 512-879-5128, Fax: 877-686-0558

SERFF Tracking Number: MEIC-127992453 State: Illinois  
 Filing Company: Medicus Insurance Company State Tracking Number: MEIC-127992453  
 Company Tracking Number: IL 01/2012 SCHEDCRED  
 TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations  
 Product Name: IL 01/2012 Rate Manual  
 Project Name/Number: IL RM 01/2012/IL RM 01/2012

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/31/2012	Rate and Rule	IL Rate Manual 01/2012	02/14/2012	IL Rate Manual 2012 01 26 (FINAL).pdf (Superceded) IL Rate Manual 2012 01 26 (CHANGES TRACKED).pdf (Superceded)
02/09/2012	Supporting Document	Form RF3 - (Summary Sheet)	02/10/2012	RF-3_2012.pdf (Superceded)
02/07/2012	Supporting Document	Form RF3 - (Summary Sheet)	02/09/2012	RF-3.pdf (Superceded)
01/17/2012	Supporting Document	Form RF3 - (Summary Sheet)	02/07/2012	RF-3 - Medicus 2012.pdf (Superceded)
01/17/2012	Supporting Document	Certification	02/08/2012	IL Cert Med Mal Rates 2012 (Signed).pdf (Superceded)



## **MANUAL**

### **SECTION I**

#### **GENERAL RULES**

##### **I. PURPOSE OF MANUAL**

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

##### **II. POLICY TERM**

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

##### **III. LOCATION OF PRACTICE**

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

The Territory Definitions are:

1. Counties: Cook, Jackson, Madison, St. Clair and Will
2. Counties: Vermillion
3. Counties: Kane, Lake, McHenry and Winnebago
4. Counties: DuPage, Kankakee and Macon
5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph
6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

8. Remainder of State

**IV. PREMIUM COMPUTATION**

- A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.
- B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

**V. FACTORS OR MULTIPLIERS**

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

**VI. WHOLE DOLLAR RULE**

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

- A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and
- B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

**VII. ADDITIONAL PREMIUM CHARGES**

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

**VIII. RETURN PREMIUM FOR MID-TERM CHANGES**

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

## **IX. POLICY CANCELLATIONS**

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
  - 1. A policy is canceled at the Company's request.
  - 2. The Insured is leaving a group practice, or
  - 3. Death, disability or retirement of the Insured.
- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.

## **X. POLICY MINIMUM PREMIUM**

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

## **XI. PREMIUM PAYMENT PLAN**

The Company offers the Insured the choice to pay in full or the following premium payment options:

- A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.
- B. The quarterly payment plan requires a 25% down payment and three quarterly installments of 25%.
- C. Our Automated Clearing House (ACH) option allows the Insured to have 12 equal monthly installments.

There are no extra fees associated with any premium payment plan.

## **XII. COVERAGE**

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverage will be rated under Standard Claims-Made Rates.

**XIII. LIMITS OF LIABILITY**

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factor as applicable for the respective insureds and used to develop the applicable premium.

**Liability Limit Factors**

<b>Liability Limit</b>	<b>Physicians</b>	<b>Surgeons</b>
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

**XIV. PRIOR ACTS COVERAGE**

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the Insured, subject to underwriting.

**XV. EXTENDED REPORTING PERIOD COVERAGE**

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.
- C. The premium for the Extended Reporting Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:
  - 1. The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

<u>Year</u>	<u>Factor</u>
1 <sup>st</sup>	3.30
2 <sup>nd</sup>	3.15
3 <sup>rd</sup>	2.40
4 <sup>th</sup>	2.00

2. For First Year Claims Made step, it is applied pro-rata.
  3. For Second Year and all years of maturity, it is applied to the last year's (365 days) annualized premium from the date of cancellation.
- D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.
- E. The length of the Extended Reporting Period will be indefinite.
- F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.
1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.
  2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.
  3. The Reporting Period is unlimited.

**- END OF SECTION I-**

## SECTION II

### MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

#### **I. DEFINITION**

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

Professional Corporations, Partnerships and Associations

- B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;
2. Are organized as a legal entity;
3. Maintain common facilities (including multiple locations) and support personnel; and
4. Maintain medical/dental records of patients of the group as a historical record of patient care.

#### **II. PREMIUM COMPUTATION**

- A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

- B. Vicarious Liability Charge: For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

### III. PREMIUM MODIFICATIONS

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.

**- END OF SECTION II-**

## SECTION III

### MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

#### I. CLASSIFICATIONS

##### A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a rate class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
2. The rate classes are found in Section III of this Manual.

##### B. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

##### C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

##### D. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.
2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the

retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Company.

E. Per Patient Visit Rating

1. Per patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.
2. The premium for the per patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.
3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.
4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

<b>Specialty</b>	<b>Conversion Factor</b>
Urgent Care	.000160
Emergency Medicine	.000278

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per Patient Visit Rating

## II. PREMIUM COMPUTATION DETAILS

### A. Specialty Class Plan

The following classification plan shall be used to determine the appropriate rating class for each individual Insured.

#### PHYSICIANS & SURGEONS

<b>Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Abdominal Surgery	80166	17
Administrative Medicine	80240(a)	2
Aerospace Medicine	80133	2
Allergy/Immunology	80254	1
Anesthesiology- All Other	80183	6
Anesthesiology- Pain Management	80182	6
Broncho-Esophagology	80101	7
Cardiac Surgery	80141	19
Cardiothoracic Surgery	80150(a)	19
Cardiovascular Disease - Minor Surgery	80281	8
Cardiovascular Disease - No Surgery	80255	3
Cardiovascular Surgery	80150	19
Colon and Rectal Surgery	80115	11
Dentistry	80210	3
Dermatology - Minor Surgery	80297(a)	3
Dermatology - No Surgery	80297	2
Diabetes - Minor Surgery	80271	4
Diabetes - No Surgery	80237	3
Emergency Medicine - incl Major Surgery	80157	12
Emergency Medicine - No Major Surgery	80102	10
Endocrinology- Minor Surgery	80272	4
Endocrinology- No Surgery	80238	2
Endocrinology Surgery	80103	12
Family Practice or General Practice - Major Surgery & OB	80117(a)	18
Family Practice or General Practice - Surgery - limited OB	80117(b)	12
Family Practice or General Practitioners - Minor Surgery, No OB	80421	9
Family Practice or General Practitioners - No Surgery	80420	3
Forensic / Legal Medicine	80240	1
Gastroenterology - Minor Surgery	80274	8
Gastroenterology - No Surgery	80241	5
Gastroenterology - Surgery	80104	12
General Surgery	80143	15
Geriatrics - Minor Surgery	80276	7
Geriatrics - No Surgery	80243	3
Geriatrics - Surgery	80105	13

<b>Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Gynecology - Minor Surgery	80277	8
Gynecology - No Surgery	80244	4
Gynecology - Surgery	80167	12
Hand Surgery	80169	12
Head and Neck Surgery	80170	15
Head and Neck Surgery - No Plastic	80170(a)	12
Hematology - Minor Surgery	80278	7
Hematology - No Surgery	80245	3
Hospitalists - Including ER	80222(b)	11
Hospitalists - Invasive	80222(a)	9
Hospitalists - Non-Invasive	80222	5
Infectious Diseases - Minor Surgery	80279	8
Infectious Diseases - No Surgery	80246	4
Intensive Care Medicine	80283	8
Internal Medicine - Minor Surgery	80284	8
Internal Medicine - No Surgery	80257	6
Neonatal/Perinatal Medicine	80804	12
Neonatology - Major Surgery	80804(a)	16
Neoplastic - Surgery	80107	14
Neoplastic Diseases - Minor Surgery	80286	8
Neoplastic Diseases - No Surgery	80259	3
Nephrology - Minor Surgery	80287	6
Nephrology - No Surgery	80260	3
Nephrology - Surgery	80108	10
Neurology - Minor Surgery	80299(a)	8
Neurology - No Surgery	80299	4
Neurology - Surgery	80152	22
Nuclear Medicine	80262	2
Nutrition	80248	1
Obstetrics & Gynecology Surgery	80153	19
Obstetrics Surgery	80168	19
Occupational Medicine	80134	1
Oncology - Minor Surgery	80301	6
Oncology - No Surgery	80302	3
Oncology - Surgery	80164	14
Ophthalmology - Minor Surgery	80289	3
Ophthalmology - No Surgery	80263	2
Ophthalmology - Surgery	80114	3
Orthopedic Surgery Including Spine	80154(s)	20
Orthopedic Surgery Not Including Spine	80154	17
Orthopedics - Minor Surgery	80204	7
Orthopedics - No Surgery	80205(a)	4

