

State: Illinois **Filing Company:** The Medical Protective Company
TOI/Sub-TOI: 11.0 Medical Malpractice - Claims Made/Occurrence/11.0000 Med Mal Sub-TOI Combinations
Product Name: Dentists and Comprehensive Liability Coverage for Healthcare Providers
Project Name/Number: Botox, Moonlighting, OMR/12-OMR-01

Filing at a Glance

Company: The Medical Protective Company
Product Name: Dentists and Comprehensive Liability Coverage for Healthcare Providers
State: Illinois
TOI: 11.0 Medical Malpractice - Claims Made/Occurrence
Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations
Filing Type: Rate/Rule
Date Submitted: 03/02/2012
SERFF Tr Num: MDPC-128137120
SERFF Status: Closed-Filed
State Tr Num: MDPC-128137120
State Status:
Co Tr Num: 12-OMR-01

Effective Date: 07/01/2012
Requested (New):
Effective Date: 07/01/2012
Requested (Renewal):
Author(s): Melissa Millican, Christopher Cole
Reviewer(s): Gayle Neuman (primary)
Disposition Date: 12/05/2012
Disposition Status: Filed
Effective Date (New): 07/01/2012
Effective Date (Renewal): 07/01/2012

State Filing Description:
routed 3/6/12

State: Illinois **Filing Company:** The Medical Protective Company
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General Information

Project Name: Botox, Moonlighting, OMR Status of Filing in Domicile: Pending
Project Number: 12-OMR-01 Domicile Status Comments:
Reference Organization: n/a Reference Number: n/a
Reference Title: n/a Advisory Org. Circular: n/a
Filing Status Changed: 12/05/2012
State Status Changed: Deemer Date:
Created By: Christopher Cole Submitted By: Melissa Millican
Corresponding Filing Tracking Number:

Filing Description:

The Medical Protective Company (MedPro) Submits for your review the attached rate and rule filing applicable to our Dentists and Comprehensive Liability Coverage for Healthcare Providers programs

Company and Contact

Filing Contact Information

Melissa Millican, Paralegal melissa.millican@medpro.com
5814 Reed Road 260-486-0838 [Phone]
Fort Wayne, IN 46835 260-486-0733 [FAX]

Filing Company Information

The Medical Protective Company CoCode: 11843 State of Domicile: Indiana
5814 Reed Road Group Code: Company Type:
Fort Wayne, IN 46835 Group Name: State ID Number:
(260) 486-0838 ext. [Phone] FEIN Number: 35-0506406

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

State: Illinois **Filing Company:** The Medical Protective Company
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Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm):
acknowledged

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.: acknowledged

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL 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://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp .: acknowledged and attached

Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: acknowledged

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.":
acknowledged

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.: n/a - rate/rule filing only

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Filing Company: The Medical Protective Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	12/05/2012	12/05/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Gayle Neuman	03/06/2012	03/06/2012

Response Letters

Responded By	Created On	Date Submitted
Melissa Millican	03/06/2012	03/06/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Certification	Melissa Millican	03/26/2012	03/26/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective Date confirmation	Note To Reviewer	Melissa Millican	12/05/2012	12/05/2012
effective date	Note To Filer	Gayle Neuman	12/05/2012	12/05/2012
Effective Date move to 7/1/12	Note To Reviewer	Melissa Millican	03/29/2012	03/29/2012

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Disposition

Disposition Date: 12/05/2012

Effective Date (New): 07/01/2012

Effective Date (Renewal): 07/01/2012

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 req'd):	Minimum % Change (where req'd):
The Medical Protective Company	-0.300%	-0.300%	\$8,832	8	\$2,943,979	0.000%	-16.700%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document (revised)	Certification		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Strike Thru's		Yes
Rate	DDS OCC Class Plan		Yes
Rate	DDS SCM Class Plan		Yes
Rate	IL - State Rate Pages - Section IV - Dentists		Yes
Rate	DDS OCC Botox Rating Rule		Yes
Rate	DDS SCM Botox Rating Rule		Yes
Rate	DDS OCC Moonlighting Rating Rule		Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Rate	DDS SCM Moonlighting Rating Rule		Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/06/2012
Submitted Date	03/06/2012
Respond By Date	03/13/2012

Dear Melissa Millican,

Introduction:

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

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?

Conclusion:

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

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

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Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/06/2012
Submitted Date	03/06/2012

Dear Gayle Neuman,

Introduction:

Response 1

Comments:

We report statistics to ISO.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if you should need anything additional.

Thank you,
Melissa

Sincerely,
Melissa Millican

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Filing Company: The Medical Protective Company

Amendment Letter

Submitted Date: 03/26/2012

Comments:

Revised certification -

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:	Certification
Comments:	attached revised per email from Neetha M. Mamoottile
Attachment(s):	
cert revised.pdf	
<i>Previous Version</i>	
<i>Satisfied - Item:</i>	<i>Certification</i>
<i>Comments:</i>	<i>attached</i>
<i>Attachment(s):</i>	
<i>certification.pdf</i>	

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Note To Reviewer

Created By:

Melissa Millican on 12/05/2012 08:56 AM

Last Edited By:

Gayle Neuman

Submitted On:

12/05/2012 09:19 AM

Subject:

Effective Date confirmation

Comments:

Yes, we implemented the filing with an effective date of 7/1/12.

Please let me know if you should need anything additional.

Thank you,

Melissa

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Note To Filer

Created By:

Gayle Neuman on 12/05/2012 07:56 AM

Last Edited By:

Gayle Neuman

Submitted On:

12/05/2012 09:19 AM

Subject:

effective date

Comments:

The Department of Insurance completed its review of this filing. Medical Protective Company had requested the filing be effective July 1, 2012. Was the filing put in effect on July 1, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

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Note To Reviewer

Created By:

Melissa Millican on 03/29/2012 09:21 AM

Last Edited By:

Gayle Neuman

Submitted On:

12/05/2012 09:19 AM

Subject:

Effective Date move to 7/1/12

Comments:

At this time, we request to move the eff date to 7/1/12.

Thank you,
Melissa

State: Illinois **Filing Company:** The Medical Protective Company
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Post Submission Update Request Processed On 03/29/2012

Status: Allowed
Created By: Melissa Millican
Processed By: Gayle Neuman
Comments:

General Information:

Field Name	Requested Change	Prior Value
Effective Date Requested (New)	07/01/2012	06/01/2012
Effective Date Requested (Renew)	07/01/2012	06/01/2012

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Filing Company: The Medical Protective Company

Rate Information

Rate data applies to filing.

Filing Method: file and use
Rate Change Type: Decrease
Overall Percentage of Last Rate Revision: -0.100%
Effective Date of Last Rate Revision: 04/01/2009
Filing Method of Last Filing: file and use

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 req'd):	Minimum % Change (where req'd):
The Medical Protective Company	-0.300%	-0.300%	\$8,832	8	\$2,943,979	0.000%	-16.700%

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Filing Company: The Medical Protective Company

Rate/Rule Schedule

Item No.	Schedule Item Status	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing Number	Attachments
1		DDS OCC Class Plan	DRC-CW; 04/01/12	Replacement		oc class plan.pdf
2		DDS SCM Class Plan	DRC-CW; 04/01/12	Replacement		cm class plan.pdf
3		IL - State Rate Pages - Section IV - Dentists	SR-IL-IV-(1-3, 12, 18); 04/01/12	Replacement		Section IV State Exception .pdf
4		DDS OCC Botox Rating Rule	BRR-IL; 08/01/11	Replacement		BRR DDS 08.11 - OCC.pdf
5		DDS SCM Botox Rating Rule	BRR-IL; 08/01/11	Replacement		BRR DDS 08.11 - SCM.pdf
6		DDS OCC Moonlighting Rating Rule	MLT-CW; 08/01/11	Replacement		Moonlighting Rule OC - DDS.pdf
7		DDS SCM Moonlighting Rating Rule	MLT-CW; 08/01/11	Replacement		Moonlighting Rule SCM - DDS.pdf

The
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Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS I A

ANY GENERAL DENTIST OR SPECIALISTS IN ORTHODONTIC, PEDIATRIC DENTISTRY, PERIODONTICS, PROSTHODONTICS AND ENDODONTICS NOT PERFORMING MINOR OR MAJOR SURGICAL PROCEDURES.

CLASS I B

ANY DENTIST PERFORMING MINOR SURGICAL PROCEDURES OR A SPECIALIST TRAINED IN ORAL PATHOLOGY.

CLASS I C

ANY DENTIST PERFORMING MAJOR DENTAL SURGICAL PROCEDURES NOT INCLUDED IN CLASS III OR A SPECIALIST TRAINED IN ORAL AND MAXILLOFACIAL RADIOLOGY.

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY.

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ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS II B

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY.

CLASS III

ANY DENTAL SPECIALIST PERFORMING PROCEDURES NOT OTHERWISE CLASSIFIED.

SPECIALISTS IN PAIN MANAGEMENT.

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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS I A

ANY GENERAL DENTIST OR SPECIALISTS IN ORTHODONTIC, PEDIATRIC DENTISTRY, PERIODONTICS, PROSTHODONTICS AND ENDODONTICS NOT PERFORMING MINOR OR MAJOR SURGICAL PROCEDURES.

CLASS I B

ANY DENTIST PERFORMING MINOR SURGICAL PROCEDURES OR A SPECIALIST TRAINED IN ORAL PATHOLOGY.

CLASS I C

ANY DENTIST PERFORMING MAJOR DENTAL SURGICAL PROCEDURES NOT INCLUDED IN CLASS III OR A SPECIALIST TRAINED IN ORAL AND MAXILLOFACIAL RADIOLOGY.

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS II B

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY.

CLASS III

ANY DENTAL SPECIALIST PERFORMING PROCEDURES NOT OTHERWISE CLASSIFIED.

SPECIALISTS IN PAIN MANAGEMENT.

DENTISTS

A. Classifications

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

CLASS I A

Any General Dentist or Specialists in orthodontic, pediatric dentistry, periodontics, prosthodontics and endodontics not performing minor or major surgical procedures.

CLASS I B

Any Dentist performing minor surgical procedures or a specialist trained in oral pathology.

CLASS I C

Any dentist performing major Dental surgical procedures not included in Class III or a specialist trained in oral and maxillofacial radiology.

CLASS II A

Specialists in Dental Anesthesiology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery.

CLASS III

Any Dental Specialist performing procedures not otherwise classified.

Specialists in Pain Management.

B. Manual Rates

1. Territory Definitions

Area 1	Cook, Madison & St. Clair County
Area 2	DuPage, Kane, Lake, Will, McHenry
Area 3	Remainder of State

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Dentists	\$50
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D. **Premium Modifications**

1. **Part Time Dentists**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-20	1,050	50%

2. **Dentists in Training**

a. **Training Activities**
(Occurrence & Standard Claims Made Programs)

The Dentist's rate shall be determined by the insured's classification and limit of liability as present on the manual rate tables, subject to any applicable credit determined by the Company to be commensurate with the exposure.

b. **Moonlighting Activities**
(Occurrence & Standard Claims Made Programs)

Credit
75%

No other premium modifications will apply concurrent with this rule except New to Company, Schedule Rating, Dental Facility Classification Plan and/or Risk Management.

c. **Dental Externship / Board Exam**
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	No Charge

d. **Student / Resident Rating Rule**
(Occurrence Program)

Type	Premium
Students	\$35 per student
Residents	\$50 per resident

17. **Botulinum Toxin and Dermal Fillers Rating Rule**
(Occurrence & Standard Claims Made Programs)

DEBIT A	DEBIT B	DEBIT C
25%	20%	13%

18. **Dental Facility Classification Plan**
(Occurrence & Standard Claims Made Programs)

Debit
60%

19. **Convertible Coverage Rating Plan**
(Standard Claims Made Program)

The applicable premium under this plan shall be equal to 100% of the manual premium that would otherwise be derived for the insured under the Occurrence Program.

20. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

21. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
\$25,000

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

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ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

BOTULINUM TOXIN AND DERMAL FILLERS RATING

RULE

THE FOLLOWING DEBIT STRUCTURE SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE IN RECOGNITION OF THE UNIQUE RISK CHARACTERISTICS OF DENTISTS, OR GROUPS OF DENTISTS, WHO ADMINISTER BOTULINUM TOXIN AND DERMAL FILLERS.

DEBIT A	DEBIT B	DEBIT C
25%	20%	13%

DEBIT A: GENERAL DENTISTS, ORTHODONTISTS, PEDIATRIC DENTISTS, PERIODONTISTS, PROSTHODONTISTS, ENDODONTISTS, OR HOST DENTISTS UNLESS CLASSIFIED UNDER DEBIT B & C.

DEBIT B: ANY DENTISTS PERFORMING MINOR SURGICAL PROCEDURES OR IMPLANTS AND ORAL PATHOLOGISTS.

DEBIT C: ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

APPROVAL FOR PARTICIPATION IN THIS RATING RULE IS SUBJECT TO UNDERWRITING GUIDELINES.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

BOTULINUM TOXIN AND DERMAL FILLERS RATING

RULE

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DEBIT A	DEBIT B	DEBIT C
25%	20%	13%

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DEBIT C: ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

APPROVAL FOR PARTICIPATION IN THIS RATING RULE IS SUBJECT TO UNDERWRITING GUIDELINES.

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DENTISTS

OCCURRENCE PROGRAM

MOONLIGHTING RATING RULE

COVERAGE IS AVAILABLE FOR INSUREDS PRACTICING PART TIME WHILE IN A RESIDENCY OR FELLOWSHIP PROGRAM CONDUCTED THRU ANY DENTAL SCHOOL OR HOSPITAL.

A CREDIT OF 75% WILL APPLY TO THE INSUREDS PREMIUM PURSUANT TO THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

NO OTHER PREMIUM MODIFICATIONS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT NEW TO COMPANY, SCHEDULE RATING, DENTAL FACILITY CLASSIFICATION PLAN AND/OR RISK MANAGEMENT.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

MOONLIGHTING RATING RULE

COVERAGE IS AVAILABLE FOR INSUREDS PRACTICING PART TIME WHILE IN A RESIDENCY OR FELLOWSHIP PROGRAM CONDUCTED THRU ANY DENTAL SCHOOL OR HOSPITAL.

A CREDIT OF 75% WILL APPLY TO THE INSUREDS PREMIUM PURSUANT TO THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

NO OTHER PREMIUM MODIFICATIONS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT NEW TO COMPANY, SCHEDULE RATING, DENTAL FACILITY CLASSIFICATION PLAN AND/OR RISK MANAGEMENT.

