

March 11, 2009

Gayle Neuman, Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
COMPANY FILE NO: 09-HCNP-02
COMPANY FEIN NO: 35-0506406 ✓ *RATE/RULE*
ILLINOIS HEALTHCARE PROFESSIONALS – NURSE PRACTITIONER
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
INITIAL RATE FILING
INITIAL RULE FILING

FILED

SEP 08 2010

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

PROPOSED EFFECTIVE DATE: July 1, 2009
FILING PROVISION: FILE AND USE

Dear Ms. Neuman:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate and rule filing applicable to its Illinois Healthcare Professionals – Nurse Practitioner product. The company requests **July 1, 2009**, as the effective date for this submission.

Please find enclosed the rule manual pages, required filing forms, actuarial certification, explanatory memo and a self-addressed stamped envelope. Upon completion of your review, would you please stamp the duplicate copy of this submission and return it to us in the envelope provided.

Should you have any questions regarding this filing, please do not hesitate to contact me. Thank you.

Sincerely,

Melissa Coker Millican

Melissa Coker Millican, Paralegal
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.millican@medpro.com

Enclosure(s)

*FO
MEM
RUL
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jh*

SUMMARY SHEET

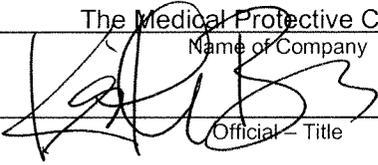
Change in Company's premium or rate level produced by rate revision effective 07/01/2009

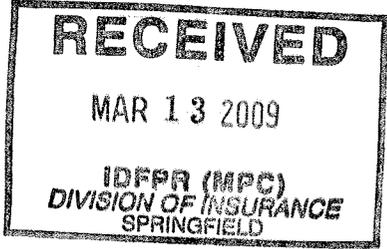
(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1. Automobile Liability Private Passenger Commercial	_____	_____
2. Automobile Physical Damage Private Passenger Commercial	_____	_____
3. Liability Other Than Auto	_____	_____
4. Burglary and Theft	_____	_____
5. Glass	_____	_____
6. Fidelity	_____	_____
7. Surety	_____	_____
8. Boiler and Machinery	_____	_____
9. Fire	_____	_____
10. Extended Coverage	_____	_____
11. Inland Marine	_____	_____
12. Homeowners	_____	_____
13. Commercial Multi-Peril	_____	_____
14. Crop Hail	_____	_____
15. Other <u>Healthcare Prof. - Nurse Practitioner</u> Line of Insurance	0 - Initial Filing	0 - Initial Filing

Does filing only apply to certain territory (territories) or certain classes? If so, specify: no

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
Initial rate and rule filing for Healthcare Professionals - Nurse Practitioners. We request an effective date of July 1, 2009.

*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

 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, Trent Heinemeyer, 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 M. Barnes, a duly authorized actuary of The Medical Protective Company am authorized to certify on behalf of (Name of Insurance Company) making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Trent Heinemeyer 3/5/2009
Signature and Title of Authorized Insurance Company Officer Date

Keith M. Barnes 3/5/2009
Signature, Title and Designation of Authorized Actuary Date

Insurance Company FEIN 35 - 0506406 Filing Number 09-HCNP-02

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46825

Contact Person's:

-Name and E-mail: Melissa Millican, melissa.millican@medpro.com

-Direct Telephone and Fax Number: (260) 486-0838 Fax: (260) 386-0733

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

NURSE PRACTITIONERS

ACTUARIAL MEMORANDUM

The Medical Protective Company (MedPro) respectfully submits support for its new Nurse Practitioner Product. The attached exhibits support rates for a stand alone Nurse Practitioner Product in the State of Illinois. The proposed rates represent a new product available to the thousands of Nurse Practitioners who do not have their professional liability insurance provided by their primary physicians practice or hospital. The proposed effective date for the new product is July 01, 2009.

Our filing is based on the most recent publicly available countrywide Nurse Practitioner data from CNA. This memorandum summarizes the results of the analysis shown in the accompanying exhibits. As a result of MedPro's countrywide review, this filing proposes the introduction of a new product specifically for nurse practitioners, to which the proposed rates would apply.

EXHIBIT I: NURSE PRACTITIONER RATES

Exhibit I presents a comparison of the nurse practitioner rates for CNA's filed product and MedPro's proposed rate structure. The rates shown are for full-time self-employed risks with 1M/6M limits occurrence coverage. The rate differential between the CNA rates and MedPro rates is uniform on a percentage basis and is supported by the calculations in Exhibit II.

EXHIBIT II: RATE LEVEL INDICATION

Exhibit II presents the development of the indicated rate level for MedPro's Nurse Practitioner Product. The countrywide experience of CNA's book of business as presented in their rate filing in Ohio effective 02/01/2007 is used to project an ultimate loss and allocated loss adjustment expense (LALE) ratio applicable to CNA's filed rates. The ultimate LALE ratio is compared to the MedPro permissible LALE ratio to arrive at a indicated rate change. This represents the percentage change to CNA's nurse practitioner rates needed to arrive at MedPro's target loss ratio.

EXHIBIT III: MEDPRO EXPENSE PROVISIONS

Exhibit III shows the MedPro expense provisions for its Nurse Practitioner Product. These are used to calculate the permissible LALE ratio, which is carried forward to the rate level indication in Exhibit II.