<b>Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Otorhinolaryngology - Minor Surgery	80291	8
Otorhinolaryngology - No Surgery	80265	1
Otorhinolaryngology - Surgery - Incl Plastic	80155	16
Otorhinolaryngology - Surgery - No Plastic	80159(a)	10
Pain Management - Advanced Procedures	80182(d)	21
Pain Management - Basic Procedures	80182(b)	13
Pain Management - Intermediate Procedures	80182(c)	18
Pain Management - No Surgery	80182(a)	7
Pathology - Minor Surgery	80305	4
Pathology - No surgery	80307	2
Pediatrics - Minor Surgery	80293	8
Pediatrics - No Surgery	80267	2
Pediatrics - Surgery	80180	16
Perinatology	80153(a)	21
Pharmacology - Clinical	80234	2
Physiatry	80209(a)	3
Physical Medicine and Rehabilitation - All Other	80209	1
Physical Medicine and Rehabilitation - Pain Management	80208	7
Physician (NOC) - Minor Surgery	80294	8
Physician (NOC) - No Surgery	80268	2
Plastic Surgery	80156	16
Podiatry	80943	3
Preventive Medicine - No Surgery Undersea/Hyperbaric Medicine	80139	2
Psychiatry	80229	2
Public Health Medicine - No Surgery	80135	2
Pulmonary Diseases - No Surgery	80269	6
Radiation Oncology	80359(a)	3
Radiology - Diagnostic - Minor Surgery	80280	8
Radiology - Diagnostic - No Surgery	80253	6
Radiology - Interventional	80360	10
Radiology - Therapeutic - Minor Surgery	80358	8
Radiology - Therapeutic - No Surgery	80359	6
Rheumatology - No Surgery	80252	2
Sports Medicine - No Surgery	80205	4
Thoracic Surgery	80144	18
Traumatic Surgery	80171	19
Urgent Care	80102(a)	5
Urological - Surgery	80145	10
Urology - Minor Surgery	80120	8
Urology - No Surgery	80121	3
Vascular Surgery	80146	19

<b>Ancillary Specialty</b>	<b>ISO Code</b>	<b>Class</b>
Acupuncturists	80966	X
Art, Music and Dance Therapists	80967	X
Audiologists	80968	X
Certified Registered Nurse Anesthetist	80960	C-1
Dental Hygienists	80712	X
Inhalation/Respiratory Therapists	80969	X
Massage Therapists	80970	X
Medical Technologists	80971	X
Nurse LPN	80963	X
Nurse Midwife	80962	N
Nurse Practitioner	80965	Z
Nurse RN	80964	Y
Nutritionists/Dieticians	80972	X
Occupational Therapists	80973	Y
Opticians	80937	X
Optometrist	80994	Y
Orthotists/Prosthetists	80974	Y
Pharmacists	59112	X
Physicians or Surgeons Assistants	80116	Z
Physiotherapists	80938	Y
Psychologists	80975	Z
X-Ray Technicians	80713	Y

B. Manual Rates

Standard Claims Made Program Step Factors

Step Factors:

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

**PHYSICIANS AND SURGEONS  
RATE TABLE**

Mature Rates (Claims-made)  
1M/3M

<b>Class</b>	<b>Territory 1</b>	<b>Territory 2</b>	<b>Territory 3</b>	<b>Territory 4</b>	<b>Territory 5</b>	<b>Territory 6</b>	<b>Territory 7</b>	<b>Territory 8</b>
1	\$15,401	\$13,938	\$13,214	\$11,751	\$11,027	\$9,564	\$7,377	\$8,101
2	\$20,632	\$18,672	\$17,702	\$15,742	\$14,772	\$12,812	\$9,883	\$10,852
3	\$29,059	\$26,298	\$24,933	\$22,172	\$20,806	\$18,046	\$13,919	\$15,285
4	\$31,965	\$28,928	\$27,426	\$24,389	\$22,887	\$19,850	\$15,311	\$16,814
5	\$33,418	\$30,243	\$28,673	\$25,498	\$23,927	\$20,752	\$16,007	\$17,578
6	\$35,161	\$31,821	\$30,168	\$26,828	\$25,176	\$21,835	\$16,842	\$18,495
7	\$38,648	\$34,977	\$33,160	\$29,489	\$27,672	\$24,001	\$18,513	\$20,329
8	\$42,426	\$38,396	\$36,402	\$32,371	\$30,377	\$26,347	\$20,322	\$22,316
9	\$46,204	\$41,814	\$39,643	\$35,254	\$33,082	\$28,693	\$22,132	\$24,303
10	\$49,981	\$45,233	\$42,884	\$38,136	\$35,787	\$31,038	\$23,941	\$26,290
11	\$54,922	\$49,704	\$47,123	\$41,905	\$39,324	\$34,106	\$26,307	\$28,889
12	\$61,314	\$55,490	\$52,608	\$46,783	\$43,901	\$38,076	\$29,370	\$32,251
13	\$67,417	\$61,012	\$57,844	\$51,439	\$48,270	\$41,866	\$32,293	\$35,461
14	\$73,519	\$66,535	\$63,080	\$56,095	\$52,640	\$45,655	\$35,216	\$38,671
15	\$80,784	\$73,110	\$69,313	\$61,638	\$57,841	\$50,167	\$38,696	\$42,492
16	\$88,049	\$79,684	\$75,546	\$67,181	\$63,043	\$54,678	\$42,175	\$46,314
17	\$97,638	\$88,363	\$83,774	\$74,498	\$69,909	\$60,633	\$46,769	\$51,358
18	\$109,843	\$99,408	\$94,245	\$83,810	\$78,648	\$68,213	\$52,615	\$57,777
19	\$124,663	\$112,820	\$106,961	\$95,118	\$89,259	\$77,416	\$59,714	\$65,573
20	\$134,253	\$121,499	\$115,189	\$102,435	\$96,125	\$83,371	\$64,307	\$70,617
21	\$165,927	\$150,164	\$142,365	\$126,602	\$118,804	\$103,041	\$79,479	\$87,278
22	\$205,738	\$186,193	\$176,523	\$156,978	\$147,308	\$127,763	\$98,548	\$108,218

**NON PHYSICIAN HEALTHCARE PROVIDERS  
RATE TABLE**

Mature Rates (Claims-made)  
1M/3M

<b>RATE CLASS</b>	<b>Separate limits</b>	<b>Shared limits</b>
<b>N</b>	<b>30% of Class 20</b>	<b>15% of Class 20</b>
<b>X</b>	<b>5% of Class 3</b>	<b>0% of Class 3</b>
<b>Y</b>	<b>15% of Class 3</b>	<b>0% of Class 3</b>
<b>Z</b>	<b>10% of Class 3</b>	<b>4% of Class 3</b>
<b>C-1</b>	<b>15% of Class 6</b>	<b>10% of Class 6</b>

### III. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

#### A. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week is considered a part time practitioner and is eligible for a reduction of 50% on the otherwise applicable rate for that specialty.
2. A Part Time Practitioner may include any practitioner in classes 1 through 10 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

#### B. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:
  - a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
  - b. Resident - Various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
  - c. Fellow - Follows completion of residency and is a higher level of training.
2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.
3. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program.
4. The credit is not applied to the Extended Reporting Period Coverage.
5. The physician-in-training credit is 50% for 1<sup>st</sup> Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

C. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A credit of 30% for first and second years and 20% for the third year will be applied. No other credits are to apply concurrent with this rule.

D. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the Insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program.
2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the Insured's teaching activities.
  - a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.
  - b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.
  - c. No other credits are to apply concurrent with this rule.
  - d. The applicable percentages are based upon hours, up to 50%.

E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the Insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval.

F. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the following schedule:

<u>Claim Free</u>	<u>Credit</u>
0	0
1	2%
2	4%
3	6%
4	8%
5	10%
6	12%
7	14%
8	16%
9	18%
10+	20%

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

G. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

**Schedule Rating: Modifications, subject to Underwriting:**

For Individuals and Groups, subject to Underwriting,

1. The Company will consider all insureds for credits/debits:

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the Insured(s) is greater/less than the expected experience for an Insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The Insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/- 25%	Characteristics of a particular Insured that differentiate the Insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the Insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the Insured.
8. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The Insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record Keeping Practices. +/- 10%	Degree to which Insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 25%
----------------------	-----------

H. Experience Rating

1. A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:
  - a. Premiums paid
  - b. Number of claims
  - c. Incurred losses
  - d. Cause of such losses
  - e. Nature of practice
2. Such credits/debits shall apply on a one year basis and will be subject to annual review.

I. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

J. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the Insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit.