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Filing Company: The Medical Protective Company

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Explanatory Memorandum		
Comments:	attached		
Attachment(s):			
memo.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Form RF3 - (Summary Sheet)		
Comments:	attached		
Attachment(s):			
RF3.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certification		
Comments:	attached revised per email from Neetha M. Mamoottile		
Attachment(s):			
cert revised.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Manual		
Comments:	attached		
Attachment(s):			
IL DDS OCC RULES.pdf IL General Manual - Section IV - Dentists.pdf IL State Rate Pages - Section IV - Dentists.pdf IL DDS SCM RULES.pdf			

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Product Name:

Dentists and Comprehensive Liability Coverage for Healthcare Providers

Project Name/Number:

Botox, Moonlighting, OMR/12-OMR-01

Item Status:

Status Date:

Satisfied - Item:	Strike Thru's		
Comments:	attached		
Attachment(s):			
BRR DDS 08.11 - OCC strike thru.pdf			
BRR DDS 08.11 - SCM strike thru.pdf			
Moonlighting Rule OC - DDS strike thru.pdf			
Moonlighting Rule SCM - DDS strike thru.pdf			
Section IV State Exception strike thru .pdf			

THE MEDICAL PROTECTIVE COMPANY

DENTISTS

EXPLANATORY MEMORANDUM

The Medical Protective Company (MedPro) respectfully submits the attached revisions to the Dentists Occurrence and Claims Made programs. The proposed revisions will result in an overall premium impact of -0.3% to be accomplished through rule revisions. The proposed effective date for these revisions is June 1, 2012 for new and renewal business.

Revise Class Plan: Addition of Oral & Maxillofacial Radiologist Specialty - The Company wishes to introduce the Oral & Maxillofacial Radiologist specialty to its Dental Occurrence & Standard Claims Made Class Plan. The revision results in a 0% rate impact to current insureds.

An Oral Maxillofacial Radiologist (OMR) is a dentist specialized in the use of complex imaging systems for the interpretation of radiographic imaging studies for the diagnosis, study, and management of oral and maxillofacial diseases and conditions in a private practice, hospital, or educational institution setting. In addition, OMRs are overseen by the American Board of Oral & Maxillofacial Radiology (ABOMR) and may belong to the American Academy of Oral & Maxillofacial Radiology (AAOMR).

Our evaluation showed that The American Dental Association recognized Oral Maxillofacial Radiology as a specialty in 1994. While there are approximately 220,000 Dentist's practicing in the country today, there are only approximately 200 OMRs.

Due to this limited volume of experience by practicing OMRs, MedPro has had to rely on internal qualitative analyses for the placement of these risks in our class plan. MedPro currently does not write these risks and the specialty is not recognized within the class plans of our competitors. Our analysis indicates that their placement is between a General Dentist and an Oral Surgeon, however, given the level of oversight of this specialty by the ABOMR and AAOMR, MedPro believes a placement of these risks in Class 1C is prudent. Experience for the new classification will be evaluated as it matures, and subsequent adjustments will be made to pricing as it is warranted. Revised Classification manual pages are enclosed for your review.

Botulinum Toxin and Dermal Fillers Rating Rule

MedPro's largest national dental competitor, the Continental Casualty Company (CNA), has recently filed modifications countrywide to their "Injectable Neurotoxins and Derm Fillers" charges for their Dentist Professional Liability program. Previously CNA charged a flat rate, but will now instead charge scheduled debits of 0 to 25% in the Exposure Modification section of their countrywide pages. The debit is to be applied to their manual rates. This effectively reduces CNA's charges to be between \$0 and approximately half of what MedPro currently charges for similar Botulinum and Dermal Fillers coverage in the state. Additionally, MedPro started writing this coverage in 2009 and the limited loss experience under this program is not credible. As such, MedPro is electing to reduce our current charge for this coverage by 50%.

Moonlighting Rating Rule

The Company wishes to revise the Moonlighting Rating Rule for the Stand Alone Occurrence and Standard Claims Made Programs to clarify which premium modifications can be used in conjunction with the Moonlighting Rule. The changes do not result in a substantive rate impact.

Revised Comprehensive Liability Coverage for Health Care Providers - Also attached are revised manual pages for Section IV of the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates and rules used for this program mirror those used for the Company's individual Dentists program, and therefore are being included in this submission for manual purposes only.

**ILLINOIS DEPARTMENT OF INSURANCE
SUMMARY SHEET**

Change in Company's premium or rate level produced by rate revision effective 06/01/2012

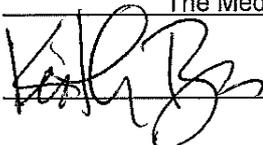
(1) <u>Coverage</u>	(2) <u>Annual Premium Volume (Illinois)*</u>	(3) <u>Percent Change (+ or -)**</u>
1. Automobile Liability Private Passenger Commercial	_____	_____
2. Automobile Physical Damage Private Passenger Commercial	_____	_____
3. Liability Other Than Auto	_____	_____
4. Burglary and Theft	_____	_____
5. Glass	_____	_____
6. Fidelity	_____	_____
7. Surety	_____	_____
8. Boiler and Machinery	_____	_____
9. Fire	_____	_____
10. Extended Coverage	_____	_____
11. Inland Marine	_____	_____
12. Homeowners	_____	_____
13. Commercial Multi-Peril	_____	_____
14. Crop Hail	_____	_____
15. Other <u>Dentist's Prof Liability</u> Line of Insurance	\$2,943,979	-0.3%

Does filing only apply to certain territory (territories) or certain classes? If so, specify: The modification of the debits associated with the Botulinum Toxin and Dermal Fillers (Botox) rating rule applies by classification as outlined in the attached rule.

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
MedPro will decrease the current debits applied to dentists performing procedures described within the Botox rating rule by 50%.

*Adjusted to reflect all prior rate changes.

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

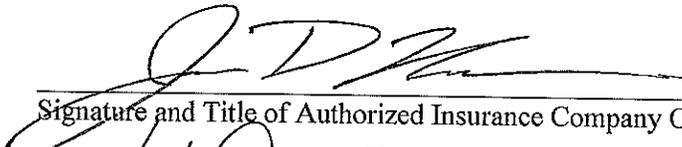
The Medical Protective Company
Name of Company
 Vice President
Official - Title

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

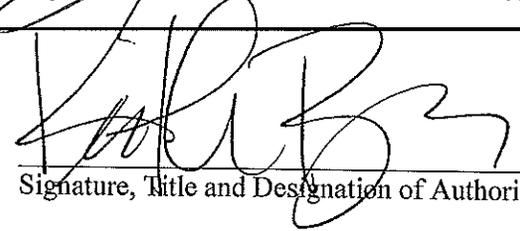
(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Jim D. Kunce, a duly authorized officer of The Medical Protective 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, Keith Barnes, a duly authorized actuary of The Medical Protective Company, am authorized to certify on behalf of The Medical Protective 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

3/26/12
Date


Signature, Title and Designation of Authorized Actuary

3/26/2012
Date

Insurance Company FEIN: 35-0506406 Filing Number: 12-DMR-01

Insurer Address: 5814 Reed Road

City: Fort Wayne State: IN Zip: 46835

- Contact Person's Name and E-mail Melissa Millican melissa.millican@medpro.com

- Direct Telephone and Fax Number Direct: 260-486-0838 Fax: 260-486-0733

The
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Fort Wayne, Indiana 46835
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ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION, MOONLIGHTING OR DEDUCTIBLE CREDITS.

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OCCURRENCE PROGRAM

BOTULINUM TOXIN AND DERMAL FILLERS RATING

RULE

THE FOLLOWING DEBIT STRUCTURE SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE IN RECOGNITION OF THE UNIQUE RISK CHARACTERISTICS OF DENTISTS, OR GROUPS OF DENTISTS, WHO ADMINISTER BOTULINUM TOXIN AND DERMAL FILLERS.

DEBIT A	DEBIT B	DEBIT C
25%	20%	13%

DEBIT A: GENERAL DENTISTS, ORTHODONTISTS, PEDIATRIC DENTISTS, PERIODONTISTS, PROSTHODONTISTS, ENDODONTISTS, OR HOST DENTISTS UNLESS CLASSIFIED UNDER DEBIT B & C.

DEBIT B: ANY DENTISTS PERFORMING MINOR SURGICAL PROCEDURES OR IMPLANTS AND ORAL PATHOLOGISTS.

DEBIT C: ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

APPROVAL FOR PARTICIPATION IN THIS RATING RULE IS SUBJECT TO UNDERWRITING GUIDELINES.

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CLAIM FREE CREDIT

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 INSURED BY THE COMPANY AND CLAIM FREE FOR 3 YEARS BUT LESS THAN 5, A 5% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.
2. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 5 YEARS BUT LESS THAN 8, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.
3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 8 YEARS OR MORE, A CREDIT OF 15% SHALL BE APPLIED TO THE NEXT POLICY RENEWAL.

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.

INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

~~1899~~
~~WELLES BROS. COMPANY~~

~~ROSE BLDG. INDIANAPOLIS 46204~~

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OCCURRENCE PROGRAM

DEFERRED PREMIUM PAYMENT PLAN RULE

THE COMPANY WILL, SUBJECT TO APPLICABLE GUIDELINES, OFFER THE INSURED VARIOUS PREMIUM PAYMENT OPTIONS. THE DEFERRED PREMIUM PAYMENT PLAN REQUIRES A MINIMUM OF 25% OF THE TOTAL PREMIUM TO BE PAID ON OR BEFORE THE INCEPTION/RENEWAL DATE OF THE POLICY. THE BALANCE OF THE PREMIUM WILL BE PAYABLE IN PERIODIC INSTALLMENTS. OTHER FEES MAY APPLY.

Edition Date: 01/15/03

EFFECTIVE DATE JUN 0 1 2003

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ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

DENTAL BOARD EXAMINATION RULE

COVERAGE IS AVAILABLE TO DENTAL STUDENTS, ON A SHORT-TERM BASIS, FOR SERVICES RENDERED BY THE STUDENT DURING A DENTAL EXTERNSHIP PRIOR TO GRADUATION AND/OR DURING THE DENTAL BOARD EXAM PURSUANT TO THE STUDENT'S PROFESSIONAL LICENSING.

THE COVERAGE WILL BE PROVIDED ON A \$1,000,000 PER OCCURRENCE AND \$3,000,000 ANNUAL AGGREGATE LIMITS BASIS FOR NO ADDITIONAL CHARGE, AND IS NOT SUBJECT TO THE MINIMUM PREMIUM RULE. COVERAGE WILL ONLY BE AVAILABLE TO DENTAL STUDENTS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

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DENTISTS

OCCURRENCE PROGRAM

DENTAL FACILITY CLASSIFICATION PLAN

A 60% DEBIT SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE FOR INSUREDS, OR GROUPS OF INSUREDS, WHO PRACTICE IN OR WITH DENTAL FACILITIES AS SUCH NON-STANDARD DENTAL PRACTICES ARE NOT CONTEMPLATED IN THE FILED RATE STRUCTURE.

PLACEMENT INTO THE DENTAL FACILITY CLASSIFICATION PLAN WILL BE DETERMINED BY THE COMPANY'S UNDERWRITING RULES AND GUIDELINES.

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DENTISTS

OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-DENTIST GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL DENTIST BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH DENTIST'S NUMBER OF HOURS OF DENTAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
1,800	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL DENTIST IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER DENTIST RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE DENTIST RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

<u>FTE*</u> <u>PER POLICY</u>	<u>PREMIUM</u> <u>MODIFICATION</u>	<u>FTE*</u> <u>PER POLICY</u>	<u>PREMIUM</u> <u>MODIFICATION</u>
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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OCCURRENCE PROGRAM

GROUP RATING RULE

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE DENTISTS MAY BE COLLECTIVELY RATED. ("GROUP PRACTICE" SHALL MEAN A GROUP OR BODY OF INSURED'S WHO MAKE A COLLECTIVE BUYING DECISION TO PURCHASE INSURANCE AS THE OWNERS, EMPLOYEES, OR AGENTS OF A SPECIFIC AND DISTINCT CORPORATION, PARTNERSHIP, OR ASSOCIATION.)

1. THE PREMIUM FOR THE GROUP WILL BE DETERMINED BY MULTIPLYING THE "GROUP'S NET PREMIUM" BY ANY CREDITS OR DEBITS ASSIGNED TO THE GROUP UNDER THE SCHEDULE RATING PLAN OR DEDUCTIBLE CREDIT RULE, AFTER FACTORING IN ANY COMMISSION FEE OR OTHER EXPENSE VARIATIONS ASSOCIATED WITH THE GROUP. (THE COMPANY WILL NEGOTIATE AN APPROPRIATE COMMISSION WITH THE INSURED'S AGENT BASED UPON THE GROUP'S SIZE AND THE AMOUNT OF WORK TO BE PERFORMED BY THE AGENT. UPON REQUEST, THE COMPANY WILL WRITE THE GROUP ON A NET OF COMMISSION BASIS IF THE GROUP HAS NEGOTIATED A SEPARATE FEE AGREEMENT WITH ITS AGENT.)
2. THE "GROUP'S NET PREMIUM" WILL EQUAL THE SUM OF THE "INDIVIDUAL NET PREMIUMS" FOR EACH INDIVIDUAL OR ENTITY RECEIVING SEPARATE LIMITS OF LIABILITY.

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OCCURRENCE PROGRAM

GROUP RATING RULE

3. THE "INDIVIDUAL NET PREMIUMS" WILL EQUAL THE FILED RATE FOR THE INSURED AFTER BEING ADJUSTED FOR ANY APPLICABLE NONDISCRETIONARY DEBITS OR CREDITS. HOWEVER, ONCE THE PREMIUM FOR THE GROUP HAS BEEN ESTABLISHED, THE COMPANY MAY ALLOCATE THAT PREMIUM AMONG THE INDIVIDUAL INSUREDS BASED UPON APPLICABLE UNDERWRITING CRITERIA.

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OCCURRENCE PROGRAM

LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO IS ON A LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE, IF REPORTED TO THE COMPANY WITHIN 30 DAYS. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD. LEAVE OF ABSENCE MAY INCLUDE THE FOLLOWING:

- THE BIRTH OF INSUREDS NEWBORN, PLACEMENT OF FOSTER CHILDREN OR INSURED ADOPTS A CHILD, PROVIDED THE LEAVE IS COMPLETED WITHIN 12 MONTHS OF THE BIRTH, PLACEMENT OR ADOPTION.
- TO CARE FOR A SPOUSE, CHILD OR PARENT WHO HAS A SERIOUS HEALTH CONDITION.
- TO CARE FOR INSUREDS OWN HEALTH CONDITION WHICH PREVENTS INSURED FROM WORKING.
- TIME TO ENHANCE THE INSUREDS EDUCATION OR OTHER REASON WHILE NOT PRACTICING.

THIS CREDIT IS NOT AVAILABLE TO AN INSUREDS LEAVE OF ABSENCE FOR VACATION PURPOSES. THE MINIMUM PREMIUM RATING RULE APPLIES TO INSUREDS ELIGIBLE FOR THE LEAVE OF ABSENCE CREDIT.

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MEDICAL PROFESSIONAL COMPANY

20111 WABER, INDIANNA 46218

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LOCUM TENENS

COVERAGE FOR A DENTIST SUBSTITUTING FOR AN INSURED DENTIST WILL BE LIMITED TO COVER ONLY PROFESSIONAL SERVICES RENDERED ON BEHALF OF THE INSURED DENTIST FOR THE SPECIFIED TIME PERIOD. LOCUM TENENS WILL SHARE IN THE INSURED DENTIST'S LIMIT OF LIABILITY. NO ADDITIONAL CHARGE WILL APPLY FOR THIS COVERAGE.

THE LOCUM TENENS DENTIST MUST COMPLETE AN APPLICATION AND SUBMIT IT TO THE COMPANY IN ADVANCE FOR APPROVAL PRIOR TO THE REQUESTED EFFECTIVE DATE OF COVERAGE.

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MEMBERSHIP ASSOCIATION CREDIT RULE

THE UNIQUE CHARACTERISTICS OF A DENTAL PRACTICE AND THEIR MEMBERSHIP IN QUALIFIED PROFESSIONAL ASSOCIATIONS SHALL MAKE THEM ELIGIBLE FOR A PREMIUM MODIFICATION IN ADDITION TO THOSE AVAILABLE TO OTHER INSURED.

A PREMIUM CREDIT OF UP TO 25% SHALL BE GIVEN TO THOSE INSURED WHOSE GROUP IS A MEMBER OF A QUALIFIED ASSOCIATION AS DETERMINED BY THE COMPANY'S UNDERWRITING GUIDELINES.

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OCCURRENCE PROGRAM

MILITARY LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO IS ON A MILITARY LEAVE OF ABSENCE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE.

THE MINIMUM PREMIUM RATING RULE DOES NOT APPLY TO INSUREDS THAT ARE ELIGIBLE FOR THE MILITARY LEAVE OF ABSENCE CREDIT.

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MINIMUM PREMIUM REQUIREMENT RULE

ALL POLICIES ARE SUBJECT TO A MINIMUM PREMIUM OF \$50. THE MINIMUM PREMIUM WILL BE RETAINED WHEN THE INSURED REQUESTS CANCELLATION UNLESS THE POLICY IS CANCELED AS OF THE INCEPTION DATE.

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MOONLIGHTING RATING RULE

COVERAGE IS AVAILABLE FOR INSUREDS PRACTICING PART TIME WHILE IN A RESIDENCY OR FELLOWSHIP PROGRAM CONDUCTED THRU ANY DENTAL SCHOOL OR HOSPITAL.

A CREDIT OF 75% WILL APPLY TO THE INSUREDS PREMIUM PURSUANT TO THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

NO OTHER PREMIUM MODIFICATIONS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT NEW TO COMPANY, SCHEDULE RATING, DENTAL FACILITY CLASSIFICATION PLAN AND/OR RISK MANAGEMENT.

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OCCURRENCE PROGRAM

NEW TO COMPANY CREDIT

AN INSURED MAY BE ELIGIBLE FOR A NEW TO COMPANY CREDIT PURSUANT TO THE FOLLOWING GUIDELINES:

- A. NEVER INSURED WITH THE COMPANY, OR
- B. PREVIOUSLY INSURED WITH COMPANY MORE THAN 3 YEARS AGO.

CREDITS IN THE AMOUNT OF 35% OF FILED MANUAL RATES SHALL APPLY TO THE INSUREDS FIRST, SECOND AND THIRD CONSECUTIVE YEARS OF COVERAGE. THE CREDIT SHALL BE REDUCED BY 5% EVERY OTHER YEAR BEGINNING IN THE 4TH YEAR UNTIL SUCH TIME THAT THE CREDIT IS 0%. ALL OTHER CREDITS WILL APPLY TO THE REDUCED RATE.

THIS CREDIT IS NOT SUBJECT TO THE AGGREGATE CREDIT RULE AND SUBJECT TO UNDERWRITING GUIDELINES. ONLY ONE REQUEST FOR THIS CREDIT PROGRAM WILL BE GRANTED TO AN ELIGIBLE INSURED DURING ANY PERIOD OF TIME INSURED BY THE COMPANY.

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OCCURRENCE PROGRAM

NEW TO PRACTICE CREDIT

A "NEW" DENTIST SHALL BE A DENTIST 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 DENTAL SPECIALITY;
- C) FULFILLMENT OF A MILITARY OBLIGATION;
- D) DENTAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

TO QUALIFY FOR THE 1ST YEAR CREDIT, THE APPLICANT WILL BE REQUIRED TO APPLY FOR A REDUCED RATE WITHIN SIX MONTHS AFTER THE COMPLETION OF ANY OF THE ABOVE PROGRAMS.

CREDITS IN THE AMOUNT OF 75% OF FILED MANUAL RATES SHALL APPLY TO NEW INSURED FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSURED FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 25% OF FILED MANUAL RATES SHALL APPLY TO NEW INSURED FOR THEIR THIRD YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR DENTAL TRAINING PROGRAM.

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OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR ANY INSURED WHO IS NOT ELIGIBLE FOR A CREDIT UNDER THE COMPANY'S CLAIM/LOSS FREE CREDIT RULE, POINTS WILL BE ASSIGNED FOR EACH CLAIM:

- 1) PENDING AGAINST THE INSURED AT THE BEGINNING OF THE CURRENT POLICY PERIOD;
 - 2) PAID ON THE INSURED'S BEHALF DURING THE PAST 5 YEARS; OR
 - 3) CLOSED WITH NO PAYMENT DURING THE PAST 5 YEARS,
- PURSUANT TO THE FOLLOWING SCHEDULE:

ASSIGNED CLAIM POINTS	
Claim Threshold	Points
Pending claim	1
Loss payment of \$0 to \$49,999	1
Loss payment of \$50,000 to \$99,999	2
Loss payment of \$100,000 to \$249,999	4
Loss payment of \$250,000 to \$499,999	6
Loss payment of \$500,000 or more	8

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DENTISTS

OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR PROVIDERS WHO HAVE BEEN PRACTICING FOR LESS THAN FIVE COMPLETE YEARS FROM THEIR INITIAL DENTAL SCHOOL GRADUATION DATE, THE TOTAL ASSIGNED CLAIM POINTS (AS CALCULATED FROM THE SCHEDULE ABOVE) WILL BE MULTIPLIED BY THE APPLICABLE FACTOR SET FORTH IN THE FOLLOWING SCHEDULE:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 2 years	5.00
At least 2 years but less than 3 years	2.50
At least 3 years but less than 4 years	1.666
At least 4 years but less than 5 years	1.25
5 years or more	No factor applied

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY WHO HAVE PENDING CLAIMS OR CLAIMS PAID ON THEIR BEHALF WITHIN THE PAST FIVE YEARS WILL BE ASSIGNED POINTS IN ACCORDANCE WITH COMPANY GUIDELINES.

MEDICAL PROFESSIONAL COMPANY

ROUTE 74302, BEND, OREGON 97701

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DENTISTS

OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

A DEBIT SHALL THEN BE APPLIED TO THE INSURED'S POLICY BASED UPON THE FOLLOWING SCHEDULE:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	25%	0%
4	25%	25%
5	50%	40%
6	50%	40%
7	200%	50%
8	500%	200%
9	700%	500%
10+	800%	700%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80201 AND 80210. TABLE A SHALL APPLY TO INSUREDS PRACTICING UNDER ANY OTHER ISO CODE.)

FOR THE PURPOSE OF THIS RULE, A "CLAIM" SHALL NOT INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

1899
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FOUR YEARS EVIDENCE 46885

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OCCURRENCE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

ANY DEBIT REQUIRED UNDER THIS RULE SHALL BE ADDITIVE WITH ANY OTHER DEBITS OR CREDITS APPLICABLE UNDER THE COMPANY'S RATING MANUAL.

THIS NON-DISCRETIONARY DEBIT PLAN SHALL ONLY APPLY TO PROVIDERS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE, AND THE COMPANY RETAINS THE RIGHT TO REFUSE TO INSURE ANY INSURED OR APPLICANT BASED UPON THE QUALITATIVE NATURE OF ANY CLAIMS MADE AGAINST THAT INDIVIDUAL OR ENTITY. AS A RESULT, THE FACT THAT THIS RULE PROVIDES (OR DOES NOT PROVIDE) A DEBIT FOR CLAIMS EXPERIENCE IS NOT AN INDICATION THAT THERE IS A RATE AVAILABLE FOR ANY PARTICULAR INSURED OR APPLICANT.

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DENTISTS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE EQUAL TO A PERCENTAGE OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED DENTISTS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION, PURSUANT TO THE FOLLOWING TABLE. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS.

LIMITS OF COVERAGE FOR THE PARTNERSHIP OR CORPORATION MAY NOT EXCEED THE LOWEST LIMITS OF COVERAGE OF ANY OF THE INSURED PARTNERS, SHAREHOLDERS OR EMPLOYED/CONTRACTED DENTISTS.

A SEPARATE POLICY IS ISSUED.

SPECIALTY	PERCENTAGE
ORAL SURGEONS	1%
ALL OTHER DENTAL SPECIALTIES	5%

The
Medical Protective Company
Fort Wayne, Indiana 46835
Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

<u>AVERAGE NUMBER HOURS PRACTICED PER WEEK</u>	<u>MAX. AGGREGATE HOURS PER YR</u>	<u>CREDIT</u>
0-20 HOURS	1,050	50%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS, AND/OR RISK MANAGEMENT.

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RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF \$25,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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RISK MANAGEMENT CREDIT RULE

THE INSURED WILL RECEIVE A FIVE PERCENT (5%) PREMIUM CREDIT APPLIED FOR UP TO THREE YEARS FOR A RISK MANAGEMENT COURSE APPROVED FOR CREDIT BY THE MEDICAL PROTECTIVE COMPANY.

ADDITIONALLY, THE INSURED WILL RECEIVE A TWO AND ONE HALF PERCENT (2.5%) PREMIUM CREDIT APPLIED FOR THREE YEARS FOR THE PROPER USE OF AN ELECTRONIC HEALTH RECORD SYSTEM WITHIN THEIR PRACTICE. THE CREDIT WILL BE PROVIDED FOR PROGRAMS MEETING THE CRITERIA OF THE MEDICAL PROTECTIVE COMPANY AND ISSUED AT THE BEGINNING OF THE NEXT POLICY PERIOD CONTINGENT UPON RECEIPT OF THEREQUIRED DOCUMENTATION OF SYSTEM CAPABILITIES AND PRACTICE USAGE.

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SCHEDULE RATING PLAN

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR INSURED(S) WHO 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 THE FOLLOWING, SUBJECT TO A MAXIMUM MODIFICATION OF -25% / +25%, 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 APPLICABLE CRITERIA AND SUPPORT FOR EACH PREMIUM MODIFICATION SHALL BE INCLUDED IN THE INSURED(S) UNDERWRITING FILE.

THE MODIFICATION SHALL BE BASED ON ONE OR MORE OF THE FOLLOWING CONSIDERATIONS:

CRITERIA	RANGE
<u>HISTORICAL LOSS EXPERIENCE:</u> 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.	-20% TO +20%

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CRITERIA	RANGE
<u>CUMULATIVE YEARS OF PATIENT EXPERIENCE:</u> THE INSURED(S) DEMONSTRATES A GREATER/LESS THAN STABLE, LONGSTANDING PRACTICE AND/OR SIGNIFICANT DEGREE OF EXPERIENCE IN THEIR CURRENT AREA OF MEDICINE.	-5% TO +5%
<u>CLASSIFICATION ANOMALIES:</u> CHARACTERISTICS OF A PARTICULAR INSURED THAT DIFFERENTIATE THE INSURED TO BE GREATER/LESS THAN 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.	-15% TO +15%
<u>CLAIM ANOMALIES:</u> ECONOMIC, SOCIETAL OR JURISDICTIONAL CHANGES OR TRENDS THAT WILL POSTIVELY OR NEGATIVELY INFLUENCE THE FREQUENCY OR SEVERITY OF CLAIMS, OR THE UNUSUAL CIRCUMSTANCES OF A CLAIM(S) WHICH UNDERSTATE/OVERSTATE THE SEVERITY OF THE CLAIM(S).	-10% TO +10%
<u>MANAGEMENT CONTROL PROCEDURES:</u> SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
<u>NUMBER/TYPE OF PATIENT EXPOSURES:</u> SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH NEGATIVELY OR POSTIVELY INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%

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 SCHEDULE RATING PLAN**

CRITERIA	RANGE
<u>ORGANIZATIONAL SIZE/STRUCTURE:</u> A GROUP'S SIZE, PROCESSES AND/OR ROSTER OF INSURED(S) ARE SUCH THAT THE COMPANY WILL INCUR GREATER OR LESSER COSTS IN ASSOCIATION WITH ITS SERVICE TO, OR COVERAGE OF, THE GROUP.	-5% TO +5%
<u>HEALTHCARE STANDARDS, QUALITY AND CLAIMS REVIEW:</u> PRESENCE (OR LACK) OF (1) COMMITTEES THAT MEET ON A ROUTINE BASIS TO REVIEW HEALTHCARE 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.	-5% TO +5%
<u>OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:</u> ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
<u>TRAINING, ACCREDITATION AND CREDENTIALING:</u> THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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CRITERIA	RANGE
<u>RECORD-KEEPING PRACTICES:</u> DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
<u>UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:</u> DEMONSTRATING THE WILLINGNESS (OR LACK THEREOF) 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.	-10% TO +10%

THE AFOREMENTIONED MODIFICATIONS CONTEMPLATE THE STANDARD ALLOWANCE FOR EXPENSES AND ARE SUBJECT TO THE MAXIMUM MODIFICATION REFERENCED ABOVE. IF THE EXPENSES ARE LESS THAN STANDARD, AN ADDITIONAL MODIFICATION MAY BE MADE TO REFLECT THIS REDUCTION.