<b>Indemnity Only Deductible Per Claim</b>		<b>Indemnity and ALAE Deductible Per Claim</b>	
\$5,000	2.5%	\$5,000	6.5%
\$10,000	4.5%	\$10,000	11.5%
\$15,000	6.0%	\$15,000	15.0%
\$20,000	8.0%	\$20,000	17.5%
\$25,000	9.0%	\$25,000	20.0%
\$50,000	15.0%	\$50,000	30.5%
\$100,000	25.0%	\$100,000	40.0%
\$200,000	37.5%	\$200,000	55.0%
\$250,000	42.0%	\$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

<b>Indemnity Only Per Claim/Aggregate</b>		<b>Indemnity &amp; ALAE Per Claim/Aggregate</b>	
\$5000/15,000	2.0%	\$5000/15,000	5.5%
\$10,000/30,000	4.0%	\$10,000/30,000	10.5%
\$25,000/75,000	8.5%	\$25,000/75,000	19.0%
\$50,000/150,000	14.0%	\$50,000/150,000	29.5%
\$100,000/300,000	24.0%	\$100,000/300,000	43.0%
\$200,000/600,000	36.0%	\$200,000/600,000	53.5%
\$250,000/750,000	40.0%	\$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each

insured involved in a claim. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to \$1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	\$10,500
10/30	.038	.035	.030	.024	\$21,000
25/75	.084	.079	.070	.058	\$52,500
50/150	.145	.139	.127	.109	\$105,000
100/300	.234	.228	.216	.196	\$120,000
200/600	.348	.346	.338	.321	\$420,000
250/750	.385	.385	.381	.368	\$525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
200/600	.396	.394	.385	.366	\$510,000
250/750	.467	.467	.462	.446	\$637,500

K. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

**-END OF SECTION III-**

## SECTION IV

### Medicus Secured Protection Program

#### I. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

- DEA License Suspension
- Professional Misconduct
- Successful Completion of Chemical Dependency Program
- Adverse Claims Experience (Severity and/or Frequency)
- Proctorship
- Medical Board Sanctions or Fines
- Unusual Practice Characteristics
- Physical or Mental Health Impairments
- Bare Exposure Period
- Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

#### II. APPLICANT REFERRAL CRITERIA:

##### A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

##### B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

### **III. LENGTH OF INSURED'S REHABILITATION**

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

### **IV. RATING APPROACH**

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

### **V. UNDERWRITING**

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.
2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).
3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.
4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

**VI. PHYSICIAN OR GROUP MANAGEMENT**

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurrence
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

**VII. INTERNAL LOGISTICS**

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

## VIII. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

### POINTS SCHEDULE A

#### Claims within the last 10 years from date of Report

- |   |                      |
|---|----------------------|
| A. Frequency and Severity Claims Schedule         | 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 with the past 5 years              | 75  |
| C. Currently in treatment for unresolved substance abuse  | 150 |
| D. Any relapse with in 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  |
| I. During the preceding 5 year, 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 a violation of a civil statute, per event.  |     |

#### Medically Related

- |   |     |
|---|-----|
| Within 5 years                                      | 100 |
| More than 5 years                                   | 50  |
| K. Medicare/Medicaid investigation                  | 40  |
| L. Loss of Medicare/Medicaid Privileges             | 50  |
| M. Loss of any health insurance provider privileges | 50  |

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

#### 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  |

POINTS SCHEDULE A (cont.)

**Medical Education**

- A. Attended more that one medical school or a residency program due to actual or planned disciplinary action 50
- B. Residency complete 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 event). 50
- B. Privileges have been suspended in the past 10 years (per event). 100
- C. Privileges have been revoked in the past 10 years (per event). 150
- 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 physician or group procedures within his/her medical specialty 100

**Patient Safety / Physician or group Management**

- A. Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements. 100

B.	Mandatory patient safety/physician or group management previously recommended and Insured had initial compliance but no follow through.	75
	<b>Gaps in Medical Practice</b>	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	<b>Payment History</b>	
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
	<b>Other</b>	
A.	Uncooperative in Claims Handling	150
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 non-renewed).	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-physician or group 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#: \_\_\_\_\_  
(If Applicable)

Effective Date: \_\_\_\_\_

Review Date: \_\_\_\_\_

<b>Claims Without Indemnity</b>			
<b>ALAE</b>			
<b>From:</b>	<b>To:</b>	<b>Claim Score</b>	
\$5,001	\$25,000	1	
\$25,001	\$50,000	2	
\$50,001	\$100,000	3	
\$100,001	& up	4	
<b>Claims With Indemnity</b>			
<b>Indemnity + ALAE</b>			
<b>From:</b>	<b>To:</b>	<b>Claim Score</b>	
\$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	

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

Total: \_\_\_\_\_

Completed by: \_\_\_\_\_

Approved by: \_\_\_\_\_

**Frequency and Severity Claims Schedule (Continued)**

Total Claim Score	Low Frequency Specialties			
	No. of Years w/MIC			
	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/MIC			
	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, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

**Points Evaluation Worksheet**

Insured: \_\_\_\_\_

Policy#: \_\_\_\_\_

Effective Date: \_\_\_\_\_

(If Applicable)  
Review Date: \_\_\_\_\_

**Criteria**

**Points**

Claims	_____
Frequency	_____
Drug or Alcohol Impairment – Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges – Any State	_____
Procedures	_____
Physician or group Management	_____
Gaps in Coverage	_____
Other	_____
<b>Total Points:</b>	_____

**Ranges & Surcharges**

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by: \_\_\_\_\_

Approved by: \_\_\_\_\_

**-END OF MANUAL-**



**MANUAL**

**SECTION I**

**GENERAL RULES**

**SECTION I**

**MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS**

**I. APPLICATION PURPOSE OF MANUAL**

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

**II. APPLICATION OF GENERAL RULES**

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

**III.II. POLICY TERM**

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

**IV.III. LOCATION OF PRACTICE**

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

The Territory Definitions are:

- 1. Counties: Cook, Jackson, Madison, St. Clair and Will
- 2. Counties: Vermillion
- 3. Counties: Kane, Lake, McHenry and Winnebago
- 4. Counties: DuPage, Kankakee and Macon

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial

Formatted: Body Text FLI .5, bt

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Font: (Default) Arial, Font color: Black

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Body Text, Indent: First line: 0"

Formatted: Left, Indent: Left: 0", Hanging: 0.5"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

5. Counties: Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle and Randolph

6. Counties: Grundy and Sangamon

7. Counties: Adams, Knox, Peoria and Rock Island

~~8. Remainder of State, However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.~~

Formatted: Font: (Default) Arial

**IV. PREMIUM COMPUTATION**

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

Formatted: Left

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Formatted: Heading 3

~~V. PREMIUM COMPUTATION (Continued)~~

~~A.~~

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

Formatted: Left

**VI. FACTORS OR MULTIPLIERS**

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

**VII. WHOLE DOLLAR RULE**

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

A. Any amount involving \$.50 or over shall be rounded up to the next highest whole dollar amount; and

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

B. Any amount involving \$.49 or less shall be rounded down to the next lowest whole dollar amount.

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**VIII. ADDITIONAL PREMIUM CHARGES**

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

- A. Prorate all changes requiring additional premium.
- B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

Formatted: Left

**IX.VIII. RETURN PREMIUM FOR MID-TERM CHANGES**

- A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.
- B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.
- C. Retain the Policy Minimum Premium.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Body Text 2

**X.IX. POLICY CANCELLATIONS**

- A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:
  1. A policy is canceled at the Company's request.
  2. The Insured is leaving a group practice, or
  3. Death, disability or retirement of the Insured.

Formatted: Font: (Default) Arial

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted: Left

- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- 4. Retain the Policy Minimum Premium when the Insured requests cancellation except when coverage is canceled as of the inception date.
  2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

Formatted: Heading 3, Tab stops: Not at 1.5" + 2"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial, Font color: Black

Formatted: Font: (Default) Arial

Formatted: Heading 3, No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Heading 3

Formatted: Left

**X. POLICY CANCELLATIONS (Continued)**

- B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.
- C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**XI.X. POLICY MINIMUM PREMIUM**

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.

Formatted: Body Text, No bullets or numbering, Tab stops: Not at 1.5"

~~1. determined by the type of health care provider shown on the appropriate Rate Pages.~~

Formatted: Font: (Default) Arial

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

### **XII.XI. PREMIUM PAYMENT PLAN**

Formatted: Font: (Default) Arial, Font color: Auto

The Company offers the ~~insured~~Insured the choice to pay in full or the following premium payment options:

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

~~A. A.~~—The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Heading 3, Indent: Left: 0", First line: 0"

~~B. B.~~—The quarterly payment plan requires a 25% down payment and three quarterly installments of 25%.

~~C. C.~~—Our Automated Clearing House (ACH) option allows the ~~insured~~Insured to have 12 equal monthly installments.

Formatted: Font: (Default) Arial

There are no extra fees associated with ~~the any~~ premium payment plan.

Formatted: Left

#### ~~Q. Mandatory Quarterly Payment Option.~~

Formatted: No underline, Not Highlight

Formatted: Not Highlight

~~For medical liability insureds whose annual premiums total \$500 or more,~~

Formatted: Heading 3, Indent: Left: 0"

~~the plan must allow the option of quarterly payments.~~

Formatted: Left

Formatted: Left, Indent: Left: 1"

Formatted: Not Highlight

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

- An initial payment of no more than 40% of the estimated total premium due at policy inception;
- The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;
- No interest charges;
- Installation charges or fees of no more than the lesser of 1% of the total premium or \$25, whichever is less; and
- A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Formatted: Heading 4, No bullets or numbering

Non-Mandatory Quarterly Payment Option.

Formatted: Left

Formatted: Heading 3, Indent: Left: 0"

- For medical liability insureds whose annual premiums are less than \$500, insurers may, but are not required to, offer quarterly installment, installment, premium payment plans;
- For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans;
- If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds;

Formatted: Heading 4, No bullets or numbering

Formatted: Not Highlight

Formatted: Not Highlight

Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

Formatted: Left

Formatted: Left, Indent: Left: 1"

The Company will offer the insured premium payment options, outlined in Section III 24.

Formatted: Body Text 2, No bullets or numbering

Formatted: Left

Formatted: Font: (Default) Arial

**XIII.XII. COVERAGE**

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. -The coverages will be rated under Standard Claims-Made Rates.

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**XIV. BASIC LIMITS OF LIABILITY**

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

**XV.XIII. LIMITS OF LIABILITY**

The Basic Limits of Liability are \$1,000,000 per claim/\$3,000,000 annual aggregate. Credits and/or debits apply only to the \$1M/\$3M layer of the Limits of Liability

Individual Limits of Liability will be modified by the Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

**Liability Limit Factors**

	<u>Limits</u>	
<u>Liability Limit</u>	<u>Physicians</u>	<u>Surgeons</u>
<u>500/1.0</u>	<u>.719</u>	<u>.719</u>
<u>1M/3M</u>	<u>1.0</u>	<u>1.0</u>
<u>2M/4M</u>	<u>1.36</u>	<u>1.55</u>
<u>3M/5M</u>	<u>1.52</u>	<u>1.73</u>

**XVI.XIV. PRIOR ACTS COVERAGE**

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). -The retroactive date can be advanced only at the request or with the written acknowledgment of the insured/insured, subject to underwriting.

**XVII.XV. EXTENDED REPORTING PERIOD COVERAGE**

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

- A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.
- B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

**XVII. EXTENDED REPORTING PERIOD COVERAGE (Continued)**

B.

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Left

Formatted

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Not Highlight

Formatted Table

Formatted

Formatted: Font: Bold, Not Highlight

Formatted: Centered

Formatted: Not Highlight

Formatted: Centered

Formatted

Formatted: Left, Space After: 0 pt

Formatted

Formatted

Formatted

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

Formatted

Formatted

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Heading 3

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

C. The premium for the Extended Reporting ~~Period Coverage~~ Endorsement shall be the following Extended Reporting Endorsement rating factors applied to the premium found in Section III:

1. The Extended Reporting Endorsement factor from the table below is applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1 <sup>st</sup>	3.30
2 <sup>nd</sup>	3.15
3 <sup>rd</sup>	2.40
4 <sup>th</sup>	2.00

2. For First Year Claims Made step, it is applied pro-rata.

3. For Second Year and all years of maturity, ~~it is applied to the expiring premium.~~ it is applied to the last year's (365 days) annualized premium from the date of cancellation.

C. ~~determined by applying the Extended Reporting Period Coverage rating factors shown in Section III-10.~~

D. Premium is fully earned and must be paid in accordance with state statutes, promptly when due.

E. The length of the Extended Reporting Period will be indefinite.

D. ~~in full within 30 days of the expiration of the policy.~~

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination

### XVIII. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/-50
Healthcare Providers	+/-50

F. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and

Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Font: (Default) Arial

Formatted: Heading 4, Indent: Left: 0", Pattern: Clear

Formatted: Font color: Auto

Formatted: Centered

Formatted: Heading 4

Formatted: Font color: Custom Color(RGB(192,80,77)), Strikethrough

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial, Font color: Auto, Not Strikethrough

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font color: Auto

Formatted: Font: (Default) Arial

Formatted: Heading 4, Indent: Left: 1"

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial

Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the Insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

Formatted: Font color: Red

Formatted: Font: (Default) Arial

- END OF SECTION I-

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL DEFINITION

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

4. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

- 1. Are comprised of 2 or more physicians;
- 2. Are organized as a legal entity;
- 3. Maintain common facilities (including multiple locations) and support personnel; and
- 4. Maintain medical/dental records of patients of the group as a historical record of patient care.

4. \_\_\_\_\_

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. ~~Claims Made Coverage~~

~~\$1,000,000 Per Claim  
\$3,000,000 Aggregate~~

III. II. PREMIUM COMPUTATION

A. ~~A.~~ The premium for professional corporations, partnerships and associations, limited liability ~~\_\_\_\_\_~~ companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

- Formatted: Font: (Default) Arial
- Formatted: Left
- Formatted: Left, Indent: Left: 1", No bullets or numbering
- Formatted: Left
- Formatted: Font: (Default) Arial, Font color: Auto
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial, Font color: Auto
- Formatted: Font color: Auto
- Formatted: Heading 3, No bullets or numbering, Tab stops: Not at 1.5"
- Formatted: Font: (Default) Arial
- Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"
- Formatted: Left
- Formatted: Left
- Formatted: Font: (Default) Arial, Font color: Auto
- Formatted: Left, Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"
- Formatted: Font: (Default) Arial
- Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial
- Formatted: Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial

III. PREMIUM COMPUTATION (Continued)

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

B. Vicarious Liability Charge: For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

B.

For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

III. CLASSIFICATIONS PREMIUM MODIFICATIONS

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III.

Physician & Surgeons	+/- 25%
----------------------	---------

Formatted: Font: (Default) Arial

Formatted: Normal, Indent: Left: 1"

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial

Formatted Table

Formatted: Font: (Default) Arial

Formatted: Heading 3

Formatted: Font: (Default) Arial, No underline

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Indent: Left: 0"

Formatted Table

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Health Care Providers +/- 25%

Formatted: Font: Not Bold

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in Section III.

Formatted: Indent: Left: 0"

**IV.**

**A. Corporations, Partnerships and Associations**

Formatted: Body Text FLI .5, bt, No bullets or numbering

- 1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.
- 2. Not otherwise identified as a Miscellaneous Entity.

Formatted: Font: (Default) Arial

Formatted: Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**B. Miscellaneous Entities**

- 1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.
- 2. Including the following types of entities:
  - a. Urgent Care Center
  - b. Surgi Center
  - c. MRI Center
  - d. Renal Dialysis Center
  - e. Peritoneal Dialysis Center

Formatted: Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**V. PREMIUM MODIFICATIONS**

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

The following premium modifications are applicable to all filed programs.

**A. Schedule Rating**

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III-22.

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**B. Manual Rates**

~~1. Corporations, Partnerships & Associations Rating Factors~~

~~As referenced in III in Section II-2:~~

~~See Table in Section II-2. Separate Corporate Limits~~

~~0% - Shared Corporate Limits~~

~~2. Miscellaneous Entities~~

~~Not eligible under this Filing.~~

~~C. Policy Writing Minimum Premium~~

~~The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of \$500.~~

~~D. Premium Modifications~~

~~1. Schedule Rating - Partnerships & Corporations~~

<del>Physician &amp; Surgeons</del>	<del>+/- 50%</del>
<del>Health Care Providers</del>	<del>+/- 50%</del>

~~2. Self-Insured Retention Credits - See Section III.V.B~~

**- END OF SECTION II-**

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Font: (Default) Arial

**Formatted:** Position: Horizontal: 7.04", Relative to: Page, Vertical: 0", Relative to: Paragraph

**Formatted:** Font: (Default) Arial

**Formatted:** Font: (Default) Arial

**Formatted:** Font: (Default) Arial

### SECTION III

## MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

Formatted: Top: 1", Bottom: 1", Footer distance from edge: 0.06"

### VI. CLASSIFICATIONS

#### A. Physicians/Surgeons and Non Physician Health Care Providers

- Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.
- The Rate Classes are found in Section III -10 to Section III-15 of this Manual.

Formatted: Left

#### B. Locum Tenens Physician

- Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
- The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
- Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

Formatted: Left

#### C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

Formatted: Heading 3

Formatted: Heading 4, Indent: Left: 1"

Formatted: Font: (Default) Arial

Formatted: No underline

Formatted: No underline

#### D. Slot Rating

- Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are

Formatted: Left

Formatted: Font: (Default) Arial

covered. Coverage will be provided on a shared limit basis for those Insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Company.

E. Per Patient Visit Rating

1. Per patient visit ratings are offered for Emergency Medicine and Urgent Care physicians.

2. The premium for the per patient volume rated policy is determined by multiplying the appropriate premium for the specialty, the retroactive date, and the limits times the conversion factor indicated in the table below (this product is rounded to the nearest penny) times the annual patients visits. This number is then multiplied by (1 + the applicable corporate rate percentage outlined in Section II). The resulting product is the total premium for the policy.

3. Annual patient visits are reported by the Insured based on their actual historical visits, and projected for the next term. Annual patient visits are subject to audit and reconciliation at the end of the policy term.

4. The conversion factor below was determined by dividing one by the average patient visits for physicians in the specialty.

<u>Specialty</u>	<u>Conversion Factor</u>
<u>Urgent Care</u>	<u>.000160</u>
<u>Emergency Medicine</u>	<u>.000278</u>

5. Waiver of premium for the Extended Reporting Endorsement does not apply to the Per Patient Visit Rating

Formatted: Font: (Default) Arial

Formatted: Left, Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5", Tab stops: Not at 1.5"

Formatted: Left, Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

Formatted: Font: (Default) Arial, Underline

Formatted: Left, Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25", Tab stops: Not at 1.25"

Formatted: Font: (Default) Arial









Fourth Year: 90%  
Fifth Year (Mature): 100%

Formatted: Font: (Default) Arial



C-1

15% of Class 6

10% of Class 6

**III. PREMIUM MODIFICATIONS**

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule.