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MEDICAL PROFESSIONALS COMPANY

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DENTISTS

OCCURRENCE PROGRAM

SOLO CORPORATION COVERAGE

SOLO INDIVIDUAL PROFESSIONAL CORPORATION OR ASSOCIATIONS MAY BE MADE AN ADDITIONAL INSURED ON A DENTIST'S PRIMARY INDIVIDUAL POLICY AT NO ADDITIONAL CHARGE.

THIS ADDITION WILL NOT OPERATE TO PROVIDE ADDITIONAL LIMITS OF LIABILITY PER OCCURRENCE OR ANNUAL AGGREGATE BEYOND THE STATED LIMITS OF THE INDIVIDUAL POLICY.

Edition Date: 01/01/03

SCC-CW

EFFECTIVE DATE: JAN 1 2003

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STUDENT / RESIDENT RATING RULE

RESTRICTED COVERAGE IS AVAILABLE FOR DENTAL STUDENTS AND RESIDENTS AT THE FOLLOWING RATE:

TYPE	RATE
STUDENTS	\$35 PER STUDENT
RESIDENTS	\$50 PER RESIDENT

NO OTHER CREDITS OR DEBITS SHALL APPLY WITH THIS RATING PROGRAM EXCEPT FOR SCHEDULE RATING MODIFICATIONS.

EFFECTIVE DATE MAR 01 2007

**MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS**

I. APPLICATION OF MANUAL

- A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Dentists.
- B. Any exceptions to these rules are contained in the respective State Rate Pages.

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. Occurrence Coverage
 - \$100,000 Each Health Care Occurrence
 - \$300,000 Aggregate
- B. Claims-Made Coverage
 - \$100,000 Each Health Care Occurrence
 - \$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per dentist, shown on the State Rate Pages, in accordance with each dentist's classification and class plan designation.

IV. CLASSIFICATIONS

- A. Dentists
 - 1. Each dental practitioner is assigned a classification code according to their specialty. When more than one classification is applicable, the highest rate classification shall apply.
 - 2. The classification codes will be contained on the State Rate Pages.

B. Part Time Dentists

1. Any insured who is determined not to be working on a full time basis will be considered a part time practitioner and will be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner is identified on the State Rate Pages.
2. A Part Time Practitioner may include any classification identified in the class plan as well as those practitioners who are moonlighting or teaching. 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 rating unless the part time practice did not exceed a specified number of hours/year over the previous five consecutive policy years with the Company or if the insured was part time for the entire retroactive period. The average number of hours in practice per week during the previous five policy years will determine the applicable credit. Refer to the State Rate Pages for the specific criteria.
4. No other credits are to apply concurrent with this rule except risk management, membership association credits and/or schedule rating modifications.

C. Dentists in Training

1. Coverage is available for activities directly related to a dentist's training program. The coverage will not apply to any professional services rendered after the training is complete.
 - a. Dental students are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.
2. Coverage is available for insureds moonlighting activities while in a residency or fellowship program conducted thru any dental school or hospital.
 - a. A credit will apply to the insureds premium pursuant to the Company's guidelines for acceptance.
 - b. No other credits may apply with this rule.
 - c. Refer to the State Rate Pages for the applicable credit.

3. Coverage is available to dental students for activities directly related to their licensing.
 - a. Coverage is available to dental students, on a short-term basis, for services rendered by the student during a dental externship prior to graduation and/or during the dental board exam pursuant to the student's professional licensing.
 - b. The coverage for dental students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages, and are not subject to the minimum premium rule. The premium shall be applied to the insured's first annual policy if coverage is purchased within one year of the successful completion of the dental board exam.
4. Restricted Coverage is available for Dental Students and Residents. No other credits, debits or minimum premium rules shall apply with this rating program except for Schedule Rating Modifications. Refer to the State Rate Pages for the appropriate premium.

D. Locum Tenens Dentists

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

E. New Dentist

1. A "new" dentist shall be a dentist 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 dental specialty;
 - c. Fulfillment of a military obligation in remuneration for dental school tuition;
 - d. Dental school or specialty training program.

2. To qualify for the 1st year 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 will be applied in accordance with the credits shown on the State Rate Pages.

F. New to Company Dentists

1. An insured may be eligible for a New to Company credit pursuant to the following guidelines:
 - i. Never insured with the Company, or
 - ii. Previously insured with the Company more than 3 years ago.
2. Credits shall apply to the insureds first, second and third year consecutive years of coverage. All other credits will apply to the reduced rate.
3. This credit is not subject to the Aggregate Credit Rule and subject to underwriting guidelines. Only one request for this three year credit program will be granted to an eligible insured during any period of time insured by the company.
4. Please refer to the state rate pages for availability and the appropriate credit for this program.

G. Dentist 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.
 - a. Faculty members are eligible for a reduction in the otherwise applicable dentist rate for coverage valid only for teaching activities related to an accredited training program. Refer to the Company to determine the applicable credit.
2. Coverage is available for the private practice of a dentist 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 dentist 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 except risk management and membership credits.
- d. The applicable percentages are presented on the State Rate Pages.

H. Dentist's Leave of Absence

1. A dentist who is on a leave of absence for a continuous period of 45 days or more may be eligible for restricted coverage at a discount of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence, if reported to the company within 30 days. Only one application of this credit may be applied to an annual policy period. Leave of absence may include the following:

- The birth of insureds newborn, placement of foster children or insured adopts a child, provided the leave is completed within 12 months of the birth, placement or adoption.
- To care for a spouse, child or parent who has a serious health condition.
- To care for insureds own health condition which prevents insured from working.
- Time to enhance the insureds education or other reason while not practicing.

This credit is not available to an insureds leave of absence for vacation purposes. The Minimum Premium Rating Rule applies to insureds eligible for the Leave of Absence Credit.

2. The credit to be applied to the applicable rate is presented on the State Rate Pages.

I. Dentist Military Leave of Absence

A Dentist who is on a military leave of absence may be eligible for restricted coverage at a discount of 100% of the applicable rate for the period of the leave of absence. This will apply retroactively to the first day of the leave of absence.

The Minimum Premium Rating Rule does not apply to insureds that are eligible for the Military Leave of Absence Credit.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the State Rate Pages.

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 policy may be modified in accordance with a maximum modification indicated on the State Rate Pages, 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 on the State Rate Pages.

B. Risk Management

The insured will receive a premium credit for up to 3 years, for a Risk Management course approved for by the Company. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

Additionally, the insured will receive an additional credit for three years for the proper use of an electronic health record system within their practice. The credit will be provided for programs meeting the criteria of The Medical Protective Company and issued at the beginning of the next policy period contingent upon receipt of the required documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit on the schedule provided on the State Rate Pages.
 - a. 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.
 - b. Insureds converting coverage to The Medical Protective Company, shall qualify for credit at the policy inception date in accordance with the Company's guidelines.

D. Deductible/Self-Insured Retention Credits

1. Deductibles
 - a. Credits shall be available, subject to underwriting guidelines.
 - b. The deductibles shall apply to the indemnity or the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.
 - c. Deductibles can only be revised at policy renewal.
 - d. The deductible credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.
 - i. The credits are expressed as a function of the per health care occurrence or per insured deductible limit.
 - ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.
 - iii. The maximum premium credit is limited to 85% of the aggregate deductible limit.
2. Self-Insured Retentions
 - a. SIR's shall be offered to qualified insureds.
 - b. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

- c. SIR's can only be revised at policy renewal.
- d. The SIR credits shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.
 - i. The credits are expressed as a function of the per health care occurrence and aggregate SIR limit.
 - ii. The insured may select an aggregate limit in accordance with underwriting guidelines.
 - iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

E. Experience Rating

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claim 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. Paid losses
 - e. Projected incurred but not reported losses
 - f. Cause of such losses
 - g. Nature of practice
2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the State Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

F. Non-Discretionary Debit Plan

For any insured who is not eligible for a credit under the Company's claim/loss free credit rule, points will be assigned for each claim, pursuant to Schedule A, found in the State Rate Pages, for the following:

- Pending against the insured at the beginning of the current policy period; or
- Paid on the insured's behalf during the past 5 years; or
- Closed with no payment during the past 5 years.

For providers who have been practicing for less than five complete years from their initial dental school graduation date, the total assigned claim points (as calculated from Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 2 years	5.00
At least 2 years but less than 3 years	2.50
At least 3 years but less than 4 years	1.666
At least 4 years but less than 5 years	1.25
5 years or more	No factor applied

Insureds with less than one year of experience shall be assumed to have one year of experience. Insureds converting coverage to The Medical Protective Company who have pending claims or claims paid on their behalf within the past five years, will be assigned points in accordance with Company guidelines.

A debit shall then be applied to the insured's policy based upon Schedule B, found in the State Rate Pages.

For the purpose of this rule, a "claim" shall not include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

Any debit required under this rule shall be additive with any other debits or credits applicable under the Company's rating manual.

This non-discretionary debit plan shall only apply to providers who meet the Company's guidelines for acceptance, and the company retains the right to refuse to insure any insured or applicant based upon the qualitative nature of any claims made against that individual or entity. As a result, the fact that this rule provides (or does not provide) a debit for claims experience is not an indication that there is a rate available for any particular insured or applicant.

G. Small Group Rating Rule

Any group practice consisting of two or more dentists may be collectively rated. (“Group Practice” shall mean a group or body of insureds who make a collective buying decision to purchase insurance as the owners, employees, or agents of a specific and distinct corporation, partnership, or association.)

1. The premium for the group will be determined by multiplying the “Groups Net Premium” by any credits or debits assigned to the group under the Schedule Rating Plan or Deductible Credit Rule, after factoring in any commission fee or other expense variations associated with the group. (The Company will negotiate an appropriate commission with the insured’s agent based upon the Group’s size and the amount of work to be performed by the agent. Upon request, the company will write the group on a net of commission basis if the group has negotiated a separate free agreement with its agent.)
2. The “Group’s net premium” will equal the sum of the “individual net premiums” for each individual or entity receiving separate limits of liability.
3. The “Individual net premiums” will equal the filed rate for the insured after being adjusted for any applicable non-discretionary debits or credits. However, once the premium for the group has been established, the company may allocate that premium among the individual insureds based upon applicable underwriting criteria.
4. For Individual insured’s within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.
5. Refer to the applicable State Rate Page for availability.

H. Botulinum Toxin and Dermal Fillers Rating Rule.

1. A debit shall apply in addition to the existing filed rate and in recognition of the unique risk characteristics of Dentists, or groups of Dentists, who administer Botulinum Toxin and Dermal Filler procedures
2. The following outlines the debit category which applies to specific dental specialists that perform Botulinum Toxin and Dermal Fillers procedures:

Debit A: General Dentists, Orthodontists, Pediatric Dentists, Periodontists, Prosthodontists, Endodontists, or Host Dentists unless classified under debit B & C.

Debit B: Any dentists performing Minor Surgical Procedures or Implants and oral pathologists.

Debit C: Any dentist performing major surgical procedures.

3. Approval for participation in this rating rule is subject to underwriting guidelines.
4. Refer to the applicable state rate page for availability.

I. Dental Facility Classification Plan

1. A debit shall apply in addition to the existing filed rate for insureds, or groups of insureds, who practice in or with dental facilities as such non-standard dental practices which are not contemplated in the filed rate structure.
2. Placement into the Dental Facility Classification plan will be determined by the company's underwriting rules and guidelines.
3. Refer to the applicable state rate pages for availability.

VI. MODIFIED PREMIUM COMPUTATION

A. Convertible Coverage Rating Plan

1. Insureds shall be provided the option, subject to underwriting guidelines, to convert from Standard Claims Made to Occurrence coverage. The insured shall be eligible for conversion after the following conditions have been met:
 - a. Payment to the Company of the applicable premium for a minimum of three annual claims made policies.
 - b. Achieve three years of continuous claims made coverage under this plan with no claims attributed to the insured. (A claim shall be a culpable loss. A claim under this plan shall not be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.)
2. At the time the aforementioned conditions are met, and the insured has purchased Occurrence coverage, the Company will issue Extended Reporting Period Coverage, covering professional services subsequent to the retroactive date and prior to the expiration of the claims made policy, and will waive any premium that would normally be due for such extension.

3. Should the insured be unable to meet the conditions for conversion, the insured may elect to purchase the Extended Reporting Period Coverage, subject to policy provisions. Refer to the Extended Reporting Period Rule to determine the applicable premium.
4. The applicable premium under this plan is presented on the State Rate Pages.
5. No other modifications are to apply concurrent with this rule except Membership Association, Risk Management, New to Company and Schedule Rating modifications.

B. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual dentist 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 dentist, part time, moonlighting, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

C. Full-Time Equivalency Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each dentist's number of hours of dental practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
1,800 - Residency Programs

2. For group practices, the minimum average FTE assigned to individual dentists is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Training/Residency programs (and other similar programs) are not subject to the group practice minimums.
3. The premium developed by applying the applicable per dentist rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the dental rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.
4. FTE policies may be subject to electronic or on-site audits. Mid-term premium adjustments may be applied based upon the audit findings for the audit period.
5. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

<u>FTE*</u> <u>Per Policy</u>	<u>Premium</u> <u>Modification</u>	<u>FTE*</u> <u>Per Policy</u>	<u>Premium</u> <u>Modification</u>
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* The table value is determined by rounding the actual FTE per policy using the .5 rounding rule. Policies with an FTE of 1 will receive the

premium modification regardless of shared or individual limits.

6. Premium modifications for new to practice, part time, claim free credit or risk management credit cannot be used in conjunction with this rating rule.

D. Out-Patient Visit Rating

1. Occurrence or Standard Claims-Made coverage for group practices is available at the Company's option, on an out-patient visit (OPV) basis rather than on an individual dentist basis. Coverage is provided on a shared or individual dentist limit basis.
2. The number of out-patient visits equivalent to a dentist year is 2,500 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 dental specialty rate is divided by the equivalent out-patient visits resulting in the out-patient visit rate to be applied to the visits projected for the policy period. The product of the OPV 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 dentist, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

E. Requirements for Waiver of Premium for Extended Reporting Period Coverage for Standard Claims Made Program.

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 disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

3. The Company may agree to waive the standard requirements for qualifying for a free extended reporting period endorsement at retirement if the insured meets the following criteria.
 - a. The insured is a member of a group practice that is insured on a claims-made basis with the Company.
 - b. The group requested the waiver for an insured who anticipates permanently retiring from the practice of medicine in less than one year and/or will not attain the required number of years of continuous claims-made coverage at the time of retirement.
 - c. The Company approved the group's request for the waiver after determining the insured had limited prior acts exposure.
 - d. The total number of insureds, within a group practice that may qualify for this waiver may not exceed a ratio of 1 in 3.
 - e. The insured otherwise meets the requirements as set forth in the policy for a free extension contract.
 - f. Refer to the State Rate Pages for availability.

F. Deferred Premium Payment Plan.

1. The Company will, subject to applicable guidelines, offer the insured various premium payment options. The deferred premium payment plan requires a down payment to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.

G. Aggregate Credit Rule.

1. The application of all approved credits contained in this rating manual shall not exceed the amount identified in the State Rate Pages for any one insured.

This rule does not apply to Part Time Practice, Leave of Absence, Military Leave of Absence, Risk Management, New to Company, New to Practice, Membership Association, Moonlighting or Deductible Credits.

DENTISTS

A. Classifications

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

CLASS I A

Any General Dentist or Specialists in orthodontic, pediatric dentistry, periodontics, prosthodontics and endodontics not performing minor or major surgical procedures.

CLASS I B

Any Dentist performing minor surgical procedures or a specialist trained in oral pathology.

CLASS I C

Any dentist performing major Dental surgical procedures not included in Class III or a specialist trained in oral and maxillofacial radiology.

CLASS II A

Specialists in Dental Anesthesiology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery.

CLASS III

Any Dental Specialist performing procedures not otherwise classified.

Specialists in Pain Management.

B. Manual Rates

1. Territory Definitions

Area 1	Cook, Madison & St. Clair County
Area 2	DuPage, Kane, Lake, Will, McHenry
Area 3	Remainder of State

2. Occurrence Program

a. Area 1

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,331	2,657	2,844	3,030	3,263	3,497	3,730	3,963
1B	2,914	3,322	3,555	3,788	4,080	4,371	4,662	4,954
1C	4,662	5,315	5,688	6,061	6,527	6,993	7,459	7,925
2A	6,993	7,972	8,531	9,091	9,790	10,490	11,189	11,888
2B	12,821	14,616	15,642	16,667	19,232	21,155	22,437	23,719
3	15,152	17,273	18,485	19,698	22,728	25,001	26,516	28,031

b. Area 2

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,943	2,215	2,370	2,526	2,720	2,915	3,109	3,303
1B	2,429	2,769	2,963	3,158	3,401	3,644	3,886	4,129
1C	3,886	4,430	4,741	5,052	5,440	5,829	6,218	6,606
2A	5,829	6,645	7,111	7,578	8,161	8,744	9,326	9,909
2B	10,687	12,183	13,038	13,893	16,031	17,634	18,702	19,771
3	12,630	14,398	15,409	16,419	18,945	20,840	22,103	23,366

c. Area 3

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,554	1,772	1,896	2,020	2,176	2,331	2,486	2,642
1B	1,943	2,215	2,370	2,526	2,720	2,915	3,109	3,303
1C	3,108	3,543	3,792	4,040	4,351	4,662	4,973	5,284
2A	4,662	5,315	5,688	6,061	6,527	6,993	7,459	7,925
2B	8,547	9,744	10,427	11,111	12,821	14,103	14,957	15,812
3	10,101	11,515	12,323	13,131	15,152	16,667	17,677	18,687

3. Standard Claims Made Program

a. Area 1

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	504	575	615	655	706	756	806	857
1B	630	718	769	819	882	945	1,008	1,071
1C	1,008	1,149	1,230	1,310	1,411	1,512	1,613	1,714
2A	1,511	1,723	1,843	1,964	2,115	2,267	2,418	2,569
2B	2,771	3,159	3,381	3,602	4,157	4,572	4,849	5,126
3	3,275	3,734	3,996	4,258	4,913	5,404	5,731	6,059

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,008	1,149	1,230	1,310	1,411	1,512	1,613	1,714
1B	1,260	1,436	1,537	1,638	1,764	1,890	2,016	2,142
1C	2,015	2,297	2,458	2,620	2,821	3,023	3,224	3,426
2A	3,023	3,446	3,688	3,930	4,232	4,535	4,837	5,139
2B	5,542	6,318	6,761	7,205	8,313	9,144	9,699	10,253
3	6,549	7,466	7,990	8,514	9,824	10,806	11,461	12,116

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,637	1,866	1,997	2,128	2,292	2,456	2,619	2,783
1B	2,047	2,334	2,497	2,661	2,866	3,071	3,275	3,480
1C	3,274	3,732	3,994	4,256	4,584	4,911	5,238	5,566
2A	4,912	5,600	5,993	6,386	6,877	7,368	7,859	8,350
2B	9,005	10,266	10,986	11,707	13,508	14,858	15,759	16,659
3	10,642	12,132	12,983	13,835	15,963	17,559	18,624	19,688

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,910	2,177	2,330	2,483	2,674	2,865	3,056	3,247
1B	2,388	2,722	2,913	3,104	3,343	3,582	3,821	4,060
1C	3,820	4,355	4,660	4,966	5,348	5,730	6,112	6,494
2A	5,730	6,532	6,991	7,449	8,022	8,595	9,168	9,741
2B	10,506	11,977	12,817	13,658	15,759	17,335	18,386	19,436
3	12,416	14,154	15,148	16,141	18,624	20,486	21,728	22,970

MATURE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,099	2,393	2,561	2,729	2,939	3,149	3,358	3,568
1B	2,624	2,991	3,201	3,411	3,674	3,936	4,198	4,461
1C	4,198	4,786	5,122	5,457	5,877	6,297	6,717	7,137
2A	6,297	7,179	7,682	8,186	8,816	9,446	10,075	10,705
2B	11,545	13,161	14,085	15,009	17,318	19,049	20,204	21,358
3	13,644	15,554	16,646	17,737	20,466	22,513	23,877	25,241

b. Area 2

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	420	479	512	546	588	630	672	714
1B	525	599	641	683	735	788	840	893
1C	840	958	1,025	1,092	1,176	1,260	1,344	1,428
2A	1,259	1,435	1,536	1,637	1,763	1,889	2,014	2,140
2B	2,309	2,632	2,817	3,002	3,464	3,810	4,041	4,272
3	2,729	3,111	3,329	3,548	4,094	4,503	4,776	5,049

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	840	958	1,025	1,092	1,176	1,260	1,344	1,428
1B	1,049	1,196	1,280	1,364	1,469	1,574	1,678	1,783
1C	1,679	1,914	2,048	2,183	2,351	2,519	2,686	2,854
2A	2,519	2,872	3,073	3,275	3,527	3,779	4,030	4,282
2B	4,618	5,265	5,634	6,003	6,927	7,620	8,082	8,543
3	5,457	6,221	6,658	7,094	8,186	9,004	9,550	10,095

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,364	1,555	1,664	1,773	1,910	2,046	2,182	2,319
1B	1,705	1,944	2,080	2,217	2,387	2,558	2,728	2,899
1C	2,728	3,110	3,328	3,546	3,819	4,092	4,365	4,638
2A	4,093	4,666	4,993	5,321	5,730	6,140	6,549	6,958
2B	7,504	8,555	9,155	9,755	11,256	12,382	13,132	13,882
3	8,868	10,110	10,819	11,528	13,302	14,632	15,519	16,406

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,592	1,815	1,942	2,070	2,229	2,388	2,547	2,706
1B	1,989	2,267	2,427	2,586	2,785	2,984	3,182	3,381
1C	3,183	3,629	3,883	4,138	4,456	4,775	5,093	5,411
2A	4,775	5,444	5,826	6,208	6,685	7,163	7,640	8,118
2B	8,754	9,980	10,680	11,380	13,131	14,444	15,320	16,195
3	10,346	11,794	12,622	13,450	15,519	17,071	18,106	19,140

MATURE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,749	1,994	2,134	2,274	2,449	2,624	2,798	2,973
1B	2,186	2,492	2,667	2,842	3,060	3,279	3,498	3,716
1C	3,498	3,988	4,268	4,547	4,897	5,247	5,597	5,947
2A	5,247	5,982	6,401	6,821	7,346	7,871	8,395	8,920
2B	9,620	10,967	11,736	12,506	14,430	15,873	16,835	17,797
3	11,369	12,961	13,870	14,780	17,054	18,759	19,896	21,033

c. Area 3

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	336	383	410	437	470	504	538	571
1B	420	479	512	546	588	630	672	714
1C	672	766	820	874	941	1,008	1,075	1,142
2A	1,007	1,148	1,229	1,309	1,410	1,511	1,611	1,712
2B	1,847	2,106	2,253	2,401	2,771	3,048	3,232	3,417
3	2,183	2,489	2,663	2,838	3,275	3,602	3,820	4,039

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	672	766	820	874	941	1,008	1,075	1,142
1B	840	958	1,025	1,092	1,176	1,260	1,344	1,428
1C	1,343	1,531	1,638	1,746	1,880	2,015	2,149	2,283
2A	2,015	2,297	2,458	2,620	2,821	3,023	3,224	3,426
2B	3,694	4,211	4,507	4,802	5,541	6,095	6,465	6,834
3	4,365	4,976	5,325	5,675	6,548	7,202	7,639	8,075

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,091	1,244	1,331	1,418	1,527	1,637	1,746	1,855
1B	1,364	1,555	1,664	1,773	1,910	2,046	2,182	2,319
1C	2,182	2,487	2,662	2,837	3,055	3,273	3,491	3,709
2A	3,274	3,732	3,994	4,256	4,584	4,911	5,238	5,566
2B	6,002	6,842	7,322	7,803	9,003	9,903	10,504	11,104
3	7,093	8,086	8,653	9,221	10,640	11,703	12,413	13,122

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,273	1,451	1,553	1,655	1,782	1,910	2,037	2,164
1B	1,592	1,815	1,942	2,070	2,229	2,388	2,547	2,706
1C	2,546	2,902	3,106	3,310	3,564	3,819	4,074	4,328
2A	3,819	4,354	4,659	4,965	5,347	5,729	6,110	6,492
2B	7,002	7,982	8,542	9,103	10,503	11,553	12,254	12,954
3	8,276	9,435	10,097	10,759	12,414	13,655	14,483	15,311

MATURE

Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,399	1,595	1,707	1,819	1,959	2,099	2,238	2,378
1B	1,749	1,994	2,134	2,274	2,449	2,624	2,798	2,973
1C	2,798	3,190	3,414	3,637	3,917	4,197	4,477	4,757
2A	4,197	4,785	5,120	5,456	5,876	6,296	6,715	7,135
2B	7,695	8,772	9,388	10,004	11,543	12,697	13,466	14,236
3	9,094	10,367	11,095	11,822	13,641	15,005	15,915	16,824

4. Increased Limit Factors

LIMIT	CLASSES 1A-2A	CLASSES 2B-3
100/300	1.000	1.000
200/600	1.140	1.140
500/1000	1.220	1.220
1000/3000	1.300	1.300
2000/4000	1.400	1.500
3000/5000	1.500	1.650
4000/6000	1.600	1.750
5000/7000	1.700	1.850

5. Extended Reporting Period Coverage Factors

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.750
4 OR MORE	1.900

6. Shared Limits Modification

Modification
Up to 25%

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Dentists	\$50
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D. **Premium Modifications**

1. **Part Time Dentists**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-20	1,050	50%

2. **Dentists in Training**

a. **Training Activities**
(Occurrence & Standard Claims Made Programs)

The Dentist's rate shall be determined by the insured's classification and limit of liability as present on the manual rate tables, subject to any applicable credit determined by the Company to be commensurate with the exposure.

b. **Moonlighting Activities**
(Occurrence & Standard Claims Made Programs)

Credit
75%

No other premium modifications will apply concurrent with this rule except New to Company, Schedule Rating, Dental Facility Classification Plan and/or Risk Management.

c. **Dental Externship / Board Exam**
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	No Charge

d. **Student / Resident Rating Rule**
(Occurrence Program)

Type	Premium
Students	\$35 per student
Residents	\$50 per resident

3. **Locum Tenens**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

4. **New Dentists**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1 st	75%
2 nd	50%
3 rd	25%

5. **New to Company Credit**
(Occurrence & Standard Claims Made Programs)

An insured may be eligible for a New to Company Credit pursuant to the following guidelines:

- a. Never insured with the Company, or
- b. Previously insured with Company more than 3 years ago.

Credits in the amount of 35% of filed manual rates shall apply to the insureds first, second and third consecutive years of coverage. The credit shall be reduced by 5% every other year beginning in the 4th year until such time that the credit is 0%. All other credits will apply to the reduced rate.

This credit is not subject to the aggregate credit rule and subject to underwriting guidelines. Only one request for this credit program will be granted to an eligible insured during any period of time insured by the Company

6. **Dentist Teaching Specialists**

- a. Training Activities

NOT AVAILABLE

- b. Teaching Specialists

NOT AVAILABLE

7. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

8. **Dentists Military Leave of Absence Credit**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description	Range
1. Historical Loss Experience	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.	-20% to +20%
2. Cumulative Years of Patient Experience.	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	-5% to +5%
3. Classification Anomalies.	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.	-15% to +15%
4. Claim Anomalies	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).	-10% to +10%
5. Management Control Procedures.	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	-5% to +5%
6. Number / Type of Patient Exposures.	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	-5% to +5%
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	-5% to +5%
8. Healthcare Standards, Quality & Claim Review.	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.	-5% to +5%
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.	-5% to +5%
10. Training, Accreditation & Credentialing.	The insured(s) exhibits greater/less than normal participation and support of such activities.	-5% to +5%
11. Record – Keeping Practices.	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.	-5% to +5%
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	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.	-10% to +10%
Maximum Modification - 25% / + 25%		

The aforementioned modifications contemplate the standard allowance for expenses and are subject to the maximum modification referenced above. If the expenses are less than standard, an additional modification may be made to reflect this reduction.

10. **Risk Management**
(Occurrence & Standard Claims Made Programs)

Year	Credit	Addtl Credit – if EMR
1	5%	2.5%
2	5%	2.5%
3	5%	2.5%

11. **Claim Free Credit**
(Occurrence & Standard Claims Made Programs)

Years Claim Free	Credit
3 but less than 5	5%
5 but less than 8	10%
8 or more	15%

12. **Deductible Credits**
(Occurrence & Standard Claims Made Program)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

Deductible (000's)	Incident Policy Limit (000's)				
	100	200	250	500	1000
50	7% to 28%	6% to 12%	5% to 20%	3% to 16%	2% to 14%
100	17% to 46%	15% to 26%	13% to 32%	10% to 25%	8% to 22%
200		30% to 47%	26% to 52%	21% to 40%	17% to 33%
250			32% to 60%	26% to 46%	21% to 38%
500				43% to 69%	36% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

Deductible (000's)	Incident Policy Limit (000's)				
	100	200	250	500	1000
50	16% to 44%	14% to 24%	12% to 30%	9% to 24%	6% to 20%
100	29% to 66%	26% to 41%	22% to 46%	17% to 35%	14% to 29%
200		44% to 67%	39% to 70%	31% to 53%	25% to 43%
250			45% to 79%	36% to 60%	30% to 49%
500				57% to 87%	46% to 70%

The Deductible Credits are applicable to the primary limit premium, net of all other applicable credits and subject to a maximum dollar credit of 85% of the aggregate limit.