B.A. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be is considered a part time practitioner and may be is eligible for a reduction of 50% o in the otherwise applicable rate for that specialty. -The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.
2. A Part Time Practitioner may include any practitioner in classes 1 through &10 only, except for Anesthesia and Emergency Medicine as identified in the class

B. Part Time Physicians (Continued)

2. plan. -The hours reported to the Company for rating purposes are subject to audit. -at the Company's discretion.
3. The part time credit is not applied to the Extended Reporting Period Coverage.
4. No other credits are to apply concurrent with this rule.

C.B. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. -For rating purposes, they are defined as follows:
  - a. a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.
  - b. b. Resident - Various lengths of time depending upon medical specialty; 3 years average. -Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.
  - c. c. Fellow - Follows completion of residency and is a higher level of training.

Formatted: Font: (Default) Arial, 11 pt, Bold, Font color: Auto

Formatted: Font color: Auto

Formatted: Font: (Default) Arial, 11 pt, Bold, Font color: Auto

Formatted: Font color: Auto

Formatted: No Spacing, Don't keep with next, Don't keep lines together

Formatted: Left

Formatted: Heading 4, Tab stops: 1.5", Left + 3.44", Left

Formatted: Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

Formatted: Left

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Heading 5, Indent: First line: 0", Space After: 6 pt

Formatted: Font: (Default) Arial, Font color: Auto

Formatted: Font: (Default) Arial, Font color: Auto

Formatted: Font: (Default) Arial

2. Coverage is available for activities directly related to a physician's training program. -The coverage will not apply to any professional services rendered after the training is complete.
3. a. \_\_\_\_\_ Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III-20.
- ~~3-4.~~ The credit is not applied to the Extended Reporting Period Coverage.
- ~~4-5.~~ The physician-in-training credit is 50% for 1<sup>st</sup> Year Resident; 40% for Resident; 30% for Fellow. No other credits are to apply concurrent with this rule.

Formatted: Font: (Default) Arial, Font color: Auto

Formatted: Left, Indent: Left: 0", First line: 0"

Formatted: Left

Formatted: Font color: Auto

Formatted: Heading 4, Indent: Left: 0", First line: 0"

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

Formatted: Left

D. Locum Tenens Physician (Continued)

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

Formatted: Left

E.C. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A reduced rate credit of 30% for first and second years and 20% for the third year will be applied. will be applied in accordance with the credits shown presented in Section III-20. No other credits are to apply concurrent with this rule.

Formatted: Left

Formatted: Left, Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25", Tab stops: Not at 1.75"

Formatted: Font color: Auto

Formatted: Left

Formatted: Font color: Auto

Formatted: Not Highlight

Formatted: Not Highlight

F.D. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice. Faculty members are eligible for a reduction in the otherwise applicable physician rate for

Formatted: Left

Formatted: Font: (Default) Arial

coverage valid only for teaching activities related to an accredited training program.

a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III-20 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. -The coverage will not apply to any aspect of the insured's teaching activities.

a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

**Formatted:** Left, Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25", Tab stops: Not at 1.75"

E. Physician Teaching Specialists  
(Continued)

**Formatted:** Font color: Auto

**Formatted:** No underline

**Formatted:** Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25"

b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

**Formatted:** No underline

**Formatted:** Font color: Auto

c. No other credits are to apply concurrent with this rule.

**Formatted:** Indent: Left: 1.5", Space After: 6 pt, Outline numbered + Level: 5 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Tab after: 3.66" + Indent at: 2.25", Tab stops: Not at 1.75"

d. The applicable percentages are based upon hours, up to 50% are presented on presented in Section III-20.

**Formatted:** Font color: Auto

**Formatted:** Font color: Auto

G-E. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may will be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

**Formatted:** Left

2. This will apply retroactively to the first day of disability or leave of absence.

**Formatted:** Font: (Default) Arial

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. Full suspension of insurance and premium is available for up to one year, subject to underwriting approval. The credit to be applied to the applicable rate is presented in Section III-20.

F. ~~E.~~ Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free, the following schedule:

<u>Claim Free</u>	<u>Credit</u>
<u>0</u>	<u>0</u>
<u>1</u>	<u>2%</u>
<u>2</u>	<u>4%</u>
<u>3</u>	<u>6%</u>
<u>4</u>	<u>8%</u>
<u>5</u>	<u>10%</u>
<u>6</u>	<u>12%</u>
<u>7</u>	<u>14%</u>
<u>8</u>	<u>16%</u>
<u>9</u>	<u>18%</u>
<u>10+</u>	<u>20%</u>

A claim for the purpose of this rule includes ALAE or indemnity payments on open or closed claims greater than or equivalent to 50% of the base rate, subject to a minimum threshold of \$10,000. For closed claims, the claims free period will be calculated and begins based on the date the claim was closed. For open claims, the claim free period will cease once the payment threshold is exceeded and will begin again once the claim is closed. For those insureds that have never had a claim, or not exceeded the threshold, the claims free period will begin on the date the physician began practicing medicine in the state, and/or following completion of residency or fellowship.

A schedule is provided in Section III-20.

G. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

- Formatted: Underline
- Formatted: Font: (Default) Arial, Underline
- Formatted: Heading 3
- Formatted: Left
- Formatted: Body Text, Indent: Left: 1", Pattern: Clear
- Formatted: Underline
- Formatted: Centered
- Formatted Table
- Formatted: Centered
- Formatted: Left

- Formatted: Font: (Default) Arial

The premium for a risk may be modified in accordance with a maximum modification indicated in the table below, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review.

M. Schedule Rating (not to be used in conjunction with Loss Rating)

**Schedule Rating: Modifications, -subject to Underwriting:**

For Individuals and Groups, subject to Underwriting,

1. The Company will consider all insureds for credits/debits:

1. <u>Historical Loss Experience</u>  +/- 25%	The frequency or severity of claims for the insured Insured(s) is greater/less than the expected experience for an insured Insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. <u>Cumulative Years of Patient Experience.</u>  +/- 10%	The insured Insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. <u>Classification Anomalies.</u>  +/- 25%	Characteristics of a particular insured Insured that differentiate the insured Insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. <u>Claim Anomalies</u>  +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. <u>Management Control Procedures.</u>  +/- 10%	Specific operational activities undertaken by the insured Insured to reduce the frequency and/or severity of claims.
6. <u>Number /Type of Patient Exposures.</u>  +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. <u>Organizational Size / Structure.</u>  +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured Insured.
8. <u>Medical Standards, Quality &amp; Claim Review.</u>	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice. (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide

- Formatted: Left
- Formatted: Font: 11 pt
- Formatted: Font: 11 pt
- Formatted: Centered, Indent: Left: 0"
- Formatted: Indent: Left: 1"
- Formatted: Heading 4, Indent: Left: 0", Pattern: Clear
- Formatted: Font: (Default) Arial
- Formatted Table

- Formatted: Font: (Default) Arial

+/- 10%	<u>consistent review of claims/incidents that have occurred and to develop corrective action.</u>
<u>9. Other Risk Management Practices and Procedures.</u>	<u>Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.</u>
+/- 10%	
<u>10. Training, Accreditation &amp; Credentialing.</u>	<u>The insured Insured(s) exhibits greater/less than normal participation and support of such activities.</u>
+/- 10%	
<u>11. Record –Keeping Practices.</u>	<u>Degree to which insured Insured incorporates methods to maintain quality patient records, referrals, and test results.</u>
+/- 10%	
<u>12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures</u>	<u>Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.</u>
+/- 10%	
<u>Maximum Modification</u>	<u>+ / - 5025%</u>

A.H. Experience Rating

1. A group practice, consisting of two or more insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

- a. Premiums paid
- b. Number of claims
- c. Incurred losses
- d. Cause of such losses
- e. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review.

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

Formatted: Font: 8 pt

Formatted Table

Formatted: Font: (Default) Arial, Underline

Formatted: Left, Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1", Tab stops: Not at 0"

Formatted: Font: (Default) Arial

Formatted: Heading 4

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Heading 5, Indent: Left: 2"

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Heading 5, Indent: Left: 2", Space After: 12 pt

Formatted: Font: (Default) Arial

Formatted: Heading 4

Formatted: Font: (Default) Arial

Formatted: Heading 3, Indent: Left: 1"

Formatted: Font: (Default) Arial

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least \$100,000 in estimated annual premium.

Formatted: Heading 3, Indent: Left: 1"

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at \$250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

Credibility x Adjusted Actual Loss Ratio - Adjusted Expected Loss Ratio = Experience Mod.

Adjusted Expected Loss Ratio

D. Experience Rating (Continued)

Formatted: No underline

Formatted: Left, Indent: Left: 1"

Formatted: Heading 3, Indent: Left: 1"

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

Formatted: Font: (Default) Arial, Underline

Formatted: Heading 3, Left, Indent: First line: 0", Space After: 0 pt, Pattern: Clear

Formatted: Font: (Default) Arial, 11 pt

I. Risk Management

Formatted: Font: (Default) Arial

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

~~VII. APPLICATION OF MANUAL~~

~~This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non-physician health care providers.~~

~~VIII. BASIC LIMITS OF LIABILITY~~

~~Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:~~

~~Claims Made Coverage~~

~~\$1,000,000 Per Claim~~

~~\$3,000,000 Aggregate~~

~~IX. PREMIUM COMPUTATION~~

~~The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown in Section III 17 to Section III 20, in accordance with each individual's medical classification and class plan designation.~~

~~X. CLASSIFICATIONS~~

~~A. Physicians/Surgeons and Non-Physician Health Care Providers~~

~~1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.~~

~~2. The Rate Classes are found in Section III 10 to Section III 15 of this Manual.~~

~~B. Part Time Physicians~~

~~1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.~~

~~2. A Part Time Practitioner may include any practitioner in classes 1 through 8 only, except for Anesthesia and Emergency Medicine as identified in the class~~

~~B. Part Time Physicians (Continued)~~

~~plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

~~3. The part time credit is not applied to the Extended Reporting Period Coverage.~~

~~4. No other credits are to apply concurrent with this rule.~~

~~C. Physicians in Training~~

~~1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:~~

~~a. First Year Resident (or Intern) 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.~~

~~b. Resident various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.~~

~~c. Fellow Follows completion of residency and is in a higher level of training.~~

~~2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.~~

~~a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III 20.~~

~~3. The credit is not applied to the Extended Reporting Period Coverage.~~

~~4. No other credits are to apply concurrent with this rule.~~

~~D. Locum Tenens Physician~~

Formatted: Font: (Default) Arial

Formatted: Normal, Indent: Left: 1", Space After: 0 pt

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", First line: 0"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5" + 3.44"

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", Tab stops: Not at 1.5" + 2" + 3.44"

Formatted: Normal, Tab stops: Not at 1.5" + 3.44"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted: Normal, Indent: Left: 1"

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

Formatted

Formatted

Formatted

Formatted

Formatted: Normal, Indent: Left: 1"

Formatted: Font: (Default) Arial

~~1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~D. Locum Tenens Physician (Continued)~~

~~2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.~~

Formatted: Normal, Indent: Left: 1"

~~3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.~~

Formatted: Normal, Indent: Left: 1", Tab stops: Not at 1.5"

~~E. New Physician~~

~~1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full-time practice for the first time:~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~e. Residency;~~

Formatted: Normal, Indent: Left: 1"

~~f. Fellowship program in their medical specialty;~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~g. Fulfillment of a military obligation in remuneration for medical school tuition;~~

Formatted: Normal, Indent: Left: 1", Space After: 0 pt, No bullets or numbering

~~h. Medical school or specialty training program.~~

~~2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~3. A reduced rate will be applied in accordance with the credits shown presented in Section III 20. No other credits are to apply concurrent with this rule.~~

~~F. Physician Teaching Specialists~~

Formatted: Normal, Indent: Left: 1"

~~1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~b. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III 20 to determine the applicable credit.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering

~~2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.~~

Formatted: Normal, Indent: Left: 1"

~~e. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~F. Physician Teaching Specialists (Continued)~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering

~~f. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

Formatted: Normal, Indent: Left: 1"

~~g. No other credits are to apply concurrent with this rule.~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering

~~h. The applicable percentages are presented on presented in Section III 20.~~

Formatted: Normal, Indent: Left: 1"

~~G. Physician's Leave of Absence~~

Formatted: Normal, Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1.5"

~~1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.~~

Formatted: Font: (Default) Arial

~~2. This will apply retroactively to the first day of disability or leave of absence.~~

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

~~3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.~~

~~4. The credit to be applied to the applicable rate is presented in Section III 20.~~

~~XI. PREMIUM MODIFICATIONS~~

~~The following premium modifications are applicable to all filed programs:~~

~~A. Schedule Rating~~

~~The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.~~

~~The premium for a risk may be modified in accordance with a maximum modification indicated in Section III 22, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III 22.~~

~~B. Risk Management~~

~~1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.~~

C.J. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). -Any discount will apply only to the primary limit premium layer up to (\$1M/\$3M). -Deductibles are subject to approval by the Company based on financial statements to be submitted by the ~~insured~~Insured and financial guarantees are required. -The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Formatted: Indent: Left: 1", Space After: 0 pt, Pattern: Clear

Formatted: Normal, Indent: Left: 1"

Formatted: Left, Space After: 0 pt, Pattern: Clear

Formatted: Font: (Default) Arial

Formatted: Heading 3, Indent: Left: 0"

Formatted: Heading 3

Formatted: Left, Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Left

Formatted: Font: (Default) Arial





**C. Deductible Credits (Continued)**

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	\$12,750
10/30	.068	.063	.054	.043	\$25,500
25/75	.119	.112	.099	.082	\$63,750
50/150	.186	.179	.163	.140	\$127,500
100/300	.258	.252	.239	.216	\$255,000
<del>200/600</del>	<del>.396</del>	<del>.394</del>	<del>.385</del>	<del>.366</del>	<del>\$510,000</del>
<del>250/750</del>	<del>.467</del>	<del>.467</del>	<del>.462</del>	<del>.446</del>	<del>\$637,500</del>
<del>200/600</del>	<del>.396</del>	<del>.394</del>	<del>.385</del>	<del>.366</del>	<del>510,000</del>
<del>250/750</del>	<del>.467</del>	<del>.467</del>	<del>.462</del>	<del>.446</del>	<del>637,500</del>

**D. Experience Rating**

~~This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.~~

~~On an optional basis, large risks with sufficiently credible loss experience may be loss rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10 year period and at least \$100,000 in estimated annual premium.~~

~~The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.~~

~~Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at \$250,000 per loss.~~

- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1"
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial
- Formatted: Font: (Default) Arial, 11 pt, Bold
- Formatted Table
- Formatted: Font: (Default) Arial, 11 pt, Bold
- Formatted: Centered
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Centered
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial, 11 pt
- Formatted Table
- Formatted: Font: (Default) Arial, 11 pt
- Formatted: Font: (Default) Arial
- Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"
- Formatted: Font: (Default) Arial

~~The experience period does not include the 12 month period immediately prior to the effective date of the experience modification.~~

~~The experience rating modification is calculated using the following formula:~~

$$\frac{\text{Credibility} \times \text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} = \text{Experience Mod.}$$

#### ~~D. Experience Rating (Continued)~~

~~Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.~~

#### ~~E. Claim Free Credit Program~~

~~If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided in Section III 20.~~

#### ~~K. F. Individual Risk Rating~~

~~\_\_\_\_\_ A risk may be individually rated by submitting a filing to the Illinois Department of \_\_\_\_\_ Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. \_\_\_\_\_ The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual \_\_\_\_\_ experience, location or dispersion of exposure, and \_\_\_\_\_ shall apply to all risks under the same or substantially the same circumstances or \_\_\_\_\_ conditions. -We must list the standards by which variations in hazards or expense \_\_\_\_\_ provisions are measured, in order -to determine that a specific risk is so different in \_\_\_\_\_ hazard/expense that it warrants individual rating.~~

### ~~XII. MODIFIED PREMIUM COMPUTATION~~

#### ~~A. Slot Rating~~

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial, Underline

Formatted: Heading 3

Formatted: Font: (Default) Arial

Formatted: Left, Indent: Left: 1"

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Left, Indent: Left: 1"

Formatted: Font: (Default) Arial

Formatted: Left

Formatted: Font: (Default) Arial

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

Formatted: Outline numbered + Level: 3 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 0" + Indent at: 1"

Formatted: Font: (Default) Arial

- ~~1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.~~
- ~~2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.~~
- ~~3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.~~

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

~~B. Requirements for Waiver of Premium for Extended Reporting Period Coverage:~~

- ~~1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.~~
- ~~2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.~~
- ~~3. The Reporting Period is unlimited.~~

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

**Formatted:** Outline numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 2.66" + Indent at: 1.5"

~~C. Blending Rates~~

~~A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his~~

**Formatted:** Space After: 12 pt

~~new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until~~

**Formatted:** Font: (Default) Arial

~~the full GYN rate is achieved at the start of the fourth year.~~

~~D. Per Patient Visit Rating~~

- ~~1. Standard Claims Made coverage for group practices is available, at the Company's option, on a per patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.~~
- ~~2. The number of patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.~~
- ~~3. The applicable medical specialty rate is divided by the equivalent patient visits resulting in the patient visit rate to be applied to the visits projected for the policy period. The product of the patient visit rate and the projected visits results in the indicated manual premium.~~
- ~~4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~
- ~~5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.~~

~~XIII. PREMIUM COMPUTATION DETAILS~~

~~A. Classifications~~

- ~~1. Applicable to Standard Claims Made Programs.~~
- ~~2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.~~

**PHYSICIANS & SURGEONS**

**CLASS 1**

- ~~Allergy/Immunology~~
- ~~Forensic Medicine~~
- ~~Occupational Medicine~~
- ~~Otorhinolaryngology-NMRP, NS~~
- ~~Physical Med. & Rehab.~~
- ~~Public Health & Preventative Med~~

Formatted: Outline numbered + Level: 2 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0" + Indent at: 0"

- Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 2**

Dermatology

Formatted: Font: (Default) Arial

Endocrinology

Formatted: Font: (Default) Arial

Geriatrics

Formatted: Font: (Default) Arial

Ophthalmology-NS

Formatted: Font: (Default) Arial

Pathology

Formatted: Font: (Default) Arial

Pediatrics, No Surgery

Formatted: Font: (Default) Arial

Psychiatry

Formatted: Font: (Default) Arial

Rheumatology

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 3**

Formatted: Font: (Default) Arial

Pediatrics-NMRP

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 4**

Diabetes

Family Practice-NMRP, NS

General Practice-NMRP, NS

General Surgery-NMRP

Hematology

Industrial Medicine

Neurosurgery-NMRP, NMAJS

Nuclear Medicine

Oncology

Ophthalmic Surgery

Oral/Maxillofacial Surgery

Orthopaedics-NMRP, NS

Radiation Oncology

Thoracic Surgery-NMRP, NS

Other, Specialty-NOG

**CLASS 5**

- Cardiovascular Disease-NMRP, NS
- Infectious Disease
- Nephrology-NMRP
- Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 6**

- Gynecology-NMRP, NS
- Internal Medicine-NMRP
- Certified Registered Nurse Anesthetist
- Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 7**

- Anesthesiology
- Nephrology-MRP
- Podiatry, Surgery
- Pulmonary Diseases
- Radiology-NMRP
- Other, Specialty-NOG

Formatted: Font: (Default) Arial

**CLASS 8**

- Cardiac Surgery-MRP, NMajS
- Cardiovascular Disease-Spec. MRP
- Gastroenterology
- General Surgery-MRP, NMajS
- Hand Surgery-MRP, NMajS
- Internal Medicine-MRP
- Neurology
- Orthopaedics-MRP, NMajS
- Otorhinolaryngology-MRP, NMajS
- Pediatrics-MRP
- Radiology-MRP
- Urology-MRP, NMajS
- Vascular Surgery-MRP, NMajS

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 9**

Family Practice-MRP, NMajS

General Practice-MRP, NMajS

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 10**

Neurosurgery-MRP, NMajS

Urological Surgery

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 11**

Cardiovascular Disease-MRP

Colon Surgery

Formatted: Font: (Default) Arial

Emergency Medicine-NMajS, prim

Formatted: Font: (Default) Arial

Gynecology/Obstetrics-MRP, Nmaj

Formatted: Font: (Default) Arial

Otorhinolaryngology; No Elective

Plastic

Formatted: Font: (Default) Arial

Radiology-MajRP

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 12**

Emergency Medicine-MajS

Formatted: Font: (Default) Arial

Family Practice-not primarily MajS

Formatted: Font: (Default) Arial

General Practice-NMajS, prim

Formatted: Font: (Default) Arial

Gynecological Surgery

Formatted: Font: (Default) Arial

Hand Surgery

Formatted: Font: (Default) Arial

Head/Neck Surgery

Formatted: Font: (Default) Arial

Otorhinolaryngology; Head/Neck

Formatted: Font: (Default) Arial

Other, Specialty-NOG

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 13**

Formatted: Font: (Default) Arial

General Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 14**

Neonatology  
Otorhinolaryngology; Other Than  
Head/Neck  
Plastic Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 15**

Orthopaedic Surgery s/o Spine  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 16**

Cardiac Surgery  
Thoracic Surgery  
Vascular Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 17**

Obstetrical/Gynecological Surgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

**CLASS 18**

Neurosurgery - No Intracranial Surgery  
Orthopaedic Surgery w/Spine  
Other, Specialty NOC

Formatted: Font: (Default) Arial

**CLASS 19**

Neurosurgery  
Other, Specialty NOC

Formatted: Font: (Default) Arial

**MEDICAL PROCEDURE DEFINITIONS**

**NMRP: — NOMINAL MINOR RISK PROCEDURE**

**NS: — NO SURGERY**

**NOC: — NOT OTHERWISE CLASSIFIED**

**NMAJS: — NO MAJOR SURGERY**

**MRP: — MINOR RISK PROCEDURES**

**MAJRP: — MAJOR RISK PROCEDURES**

**NON PHYSICIAN HEALTH CARE PROVIDERS**

**Class X**

Follow, Intern, Optician, Resident, Social Worker

**Class Y**

Optometrist, Physical Therapist, X-Ray and Lab Technicians

**Class Z**

~~Nurse Practitioner — Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care~~

~~Physician Assistant — Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care~~

~~Psychologist — Class 1~~

~~Certified Registered Nurse Anesthetist~~

~~Shared Limits — 20% times Anesthesiologist rate~~

~~Separate Limits — 25% times Anesthesiologist rate~~

~~Certified Nurse Midwife — No complicated OB or surgery~~

~~Shared Limits — Not available~~

~~Separate Limits — 50% of OB/GYN rate~~

**B. Territory Definitions**

Formatted: Font: (Default) Arial

**TERRITORY 1 COUNTIES**

Cook, Jackson, Madison, St. Clair and Will

**TERRITORY 2 COUNTIES**

Lake, Vermillion

**TERRITORY 3 COUNTIES**

Kane, McHenry, Winnebago

**TERRITORY 4 COUNTIES**

DuPage, Kankakee, Macon

**TERRITORY 5 COUNTIES**

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

**TERRITORY 6 COUNTIES**

Grundy, Sangamon

**TERRITORY 7 COUNTIES**

Peoria

**TERRITORY 8 COUNTIES**

Remainder of State

C. Standard Claims Made Program Step Factors

First Year: \_\_\_\_\_ 25%  
Second Year: \_\_\_\_\_ 50%  
Third Year: \_\_\_\_\_ 78%  
Fourth Year: \_\_\_\_\_ 90%  
Fifth Year (Mature): \_\_\_\_\_ 100%

Mature Rates for Physicians and Surgeons (Claims made):

\_\_\_\_\_ **\$1,000,000 / 3,000,000**

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,594	9,295	7,354	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,594	9,295	7,354	7,999

Formatted: Font: (Default) Arial







Formatted: Font: (Default) Arial

D. Mature Rates for non-Physician Health Care Providers

Class X equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 10% of Class 4 rate for separate limits.

Class Y equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 15% of the Class 4 rate for separate limits.

Class Z equals 10% of the Class 1 Physician/Surgeon rate for shared limits; 25% of Class 1 Physician/Surgeon rate for separate limits.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 11 rate.

E. Liability Limits Factors:

	Limits	
	Physicians	Surgeons
500/1.0	.710	.710
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

Formatted: Font: (Default) Arial

F. Extended Reporting Period Coverage Factors:

1. The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Formatted: Font: (Default) Arial

<u>Year</u>	<u>Factor</u>
1 <sup>st</sup>	3.30
2 <sup>nd</sup>	3.15
3 <sup>rd</sup>	2.40
4 <sup>th</sup>	2.00

2. For First Year Claims Made step, the corresponding factor above is applied pro-rata. For Second Year and all years of maturity, the corresponding factor above is applied to the expiring premium.

F. Extended Reporting Period Coverage Factors (Continued):

3. The Reporting Period is unlimited.

G. Shared Limits Modification:  
Not available.

H. Policy Writing Minimum Premium:

Physicians & Surgeons—\$500.

I. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers—\$500

J. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1

Class Y: 25% of Class 1

Class Z: 35% of Class 1

K. Premium Modifications

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons—30%
2. Physicians in Training—1<sup>st</sup> Year Resident 50%; Resident 40%; Fellow 30%.
3. Locum Tenens—no premium, subject to prior underwriting approval
4. New Physicians & Surgeons—30% for the first two years of practice
5. Physician Teaching Specialists—Non-surgical 50%; Surgical 40%.
6. Physician's Leave of Absence—full suspension of insurance and premium for up to one year, subject to underwriting approval

L. Claim Free Credit Program

Formatted: Font: (Default) Arial

~~If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:~~

- ~~1. If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date. [indented over]~~
- ~~2. If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.~~
- ~~3. If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.~~
- ~~4. If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.~~

~~A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.~~

Formatted: Font: (Default) Arial

M. Schedule Rating (not to be used in conjunction with Loss Rating)

<del>1. Historical Loss Experience +/- 25%</del>	<del>The frequency or severity of claims for the insured(e) is greater/less than the expected experience for an insured(e) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.</del>
<del>2. Cumulative Years of Patient Experience. +/- 10%</del>	<del>The insured(e) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.</del>
<del>3. Classification Anomalies. +/- 25%</del>	<del>Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.</del>
<del>4. Claim Anomalies +/- 25%</del>	<del>Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).</del>
<del>5. Management Control Procedures. +/- 10%</del>	<del>Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.</del>
<del>6. Number /Type of Patient Exposures. +/- 10%</del>	<del>Size and/or demographics of the patient population which influences the frequency and/or severity of claims.</del>
<del>7. Organizational Size / Structure +/- 10%</del>	<del>The organization's size and processes are such that economies of scale are achieved while servicing the insured.</del>
<del>8. Medical Standards, Quality &amp; Claim Review. +/- 10%</del>	<del>Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees that meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.</del>
<del>9. Other Risk Management Practices and Procedures. +/- 10%</del>	<del>Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.</del>
<del>10. Training, Accreditation &amp; Credentialing. +/- 10%</del>	<del>The insured(e) exhibits greater/less than normal participation and support of such activities.</del>
<del>11. Record Keeping Practices. +/- 10%</del>	<del>Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.</del>
<del>12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%</del>	<del>Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.</del>
<del>Maximum Modification +/- 50%</del>	