For Deductible and Limit combinations not listed, credits will be interpolated or extrapolated from the above ranges.

13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non Discretionary Debit Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Claim Threshold	Points
Pending claim	1
Loss payment of \$0 to \$49,999	1
Loss payment of \$50,000 to \$99,999	2
Loss payment of \$100,000 to \$249,999	4
Loss payment of \$250,000 to \$499,999	6
Loss payment of \$500,000 or more	8

Schedule B:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	25%	0%
4	25%	25%
5	50%	40%
6	50%	40%
7	200%	50%
8	500%	200%
9	700%	500%
10+	800%	700%

For the purposes of this schedule, Table B shall apply to all insureds practicing in the following ISO Codes: 73223, 80201, 80207 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

16. **Group Rating Rule**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

17. **Botulinum Toxin and Dermal Fillers Rating Rule**
(Occurrence & Standard Claims Made Programs)

DEBIT A	DEBIT B	DEBIT C
25%	20%	13%

18. **Dental Facility Classification Plan**
(Occurrence & Standard Claims Made Programs)

Debit
60%

19. **Convertible Coverage Rating Plan**
(Standard Claims Made Program)

The applicable premium under this plan shall be equal to 100% of the manual premium that would otherwise be derived for the insured under the Occurrence Program.

20. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

21. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
\$25,000

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

25. **Accelerated Extension Contract Rating**
(Standard Claims Made Program)

AVAILABLE

26. **Membership Credit**
(Occurrence & Standard Claims Made Programs)

Credit
up to 25%

27. **Aggregate Credit Rule**
(Occurrence & Standard Claims Made Programs)

Max Available Credit
50%

28. **Quarterly Installment Option**
(Occurrence & Standard Claims Made Programs)

The following Interest Free Installment Payment Plans are available, at the insureds request.

- 4 PAY - 25% down, 3 equal quarterly payments thereafter

If manual premium is over \$150,000

- 25% Down, 9 equal monthly payments thereafter

The Company may assess installment fees. Such fees will not exceed \$25 or 1% of the total policy premium, whichever is less, and will not exceed a total fee payment of \$100 over any one policy term.

Premium bearing adjustments will be spread across remaining installments in equal amounts.

Installments are not available for Extension Contract Premium.

29. **Temporary Staffing Rating Agency**
(Occurrence and Standard Claims Made Programs)

Formula
$(\text{Applicable Manual Rate} / 3120) * 1.60$

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STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENDED REPORTING PERIOD ENDORSEMENT AT RETIREMENT IF THE INSURED MEETS THE FOLLOWING CRITERIA:

- 1) THE INSURED IS A MEMBER OF A GROUP PRACTICE THAT IS INSURED ON A CLAIMS-MADE BASIS WITH THE COMPANY.
- 2) THE GROUP REQUESTED THE WAIVER FOR AN INSURED WHO ANTICIPATES PERMANENTLY RETIRING FROM THE PRACTICE OF DENTISTRY IN LESS THAN 1 YEAR AND/OR WILL NOT ATTAIN THE REQUIRED NUMBER OF YEARS OF CONTINUOUS CLAIMS-MADE COVERAGE AT THE TIME OF RETIREMENT.
- 3) THE INSURED OTHERWISE MEETS THE REQUIREMENTS AS SET FORTH IN THE POLICY FOR A FREE EXTENSION CONTRACT.
- 4) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSURED HAD LIMITED PRIOR ACTS EXPOSURE.

THE TOTAL NUMBER OF INSUREDS WITHIN A GROUP PRACTICE THAT MAY QUALIFY FOR THIS WAIVER MAY NOT EXCEED A RATIO OF 1 IN 3.

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STANDARD CLAIMS MADE PROGRAM

AGGREGATE CREDIT RULE

THE APPLICATION OF ALL APPROVED CREDITS CONTAINED IN THIS RATING MANUAL SHALL NOT EXCEED 50% FOR ANY ONE INSURED.

THIS RULE DOES NOT APPLY TO PART TIME PRACTICE, LEAVE OF ABSENCE, MILITARY LEAVE OF ABSENCE, RISK MANAGEMENT, NEW TO COMPANY, NEW TO PRACTICE, MEMBERSHIP ASSOCIATION, MOONLIGHTING OR DEDUCTIBLE CREDITS.

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STANDARD CLAIMS MADE PROGRAM

BOTULINUM TOXIN AND DERMAL FILLERS RATING

RULE

THE FOLLOWING DEBIT STRUCTURE SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE IN RECOGNITION OF THE UNIQUE RISK CHARACTERISTICS OF DENTISTS, OR GROUPS OF DENTISTS, WHO ADMINISTER BOTULINUM TOXIN AND DERMAL FILLERS.

DEBIT A	DEBIT B	DEBIT C
25%	20%	13%

DEBIT A: GENERAL DENTISTS, ORTHODONTISTS, PEDIATRIC DENTISTS, PERIODONTISTS, PROSTHODONTISTS, ENDODONTISTS, OR HOST DENTISTS UNLESS CLASSIFIED UNDER DEBIT B & C.

DEBIT B: ANY DENTISTS PERFORMING MINOR SURGICAL PROCEDURES OR IMPLANTS AND ORAL PATHOLOGISTS.

DEBIT C: ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

APPROVAL FOR PARTICIPATION IN THIS RATING RULE IS SUBJECT TO UNDERWRITING GUIDELINES.

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STANDARD CLAIMS MADE PROGRAM

CLAIM FREE CREDIT

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 INSURED BY THE COMPANY AND CLAIM FREE FOR 3 YEARS BUT LESS THAN 5, A 5% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.
2. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 5 YEARS BUT LESS THAN 8, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.
3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 8 YEARS OR MORE, A CREDIT OF 15% SHALL BE APPLIED TO THE NEXT POLICY RENEWAL.

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.

INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

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STANDARD CLAIMS MADE PROGRAM

CONVERTIBLE COVERAGE RATING PLAN

INSUREDS SHALL BE PROVIDED THE OPTION, SUBJECT TO UNDERWRITING GUIDELINES, TO CONVERT FROM STANDARD CLAIMS MADE TO OCCURRENCE COVERAGE. THE INSURED SHALL BE ELIGIBLE FOR CONVERSION AFTER THE FOLLOWING CONDITIONS HAVE BEEN MET:

- 1) PAYMENT TO THE COMPANY OF THE APPLICABLE PREMIUM FOR A MINIMUM OF THREE ANNUAL CLAIMS MADE POLICIES.
- 2) ACHIEVE THREE YEARS OF CONTINUOUS CLAIMS MADE COVERAGE UNDER THIS PLAN WITH NO CLAIMS ATTRIBUTED TO THE INSURED.

* A CLAIM UNDER THIS PLAN SHALL NOT BE CONSTRUED TO INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

AT THE TIME THE AFOREMENTIONED CONDITIONS ARE MET, AND THE INSURED ELECTS TO PURCHASE OCCURRENCE COVERAGE, THE COMPANY WILL ISSUE AN EXTENSION CONTRACT, COVERING SERVICES SUBSEQUENT TO THE RETROACTIVE DATE AND PRIOR TO THE EXPIRATION OF THE CLAIMS MADE POLICY, AND WILL WAIVE ANY PREMIUM THAT WOULD NORMALLY BE DUE FOR SUCH EXTENSION.

EFFECTIVE DATE **MAR 01 2007**

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STANDARD CLAIMS MADE PROGRAM

CONVERTIBLE COVERAGE RATING PLAN (CONT.)

THE APPLICABLE PREMIUM UNDER THIS PLAN SHALL BE EQUAL TO 100% OF THE MANUAL PREMIUM THAT WOULD OTHERWISE BE DERIVED FOR THE INSURED UNDER THE OCCURRENCE PROGRAM. NO OTHER MODIFICATIONS ARE TO APPLY CONCURRENT WITH THIS RULE WITH THE EXCEPTION OF MEMBERSHIP, RISK MANAGEMENT, NEW TO COMPANY AND SCHEDULE RATING MODIFICATIONS.

SHOULD THE INSURED BE UNABLE TO MEET THE CONDITIONS FOR CONVERSION, THE INSURED MAY ELECT TO PURCHASE AN EXTENSION CONTRACT SUBJECT TO POLICY PROVISIONS. REFER TO THE EXTENSION CONTRACT RATING RULE TO DETERMINE THE APPLICABLE PREMIUM.

EFFECTIVE DATE **MAR 01 2007**

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DEFERRED PREMIUM PAYMENT PLAN RULE

THE COMPANY WILL, SUBJECT TO APPLICABLE GUIDELINES, OFFER THE INSURED VARIOUS PREMIUM PAYMENT OPTIONS. THE DEFERRED PREMIUM PAYMENT PLAN REQUIRES A MINIMUM OF 25% OF THE TOTAL PREMIUM TO BE PAID ON OR BEFORE THE INCEPTION/RENEWAL DATE OF THE POLICY. THE BALANCE OF THE PREMIUM WILL BE PAYABLE IN PERIODIC INSTALLMENTS. OTHER FEES MAY APPLY.

Edition Date: 01/15/03

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STANDARD CLAIMS MADE PROGRAM

DENTAL FACILITY CLASSIFICATION PLAN

A 60% DEBIT SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE FOR INSUREDS, OR GROUPS OF INSUREDS, WHO PRACTICE IN OR WITH DENTAL FACILITIES AS SUCH NON-STANDARD DENTAL PRACTICES ARE NOT CONTEMPLATED IN THE FILED RATE STRUCTURE.

PLACEMENT INTO THE DENTAL FACILITY CLASSIFICATION PLAN WILL BE DETERMINED BY THE COMPANY'S UNDERWRITING RULES AND GUIDELINES.

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STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING

THE PREMIUM FOR THE EXTENSION CONTRACT ENDORSEMENT SHALL BE DETERMINED BY APPLYING THE EXTENSION CONTRACT RATING FACTORS CONTAINED IN THE RATES SECTION OF THIS MANUAL TO THE APPLICABLE STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT, DEDUCTIBLE AND SCHEDULE RATING MODIFICATIONS.

PARTNERSHIP / CORPORATION EXTENSION CONTRACT RATING SHALL BE BASED ON THE NUMBER OF SHAREHOLDERS, PARTNERS AND INDEPENDENT CONTRACTORS AT THE INCEPTION DATE OF THE MOST RECENT POLICY.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR A MULTI-DENTIST GROUP IS AVAILABLE, AT THE COMPANY'S OPTION, ON A FULL TIME EQUIVALENT (FTE) BASIS RATHER THAN ON AN INDIVIDUAL DENTIST BASIS. COVERAGE IS PROVIDED ON AN INDIVIDUAL LIMIT OR SHARED LIMIT BASIS. FULL TIME EQUIVALENCY IS BASED ON EACH DENTIST'S NUMBER OF HOURS OF DENTAL PRACTICE PER YEAR. THE DEFINITION OF ONE FTE IS BASED ON THE FOLLOWING NUMBER OF HOURS PER YEAR:

2,500	-GROUP PRACTICE
1,800	-RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL DENTIST IS .05 (125 HOURS), SUBJECT TO A TOTAL FTE PER POLICY OF NO LESS THAN 1.0. TRAINING/RESIDENCY PROGRAMS (AND OTHER SIMILAR PROGRAMS) ARE NOT SUBJECT TO THE GROUP PRACTICE MINIMUMS.

THE PREMIUM DEVELOPED BY APPLYING THE APPLICABLE PER DENTIST RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE DENTIST RATES.

FTE POLICIES MAY BE SUBJECT TO ELECTRONIC OR ON-SITE AUDITS. MID-TERM PREMIUM ADJUSTMENTS MAY BE APPLIED BASED UPON THE AUDIT FINDINGS FOR THE AUDIT PERIOD.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CON'T)

THE FOLLOWING TABLE IDENTIFIES THE APPLICABLE PREMIUM MODIFICATION PER THE NUMBER OF FTE'S IN THE POLICY FOR A SHARED LIMIT:

<u>FTE*</u> <u>PER POLICY</u>	<u>PREMIUM</u> <u>MODIFICATION</u>	<u>FTE*</u> <u>PER POLICY</u>	<u>PREMIUM</u> <u>MODIFICATION</u>
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

* THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .5 ROUNDING RULE.

PREMIUM MODIFICATIONS FOR CLAIM FREE, NEW TO PRACTICE, PART TIME PRACTICE, OR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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STANDARD CLAIMS MADE PROGRAM

GROUP RATING RULE

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE DENTISTS MAY BE COLLECTIVELY RATED. ("GROUP PRACTICE" SHALL MEAN A GROUP OR BODY OF INSURED'S WHO MAKE A COLLECTIVE BUYING DECISION TO PURCHASE INSURANCE AS THE OWNERS, EMPLOYEES, OR AGENTS OF A SPECIFIC AND DISTINCT CORPORATION, PARTNERSHIP, OR ASSOCIATION.)

1. THE PREMIUM FOR THE GROUP WILL BE DETERMINED BY MULTIPLYING THE "GROUP'S NET PREMIUM" BY ANY CREDITS OR DEBITS ASSIGNED TO THE GROUP UNDER THE SCHEDULE RATING PLAN OR DEDUCTIBLE CREDIT RULE, AFTER FACTORING IN ANY COMMISSION FEE OR OTHER EXPENSE VARIATIONS ASSOCIATED WITH THE GROUP. (THE COMPANY WILL NEGOTIATE AN APPROPRIATE COMMISSION WITH THE INSURED'S AGENT BASED UPON THE GROUP'S SIZE AND THE AMOUNT OF WORK TO BE PERFORMED BY THE AGENT. UPON REQUEST, THE COMPANY WILL WRITE THE GROUP ON A NET OF COMMISSION BASIS IF THE GROUP HAS NEGOTIATED A SEPARATE FEE AGREEMENT WITH ITS AGENT.)
2. THE "GROUP'S NET PREMIUM" WILL EQUAL THE SUM OF THE "INDIVIDUAL NET PREMIUMS" FOR EACH INDIVIDUAL OR ENTITY RECEIVING SEPARATE LIMITS OF LIABILITY.