Formatted: Font: (Default) Arial

~~N~~ [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

~~Q. Mandatory Quarterly Payment Option.~~

~~For medical liability insureds whose annual premiums total \$500 or more, the plan must allow the option of quarterly payments.~~

- ~~6. An initial payment of no more than 40% of the estimated total premium due at policy inception.~~
- ~~7. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively.~~
- ~~8. No interest charges.~~
- ~~9. Installment charges or fees of no more than the lesser of 1% of the total premium or \$25, whichever is less; and~~
- ~~10. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.~~

~~Non-Mandatory Quarterly Payment Option.~~

- ~~4. For medical liability insureds whose annual premiums are less than \$500, insurers may, but are not required to, offer quarterly installment, premium payment plans.~~
- ~~5. For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.~~
- ~~6. If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.~~

~~Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may~~

Formatted: Font: (Default) Arial, Highlight

Formatted: Font: (Default) Arial

but need not re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

Formatted: Font: (Default) Arial

**-END OF SECTION III-**

Formatted: Font: (Default) Arial

**SECTION IV**

**Medicus Secured Protection Program**

**I. OVERVIEW**

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

- DEA License Suspension
- Professional Misconduct
- Successful Completion of Chemical Dependency Program
- Adverse Claims Experience (Severity and/or Frequency)
- Proctorship
- Medical Board Sanctions or Fines
- Unusual Practice Characteristics
- Physical or Mental Health Impairments
- Bare Exposure Period
- Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non-standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

**II. APPLICANT REFERRAL CRITERIA:**

**A. Eligibility-New Business**

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

**B. Eligibility-Renewal Business**

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

- Formatted: Heading 1, Left, Widow/Orphan control
- Formatted: Left: 1", Right: 1"
- Formatted: Font: (Default) Arial, Bold
- Formatted: Font: (Default) Arial
- Formatted: Heading 2, Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial

- Formatted: Heading 2, Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial, Not Bold, Underline
- Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial, Not Bold, Underline
- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1"
- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1", Space After: 12 pt
- Formatted: Font: (Default) Arial, Not Bold, Underline
- Formatted: Heading 3, Indent: Left: 0", Widow/Orphan control, Hyphenate
- Formatted: Font: (Default) Arial, Not Bold
- Formatted: Font: (Default) Arial
- Formatted: Indent: Left: 1"

~~1.~~ ~~4.~~ A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

Formatted: Heading 4, Indent: Left: 0", First line: 0", Widow/Orphan control, Hyphenate

~~2.~~ ~~2.~~ A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

Formatted: Indent: Left: 0.75"

Formatted: Heading 4, Indent: Left: 0", First line: 0", Widow/Orphan control, Hyphenate

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

Formatted: Indent: Left: 0.75"

Formatted: Indent: Left: 1"

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

Formatted: Indent: Left: 0.25"

Formatted: Indent: Left: 1"

**III. 3. LENGTH OF INSURED'S REHABILITATION**

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

**IV. 4. RATING APPROACH**

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the ~~insured~~ ~~insured~~ has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial

**V. 5. UNDERWRITING**

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0.5"

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

Formatted: Indent: Left: 0.31"

Formatted: Indent: Left: 0.31"

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Font: (Default) Arial, Underline

Formatted: Font: (Default) Arial, Not Bold, Underline

A. Coverage Modifications

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial, Not Bold, Underline

1. The only limits available to physicians in the program are \$1 million/\$3 million or state minimum requirement.

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial

2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).

Formatted: Heading 4, No bullets or numbering, Widow/Orphan control, Hyphenate, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Heading 4, Widow/Orphan control, Hyphenate

3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.

Formatted: Heading 4, No bullets or numbering, Widow/Orphan control, Hyphenate, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Heading 4, Widow/Orphan control, Hyphenate

4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a \$5,000 per physician per claim deductible with a \$15,000 deductible annual aggregate.

Formatted: Heading 4, No bullets or numbering, Widow/Orphan control, Hyphenate, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Font: (Default) Arial, Not Bold, Underline

B. Consent to Settle

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

Formatted: Indent: Left: 0.5"

Formatted: Font: (Default) Arial, Not Bold, Underline

C. Impaired Physicians

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.5"

#### D. ~~D.~~ Prior Acts

Formatted: Font: (Default) Arial, Not Bold, Underline

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

Formatted: Heading 3, Indent: First line: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.5"

#### E. ~~E.~~ Imposed Deductibles

Formatted: Font: (Default) Arial

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed \$5,000 per claim with a \$15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

Formatted: Font: (Default) Arial, Not Bold, Underline

Formatted: Heading 3, Indent: Left: 0", Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0.25"

### VI. ~~6.~~ PHYSICIAN OR GROUP MANAGEMENT

Formatted: Indent: Left: 0.5"

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III ~~(K)~~ Premium Modifications.

Formatted: Font: (Default) Arial

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial, Not Bold

Formatted: Font: (Default) Arial

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0"

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurrence
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

Formatted: Indent: Left: 0.38"

**VII. ~~7.~~ INTERNAL LOGISTICS**

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

Formatted: Font: (Default) Arial, Not Bold

Formatted: Heading 2, Widow/Orphan control, Hyphenate

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 0"

Formatted: Heading 2, Widow/Orphan control













**Section 754.EXHIBIT A Summary Sheet (Form RF-3)**

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 03/01/2012.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger	0	
	Commercial	0	
2.	Automobile Physical Damag Private Passenger	0	
	Commercial	0	
3.	Liability Other Than Auto	\$17,523,881	-1.5%
4.	Burglary and Theft	0	
5.	Glass	0	
6.	Fidelity	0	
7.	Surety	0	
8.	Boiler and Machinery	0	
9.	Fire	0	
10.	Extended Coverage	0	
11.	Inland Marine	0	
12.	Homeowners	0	
13.	Commercial Multi-Peril	0	
14.	Crop Hail	0	
15.	Other	0	
	Life of Insurance		

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: Applies to all territories.

Brief description of filing. (If filing follows rates of an advisory

Organization, specify organization):

We are revising our class/specialty plan, territories, part-time credit, as well as our scheduled credit plan per state mandate. Please see the filing description.

\*Adjusted to reflect all prior rate changes.

\*\*Change in Company's premium level which will result from application of new rates.

Medicus Insurance Company

Name of Company

Mark Johnson - Vice President and CFO

Official – Title

**Section 754.EXHIBIT A Summary Sheet (Form RF-3)**

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 03/01/2012.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger	0	
	Commercial	0	
2.	Automobile Physical Damag Private Passenger	0	
	Commercial	0	
3.	Liability Other Than Auto	0	
4.	Burglary and Theft	0	
5.	Glass	0	
6.	Fidelity	0	
7.	Surety	0	
8.	Boiler and Machinery	0	
9.	Fire	0	
10.	Extended Coverage	0	
11.	Inland Marine	0	
12.	Homeowners	0	
13.	Commercial Multi-Peril	0	
14.	Crop Hail	0	
15.	Other	0	
	Life of Insurance		

\* Does filing only apply to certain territory (territories) or certain Classes? If so, specify: NO

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization):

We are revising our class/specialty plan, territories, part-time credit, as well as our scheduled credit plan per state mandate. Please see the filing description.

\*Adjusted to reflect all prior rate changes.

\*\*Change in Company's premium level which will result from application of new rates.

Medicus Insurance Company

Name of Company

Mark Johnson - Vice President and CFO

Official – Title

**Section 754.EXHIBIT A Summary Sheet (Form RF-3)**

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective \_\_\_\_\_.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger	_____	_____
	Commercial	_____	_____
2.	Automobile Physical Damag 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	_____	_____
	Life of Insurance	_____	_____

\* Does filing only apply to certain territory (territories) or certain Classes? If so, specify: \_\_\_\_\_

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): \_\_\_\_\_

\*Adjusted to reflect all prior rate changes.

\*\*Change in Company's premium level which will result from application of new rates.

\_\_\_\_\_  
Name of Company

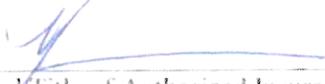
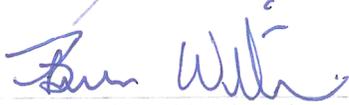
\_\_\_\_\_  
Official – Title

## ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates 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.

I, Mark Johnson, a duly authorized officer of Medicus Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Bruce Williams, a duly authorized actuary of NORCAL Mutual Insurance Company, am authorized to certify on behalf of Medicus Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

 Signature and Title of Authorized Insurance Company Officer	<u>Vice President &amp; CFO</u>	<u>01/31/2012</u> Date
 Signature, Title and Designation of Authorized Actuary	<u>AVP, ACAS, MAAA</u>	<u>1/31/2012</u> Date

Insurance Company FEIN 20-5623491 Filing Number IL 01-2012 Rate Manual

Insurer's Address 4807 Spicewood Springs, Bldg 4-100

City Austin State TX Zip Code 78759

Contact Person's  
Name and E-mail Jane M. Cundiff (jcundiff@medicusins.com)

Direct Telephone and Fax Number 512-879-5128, Fax: 877-686-0558