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GROUP RATING RULE

3. THE "INDIVIDUAL NET PREMIUMS" WILL EQUAL THE FILED RATE FOR THE INSURED AFTER BEING ADJUSTED FOR ANY APPLICABLE NONDISCRETIONARY DEBITS OR CREDITS. HOWEVER, ONCE THE PREMIUM FOR THE GROUP HAS BEEN ESTABLISHED, THE COMPANY MAY ALLOCATE THAT PREMIUM AMONG THE INDIVIDUAL INSUREDS BASED UPON APPLICABLE UNDERWRITING CRITERIA.
4. FOR INDIVIDUAL INSUREDS WITHIN THE GROUP, THE EXTENSION CONTRACT PREMIUM WILL BE CALCULATED PER THE FILED EXTENSION CONTRACT RATING RULE.

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STANDARD CLAIMS MADE PROGRAM

LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO IS ON A LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE, IF REPORTED TO THE COMPANY WITHIN 30 DAYS. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD. LEAVE OF ABSENCE MAY INCLUDE THE FOLLOWING:

- THE BIRTH OF INSUREDS NEWBORN, PLACEMENT OF FOSTER CHILDREN OR INSURED ADOPTS A CHILD, PROVIDED THE LEAVE IS COMPLETED WITHIN 12 MONTHS OF THE BIRTH, PLACEMENT OR ADOPTION.
- TO CARE FOR A SPOUSE, CHILD OR PARENT WHO HAS A SERIOUS HEALTH CONDITION.
- TO CARE FOR INSUREDS OWN HEALTH CONDITION WHICH PREVENTS INSURED FROM WORKING.
- TIME TO ENHANCE THE INSUREDS EDUCATION OR OTHER REASON WHILE NOT PRACTICING.

THIS CREDIT IS NOT AVAILABLE TO AN INSUREDS LEAVE OF ABSENCE FOR VACATION PURPOSES. THE MINIMUM PREMIUM RATING RULE APPLIES TO INSUREDS ELIGIBLE FOR THE LEAVE OF ABSENCE CREDIT.

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STANDARD CLAIMS MADE PROGRAM

LOCUM TENENS

COVERAGE FOR A DENTIST SUBSTITUTING FOR AN INSURED DENTIST WILL BE LIMITED TO COVER ONLY PROFESSIONAL SERVICES RENDERED ON BEHALF OF THE INSURED DENTIST FOR THE SPECIFIED TIME PERIOD. LOCUM TENENS WILL SHARE IN THE INSURED DENTIST'S LIMIT OF LIABILITY. NO ADDITIONAL CHARGE WILL APPLY FOR THIS COVERAGE.

THE LOCUM TENENS DENTIST MUST COMPLETE AN APPLICATION AND SUBMIT IT TO THE COMPANY IN ADVANCE FOR APPROVAL PRIOR TO THE REQUESTED EFFECTIVE DATE OF COVERAGE.

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STANDARD CLAIMS MADE PROGRAM

MEMBERSHIP ASSOCIATION CREDIT RULE

THE UNIQUE CHARACTERISTICS OF A DENTAL PRACTICE AND THEIR MEMBERSHIP IN QUALIFIED PROFESSIONAL ASSOCIATIONS SHALL MAKE THEM ELIGIBLE FOR A PREMIUM MODIFICATION IN ADDITION TO THOSE AVAILABLE TO OTHER INSUREDS.

A PREMIUM CREDIT OF UP TO 25% SHALL BE GIVEN TO THOSE INSUREDS WHOSE GROUP IS A MEMBER OF A QUALIFIED ASSOCIATION AS DETERMINED BY THE COMPANY'S UNDERWRITING GUIDELINES.

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MILITARY LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO IS ON A MILITARY LEAVE OF ABSENCE MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 100% OF THE APPLICABLE RATE FOR THE PERIOD OF THE LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE.

THE MINIMUM PREMIUM RATING RULE DOES NOT APPLY TO INSURED THAT ARE ELIGIBLE FOR THE MILITARY LEAVE OF ABSENCE CREDIT.

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MINIMUM PREMIUM REQUIREMENT RULE

ALL POLICIES ARE SUBJECT TO A MINIMUM PREMIUM OF \$50. THE MINIMUM PREMIUM WILL BE RETAINED WHEN THE INSURED REQUESTS CANCELLATION UNLESS THE POLICY IS CANCELED AS OF THE INCEPTION DATE.

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STANDARD CLAIMS MADE PROGRAM

MOONLIGHTING RATING RULE

COVERAGE IS AVAILABLE FOR INSUREDS PRACTICING PART TIME WHILE IN A RESIDENCY OR FELLOWSHIP PROGRAM CONDUCTED THRU ANY DENTAL SCHOOL OR HOSPITAL.

A CREDIT OF 75% WILL APPLY TO THE INSUREDS PREMIUM PURSUANT TO THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

NO OTHER PREMIUM MODIFICATIONS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT NEW TO COMPANY, SCHEDULE RATING, DENTAL FACILITY CLASSIFICATION PLAN AND/OR RISK MANAGEMENT.

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STANDARD CLAIMS MADE PROGRAM

NEW TO COMPANY CREDIT

AN INSURED MAY BE ELIGIBLE FOR A NEW TO COMPANY CREDIT PURSUANT TO THE FOLLOWING GUIDELINES:

- A. NEVER INSURED WITH THE COMPANY, OR
- B. PREVIOUSLY INSURED WITH COMPANY MORE THAN 3 YEARS AGO.

CREDITS IN THE AMOUNT OF 35% OF FILED MANUAL RATES SHALL APPLY TO THE INSUREDS FIRST, SECOND AND THIRD CONSECUTIVE YEARS OF COVERAGE. THE CREDIT SHALL BE REDUCED BY 5% EVERY OTHER YEAR BEGINNING IN THE 4TH YEAR UNTIL SUCH TIME THAT THE CREDIT IS 0%. ALL OTHER CREDITS WILL APPLY TO THE REDUCED RATE.

THIS CREDIT IS NOT SUBJECT TO THE AGGREGATE CREDIT RULE AND SUBJECT TO UNDERWRITING GUIDELINES. ONLY ONE REQUEST FOR THIS CREDIT PROGRAM WILL BE GRANTED TO AN ELIGIBLE INSURED DURING ANY PERIOD OF TIME INSURED BY THE COMPANY.

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NEW TO PRACTICE CREDIT

A "NEW" DENTIST SHALL BE A DENTIST 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 DENTAL SPECIALITY;
- C) FULFILLMENT OF A MILITARY OBLIGATION;
- D) DENTAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

TO QUALIFY FOR THE 1ST YEAR CREDIT, THE APPLICANT WILL BE REQUIRED TO APPLY FOR A REDUCED RATE WITHIN SIX MONTHS AFTER THE COMPLETION OF ANY OF THE ABOVE PROGRAMS.

CREDITS IN THE AMOUNT OF 75% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 25% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR THIRD YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR DENTAL TRAINING PROGRAM.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR ANY INSURED WHO IS NOT ELIGIBLE FOR A CREDIT UNDER THE COMPANY'S CLAIM/LOSS FREE CREDIT RULE, POINTS WILL BE ASSIGNED FOR EACH CLAIM:

- 1) PENDING AGAINST THE INSURED AT THE BEGINNING OF THE CURRENT POLICY PERIOD;
 - 2) PAID ON THE INSURED'S BEHALF DURING THE PAST 5 YEARS; OR
 - 3) CLOSED WITH NO PAYMENT DURING THE PAST 5 YEARS,
- PURSUANT TO THE FOLLOWING SCHEDULE:

ASSIGNED CLAIM POINTS	
Claim Threshold	Points
Pending claim	1
Loss payment of \$0 to \$49,999	1
Loss payment of \$50,000 to \$99,999	2
Loss payment of \$100,000 to \$249,999	4
Loss payment of \$250,000 to \$499,999	6
Loss payment of \$500,000 or more	8

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

FOR PROVIDERS WHO HAVE BEEN PRACTICING FOR LESS THAN FIVE COMPLETE YEARS FROM THEIR INITIAL DENTAL SCHOOL GRADUATION DATE, THE TOTAL ASSIGNED CLAIM POINTS (AS CALCULATED FROM THE SCHEDULE ABOVE) WILL BE MULTIPLIED BY THE APPLICABLE FACTOR SET FORTH IN THE FOLLOWING SCHEDULE:

Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 2 years	5.00
At least 2 years but less than 3 years	2.50
At least 3 years but less than 4 years	1.666
At least 4 years but less than 5 years	1.25
5 years or more	No factor applied

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY WHO HAVE PENDING CLAIMS OR CLAIMS PAID ON THEIR BEHALF WITHIN THE PAST FIVE YEARS WILL BE ASSIGNED POINTS IN ACCORDANCE WITH COMPANY GUIDELINES.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

A DEBIT SHALL THEN BE APPLIED TO THE INSURED'S POLICY BASED UPON THE FOLLOWING SCHEDULE:

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	25%	0%
4	25%	25%
5	50%	40%
6	50%	40%
7	200%	50%
8	500%	200%
9	700%	500%
10+	800%	700%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80201 AND 80210. TABLE A SHALL APPLY TO INSUREDS PRACTICING UNDER ANY OTHER ISO CODE.)

FOR THE PURPOSE OF THIS RULE, A "CLAIM" SHALL NOT INCLUDE INSTANCES OF MISTAKEN IDENTITY, BLANKET DEFENDANT LISTINGS, IMPROPER INCLUSION, OR NON-MERITORIOUS OR FRIVOLOUS CLAIMS.

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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

ANY DEBIT REQUIRED UNDER THIS RULE SHALL BE ADDITIVE WITH ANY OTHER DEBITS OR CREDITS APPLICABLE UNDER THE COMPANY'S RATING MANUAL.

THIS NON-DISCRETIONARY DEBIT PLAN SHALL ONLY APPLY TO PROVIDERS WHO MEET THE COMPANY'S GUIDELINES FOR ACCEPTANCE, AND THE COMPANY RETAINS THE RIGHT TO REFUSE TO INSURE ANY INSURED OR APPLICANT BASED UPON THE QUALITATIVE NATURE OF ANY CLAIMS MADE AGAINST THAT INDIVIDUAL OR ENTITY. AS A RESULT, THE FACT THAT THIS RULE PROVIDES (OR DOES NOT PROVIDE) A DEBIT FOR CLAIMS EXPERIENCE IS NOT AN INDICATION THAT THERE IS A RATE AVAILABLE FOR ANY PARTICULAR INSURED OR APPLICANT.

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STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

AT THE CALCULATED MATURITY LEVEL, THE PREMIUM WILL EQUAL TO A PERCENTAGE OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED DENTISTS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION, PURSUANT TO THE FOLLOWING TABLE. THE PREMIUM (MATURITY LEVEL) WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS.

LIMITS OF COVERAGE FOR THE PARTNERSHIP OR CORPORATION MAY NOT EXCEED THE LOWEST LIMITS OF COVERAGE OF ANY OF THE INSURED PARTNERS, SHAREHOLDERS OR EMPLOYED/CONTRACTED DENTISTS.

A SEPARATE POLICY IS ISSUED.

SPECIALTY	PERCENTAGE
ORAL SURGEONS	1%
ALL OTHER DENTAL SPECIALTIES	5%

The
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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE

ANY INSURED WHO PRACTICES ON AVERAGE 20 HOURS OR LESS IN A WEEK OR LESS THAN AN AGGREGATE OF 1,050 HOURS DURING THE TERM OF AN ANNUAL POLICY WILL BE CONSIDERED A PART TIME PRACTITIONER AND WILL BE ELIGIBLE FOR A REDUCTION IN THE OTHERWISE APPLICABLE RATE BASED ON THE FOLLOWING SCHEDULE.

<u>AVERAGE NUMBER HOURS PRACTICED PER WEEK</u>	<u>MAX. AGGREGATE HOURS PER YR</u>	<u>CREDIT</u>
0-20 HOURS	1,050	50%

A PART TIME PRACTITIONER MAY INCLUDE ANY CLASSIFICATION IDENTIFIED IN THE CLASS PLAN AS WELL AS THOSE PRACTITIONERS WHO ARE MOONLIGHTING OR TEACHING. THE HOURS REPORTED TO THE COMPANY FOR RATING PURPOSES ARE SUBJECT TO AUDIT, AT THE COMPANY'S DISCRETION.

NO OTHER CREDITS WILL APPLY CONCURRENT WITH THIS RULE EXCEPT MEMBERSHIP ASSOCIATION, SCHEDULE RATING MODIFICATIONS, AND/OR RISK MANAGEMENT.

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STANDARD CLAIMS MADE PROGRAM

PART TIME PRACTICE RULE (CON'T)

THE PART TIME PRACTICE CREDIT WILL NOT BE APPLIED TO THE EXTENSION CONTRACT RATING UNLESS THE PART TIME PRACTICE DID NOT EXCEED AN AVERAGE OF 1,050 HOURS/YEAR OVER THE PREVIOUS FIVE CONSECUTIVE POLICY YEARS WITH THE COMPANY. IF SO, THE AVERAGE NUMBER OF HOURS IN PRACTICE PER WEEK DURING THE PREVIOUS FIVE POLICY YEARS WILL DETERMINE THE APPLICABLE CREDIT.

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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 WITH THE WRITTEN ACKNOWLEDGEMENT OF THE INSURED AND APPROVAL BY THE COMPANY.

Edition Date: 01/01/03

PAC-CW

EFFECTIVE DATE JUN 01 2003

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STANDARD CLAIMS MADE PROGRAM

RENEWAL RATING RULE

MEMBERS OF A QUALIFIED MEDICAL/DENTAL PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS:

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF \$25,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING REVIEW. HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP, CLAIM FREE STATUS AND OTHER NON-DISCRETIONARY CREDITS WILL BE APPLIED IN THE USUAL MANNER.

ONLY ONE CONSECUTIVE RENEWAL MAY RECEIVE APPLICATION OF THIS RULE. THE GROUP PRACTICE/ASSOCIATION MAY AGAIN QUALIFY FOR THIS RULE AFTER PAYMENT OF ONE RENEWAL PREMIUM BASED UPON CURRENTLY FILED RATES.

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STANDARD CLAIMS MADE PROGRAM

RISK MANAGEMENT CREDIT RULE

THE INSURED WILL RECEIVE A FIVE PERCENT (5%) PREMIUM CREDIT APPLIED FOR UP TO THREE YEARS FOR A RISK MANAGEMENT COURSE APPROVED FOR CREDIT BY THE MEDICAL PROTECTIVE COMPANY.

ADDITIONALLY, THE INSURED WILL RECEIVE A TWO AND ONE HALF PERCENT (2.5%) PREMIUM CREDIT APPLIED FOR THREE YEARS FOR THE PROPER USE OF AN ELECTRONIC HEALTH RECORD SYSTEM WITHIN THEIR PRACTICE. THE CREDIT WILL BE PROVIDED FOR PROGRAMS MEETING THE CRITERIA OF THE MEDICAL PROTECTIVE COMPANY AND ISSUED AT THE BEGINNING OF THE NEXT POLICY PERIOD CONTINGENT UPON RECEIPT OF THEREQUIRED DOCUMENTATION OF SYSTEM CAPABILITIES AND PRACTICE USAGE.

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STANDARD CLAIMS MADE PROGRAM
SCHEDULE RATING PLAN

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR INSURED(S) WHO 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 THE FOLLOWING, SUBJECT TO A MAXIMUM MODIFICATION OF -25% / +25%, 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 APPLICABLE CRITERIA AND SUPPORT FOR EACH PREMIUM MODIFICATION SHALL BE INCLUDED IN THE INSURED(S) UNDERWRITING FILE.

THE MODIFICATION SHALL BE BASED ON ONE OR MORE OF THE FOLLOWING CONSIDERATIONS:

CRITERIA	RANGE
<u>HISTORICAL LOSS EXPERIENCE:</u> 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.	-20% TO +20%

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STANDARD CLAIMS MADE PROGRAM

SCHEDULE RATING PLAN

CRITERIA	RANGE
<p><u>CUMULATIVE YEARS OF PATIENT EXPERIENCE:</u> THE INSURED(S) DEMONSTRATES A GREATER/LESS THAN STABLE, LONGSTANDING PRACTICE AND/OR SIGNIFICANT DEGREE OF EXPERIENCE IN THEIR CURRENT AREA OF MEDICINE.</p>	-5% TO +5%
<p><u>CLASSIFICATION ANOMALIES:</u> CHARACTERISTICS OF A PARTICULAR INSURED THAT DIFFERENTIATE THE INSURED TO BE GREATER/LESS THAN 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.</p>	-15% TO +15%
<p><u>CLAIM ANOMALIES:</u> ECONOMIC, SOCIETAL OR JURISDICTIONAL CHANGES OR TRENDS THAT WILL POSTIVELY OR NEGATIVELY INFLUENCE THE FREQUENCY OR SEVERITY OF CLAIMS, OR THE UNUSUAL CIRCUMSTANCES OF A CLAIM(S) WHICH UNDERSTATE/OVERSTATE THE SEVERITY OF THE CLAIM(S).</p>	-10% TO +10%
<p><u>MANAGEMENT CONTROL PROCEDURES:</u> SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.</p>	-5% TO +5%
<p><u>NUMBER/TYPE OF PATIENT EXPOSURES:</u> SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH NEGATIVELY OR POSTIVELY INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.</p>	-5% TO +5%

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**STANDARD CLAIMS MADE PROGRAM
 SCHEDULE RATING PLAN**

CRITERIA	RANGE
<u>ORGANIZATIONAL SIZE/STRUCTURE:</u> A GROUP'S SIZE, PROCESSES AND/OR ROSTER OF INSURED(S) ARE SUCH THAT THE COMPANY WILL INCUR GREATER OR LESSER COSTS IN ASSOCIATION WITH ITS SERVICE TO, OR COVERAGE OF, THE GROUP.	-5% TO +5%
<u>HEALTHCARE STANDARDS, QUALITY AND CLAIMS REVIEW:</u> PRESENCE (OR LACK) OF (1) COMMITTEES THAT MEET ON A ROUTINE BASIS TO REVIEW HEALTHCARE 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.	-5% TO +5%
<u>OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:</u> ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
<u>TRAINING, ACCREDITATION AND CREDENTIALING:</u> THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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**STANDARD CLAIMS MADE PROGRAM
SCHEDULE RATING PLAN**

CRITERIA	RANGE
<u>RECORD-KEEPING PRACTICES:</u> DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
<u>UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:</u> DEMONSTRATING THE WILLINGNESS (OR LACK THEREOF) 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.	-10% TO +10%

THE AFOREMENTIONED MODIFICATIONS CONTEMPLATE THE STANDARD ALLOWANCE FOR EXPENSES AND ARE SUBJECT TO THE MAXIMUM MODIFICATION REFERENCED ABOVE. IF THE EXPENSES ARE LESS THAN STANDARD, AN ADDITIONAL MODIFICATION MAY BE MADE TO REFLECT THIS REDUCTION.

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MEDICAL PROFESSIONALS COMPANY

YOUR VARIOUS ENDORSEMENTS 468385

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STANDARD CLAIMS MADE PROGRAM

SLOT RATING RULE

COVERAGE FOR MULTI-DENTIST GROUPS IS AVAILABLE, AT THE COMPANY'S OPTION, ON A SLOT BASIS RATHER THAN ON AN INDIVIDUAL DENTIST 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.

THE APPLICABLE MANUAL RATE WILL BE DETERMINED BY THE CLASSIFICATION OF THE SLOT. POLICIES CONVERTED TO A SLOT BASIS WILL BE RATED AS A STANDARD CLAIMS MADE POLICY, UTILIZING THE RETROACTIVE DATE OF THE SLOT. EXTENSION CONTRACT COVERAGE MAY BE PURCHASED FOR THE SLOT BASED ON THE APPLICABLE RETROACTIVE DATE, CLASSIFICATION AND LIMITS.

PREMIUM MODIFICATIONS FOR NEW TO PRACTICE, PART TIME PRACTICE, RISK MANAGEMENT AND CLAIM FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

Edition Date: 01/01/03

SRR-CW

EFFECTIVE DATE JUN 01 2003

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HOME OFFICE: INDIANAPOLIS, INDIANA 46204

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

SOLO CORPORATION COVERAGE

SOLO INDIVIDUAL PROFESSIONAL CORPORATION OR ASSOCIATIONS MAY BE MADE AN ADDITIONAL INSURED ON A DENTIST'S PRIMARY INDIVIDUAL POLICY AT NO ADDITIONAL CHARGE.

THIS ADDITION WILL NOT OPERATE TO PROVIDE ADDITIONAL LIMITS OF LIABILITY PER CLAIM FILED OR ANNUAL AGGREGATE BEYOND THE STATED LIMITS OF THE INDIVIDUAL POLICY.

Edition Date: 01/01/03

SCC-CW

EFFECTIVE DATE JUN 01 2003

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STANDARD CLAIMS MADE PROGRAM

STUDENT / RESIDENT RATING RULE

RESTRICTED COVERAGE IS AVAILABLE FOR DENTAL STUDENTS AND RESIDENTS AT THE FOLLOWING RATE:

TYPE	RATE
STUDENTS	\$35 PER STUDENT
RESIDENTS	\$50 PER RESIDENT

NO OTHER CREDITS OR DEBITS SHALL APPLY WITH THIS RATING PROGRAM EXCEPT FOR SCHEDULE RATING MODIFICATIONS.

EFFECTIVE DATE **MAR 01 2007**

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DENTISTS

OCCURRENCE PROGRAM

BOTULINUM TOXIN AND DERMAL FILLERS RATING

RULE

THE FOLLOWING DEBIT STRUCTURE SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE IN RECOGNITION OF THE UNIQUE RISK CHARACTERISTICS OF DENTISTS, OR GROUPS OF DENTISTS, WHO ADMINISTER BOTULINUM TOXIN AND DERMAL FILLERS.

DEBIT A	DEBIT B	DEBIT C
50% <u>25%</u>	40% <u>20%</u>	25% <u>13%</u>

DEBIT A: GENERAL DENTISTS, ORTHODONTISTS, PEDIATRIC DENTISTS, PERIODONTISTS, PROSTHODONTISTS, ENDODONTISTS, OR HOST DENTISTS UNLESS CLASSIFIED UNDER DEBIT B & C.

DEBIT B: ANY DENTISTS PERFORMING MINOR SURGICAL PROCEDURES OR IMPLANTS AND ORAL PATHOLOGISTS.

DEBIT C: ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

APPROVAL FOR PARTICIPATION IN THIS RATING RULE IS SUBJECT TO UNDERWRITING GUIDELINES.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

BOTULINUM TOXIN AND DERMAL FILLERS RATING

RULE

THE FOLLOWING DEBIT STRUCTURE SHALL APPLY IN ADDITION TO THE EXISTING FILED RATE IN RECOGNITION OF THE UNIQUE RISK CHARACTERISTICS OF DENTISTS, OR GROUPS OF DENTISTS, WHO ADMINISTER BOTULINUM TOXIN AND DERMAL FILLERS.

DEBIT A	DEBIT B	DEBIT C
50% <u>25%</u>	40% <u>20%</u>	25% <u>13%</u>

DEBIT A: GENERAL DENTISTS, ORTHODONTISTS, PEDIATRIC DENTISTS, PERIODONTISTS, PROSTHODONTISTS, ENDODONTISTS, OR HOST DENTISTS UNLESS CLASSIFIED UNDER DEBIT B & C.

DEBIT B: ANY DENTISTS PERFORMING MINOR SURGICAL PROCEDURES OR IMPLANTS AND ORAL PATHOLOGISTS.

DEBIT C: ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

APPROVAL FOR PARTICIPATION IN THIS RATING RULE IS SUBJECT TO UNDERWRITING GUIDELINES.

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DENTISTS

OCCURRENCE PROGRAM

MOONLIGHTING RATING RULE

COVERAGE IS AVAILABLE FOR INSUREDS PRACTICING PART TIME WHILE IN A RESIDENCY OR FELLOWSHIP PROGRAM CONDUCTED THRU ANY DENTAL SCHOOL OR HOSPITAL.

A CREDIT OF 75% WILL APPLY TO THE INSUREDS PREMIUM PURSUANT TO THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

NO OTHER ~~CREDITS MAY PREMIUM MODIFICATIONS WILL~~ APPLY CONCURRENT WITH THIS RULE: EXCEPT NEW TO COMPANY, SCHEDULE RATING, DENTAL FACILITY CLASSIFICATION PLAN AND/OR RISK MANAGEMENT.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

MOONLIGHTING RATING RULE

COVERAGE IS AVAILABLE FOR INSUREDS PRACTICING PART TIME WHILE IN A RESIDENCY OR FELLOWSHIP PROGRAM CONDUCTED THRU ANY DENTAL SCHOOL OR HOSPITAL.

A CREDIT OF 75% WILL APPLY TO THE INSUREDS PREMIUM PURSUANT TO THE COMPANY'S GUIDELINES FOR ACCEPTANCE.

NO OTHER CREDITS-MAYPREMIUM MODIFICATIONS WILL APPLY CONCURRENT WITH THIS RULE- EXCEPT NEW TO COMPANY, SCHEDULE RATING, DENTAL FACILITY CLASSIFICATION PLAN AND/OR RISK MANAGEMENT.

DENTISTS

A. Classifications

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

CLASS I A

Any General Dentist or Specialists in orthodontic, pediatric dentistry, periodontics, prosthodontics and endodontics not performing minor or major surgical procedures.

CLASS I B

Any Dentist performing minor surgical procedures or a specialist trained in oral pathology.

CLASS I C

Any dentist performing major Dental surgical procedures not included in Class III or a specialist trained in oral and maxillofacial radiology. ~~class III.~~

CLASS II A

Specialists in Dental Anesthesiology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery.

CLASS III

Any Dental Specialist performing procedures not otherwise classified.

Specialists in Pain Management.

B. Manual Rates

1. Territory Definitions

Area 1	Cook, Madison & St. Clair County
Area 2	DuPage, Kane, Lake, Will, McHenry
Area 3	Remainder of State

C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Dentists	\$50
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D. **Premium Modifications**

1. **Part Time Dentists**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-20	1,050	50%

2. **Dentists in Training**

a. **Training Activities**
(Occurrence & Standard Claims Made Programs)

The Dentist's rate shall be determined by the insured's classification and limit of liability as present on the manual rate tables, subject to any applicable credit determined by the Company to be commensurate with the exposure.

b. **Moonlighting Activities**
(Occurrence & Standard Claims Made Programs)

Credit
75%

No other premium modifications will apply concurrent with this rule except New to Company, Schedule Rating, Dental Facility Classification Plan and/or Risk Management.

c. **Dental Externship / Board Exam**
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	No Charge

d. **Student / Resident Rating Rule**
(Occurrence Program)

Type	Premium
Students	\$35 per student
Residents	\$50 per resident

17. **Botulinum Toxin and Dermal Fillers Rating Rule**
(Occurrence & Standard Claims Made Programs)

DEBIT A	DEBIT B	DEBIT C
2550%	2040%	1325%

18. **Dental Facility Classification Plan**
(Occurrence & Standard Claims Made Programs)

Debit
60%

19. **Convertible Coverage Rating Plan**
(Standard Claims Made Program)

The applicable premium under this plan shall be equal to 100% of the manual premium that would otherwise be derived for the insured under the Occurrence Program.

20. **Slot Rating**
(Standard Claims Made Program)

AVAILABLE

21. **Full-Time Equivalency Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

22. **OPV Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

23. **Renewal Rate Rule**
(Occurrence & Standard Claims Made Programs)

Premium Threshold
\$25,000

24. **Deferred Premium Payment Plan**
(Occurrence & Standard Claims Made Programs)

Refer to Quarterly Installment Option rule.

SERFF Tracking #:

MDPC-128137120

State Tracking #:

MDPC-128137120

Company Tracking #:

12-OMR-01

State:

Illinois

Filing Company:

The Medical Protective Company

TOI/Sub-TOI:

11.0 Medical Malpractice - Claims Made/Occurrence/11.0000 Med Mal Sub-TOI Combinations

Product Name:

Dentists and Comprehensive Liability Coverage for Healthcare Providers

Project Name/Number:

Botox, Moonlighting, OMR/12-OMR-01

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.

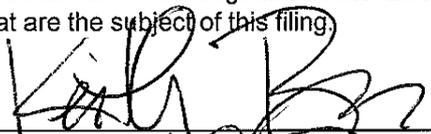
Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/01/2012		Supporting Document	Certification	03/26/2012	certification.pdf (Superseded)

**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, Keith Barnes, a duly authorized officer of The Medical Protective 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, Keith Barnes, a duly authorized actuary of The Medical Protective Company am authorized to certify on behalf of The Medical Protective 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

2/4/12

Date



Signature, Title and Designation of Authorized Actuary

2/4/12

Date

Insurance Company FEIN 35 - 0506406 Filing Number _____

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:

-Name and E-mail Melissa Millican - Melissa.Millican@Medro.com

-Direct Telephone and Fax Number (260) 486-0838 fax: (260) 486-0733