EXHIBIT IV: CNA ULTIMATE LOSS PROJECTIONS

Exhibit IV shows the various accident year ultimate loss projections provided in the CNA actuarial analysis, along with their selections of ultimate settlement values. The ultimate selections are carried forward to the rate level indication in Exhibit II.

EXHIBIT V: CNA ULTIMATE ALE PROJECTIONS

Exhibit V shows the various accident year ultimate allocated loss adjustment expense (ALE) projections provided in the CNA actuarial analysis, along with their selections of ultimate settlement values. The ultimate selections are carried forward to the rate level indication in Exhibit II.

EXHIBIT VI: SEVERITY ANALYSIS

Annual trend values for loss and ALE are each derived in Exhibit VI. Two-year moving average severities are used to reduce the volatility of the accident year severity estimates. They are fit utilizing an exponential least-squares technique for several combinations of years. Based upon the resulting trends and R-squared values, annual trends of 1.5% and 3.5% were selected for loss and ALE, respectively, to adjust historical values to the current cost level in Exhibit II.

EXHIBIT VII: FREQUENCY ANALYSIS

The frequency adjustment factors applied in the rate level indication are derived in Exhibit VII. Frequency per \$1000 of current level earned premium is calculated for each accident year. The selected prospective value is then used along with the accident year values to determine frequency adjustment factors for each accident year. These are carried forward to the rate level indication in Exhibit II.

REVISED MANUAL RATES

The proposed rate pages for the Nurse Practitioner Product are attached to this filing.

REVISED MANUAL RULES

The Medical Protective Company proposes the following rating rules which conform to the countrywide template and largely do not constitute a substantive change in use or content from most rules currently on file for other Medical Protective Products.

ACCELERATED EXTENSION CONTRACT RULE

The Company proposes to file an Accelerated Extension Contract Rule for its Standard Claims Made Program. If requirements outlined in the rule are met, the insured may qualify for an Accelerated Extension Contract. The total number of insureds within a group practice that may qualify should not exceed a ratio of one in three. There is no rate impact associated with this rule.

AGGREGATE CREDIT RULE

The Company proposes to file an Aggregate Credit Rule for its Occurrence and Standard Claims Made Programs. This rule outlines the limitation of all credits shall not exceed 50%, with the exception of Part Time, Leave of Absence or Military Leave of Absence credits. This rule conforms with the countrywide format.

CONVERTIBLE CLAIMS MADE RATING RULE

The Company proposes to file the Convertible Claims Made Rating Plan for its Standard Claims Made Program. This rule outlines the conditions on which an insured would be eligible to convert a Standard Claims Made policy to an Occurrence policy at no charge. This rule conforms with the countrywide format.

DEFERRED PAYMENT PLAN RULE

The Company wishes to file the Deferred Payment Plan Rule for its Occurrence and Standard Claims Made Programs. This plan requires a down payment to be paid on or before the inception/renewal date of the policy. There is no rate impact associated with this rule.

EXTENSION CONTRACT RATING

The Company proposes to file an Extension Contract Rating Rule for its Standard Claims Made Program to clarify the modifications employed in the extension contract premium calculation. This rule is consistent with our countrywide format.

FULL TIME EQUIVALENCY RATING RULE

The Company proposes to file the Full Time Equivalency Rating Rule for its Occurrence and Standard Claims Made Programs. This rule outlines rating for coverage for a multi-provider groups which is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual healthcare provider basis. This rule is consistent with our countrywide format.

GROUP RATING RULE

The Company proposes to file the Group Rating Rule for its Occurrence and Standard Claims Made Programs. The rule outlines the methodology in which a group of two or more healthcare professionals will be rated. The rule also outlines how premium will be allocated to each member within such group. This rule conforms with the countrywide format.

LEAVE OF ABSENCE CREDIT RULE

The Company proposes to file the Leave of Absence Credit Rule for its Occurrence and Standard Claims Made Programs. The rule provides rating for those insureds which have a "continuous" leave of absence of 45 days. This rule is consistent with our countrywide format.

MEMBERSHIP ASSOCIATION CREDIT RULE

The Company wishes to revise the Membership Association Credit Rule for its Occurrence and Standard Claims Made Programs. This rule allows for a premium modification, due to unique characteristics of a healthcare practice and their membership in qualified professional associations. The rule is consistent with the countrywide format.

MILITARY LEAVE OF ABSENCE CREDIT RULE

The Company proposes to file the Military Leave of Absence Credit Rule for its Occurrence and Standard Claims Made Programs. The rule provides rating for those insureds which are on active military leave. This rule is consistent with our countrywide format.

MINIMUM PREMIUM RULE

The Company wishes to file the Minimum Premium Rule for its Occurrence and Standard Claims Made Programs. This rule requires a minimum policy premium of \$50, is consistent with the countrywide format, and does not present a substantive rate impact.

NEW TO PRACTICE CREDIT RULE

The Company proposes to file the New to Practice Credit for the Occurrence and Standard Claims Made Programs. The revisions include explicitly limiting the application of this credit to those healthcare providers that are starting their practice for the first time. The rule is consistent with the countrywide format.

PARTNERSHIP OR CORPORATION COVERAGE RULE

The Company proposes to file a Partnership or Corporation Rating Rule for the Occurrence and Standard Claims Made programs. The rule outlines that such coverage shall be calculated as 10% of the individual insureds premium. This rule is consistent with our countrywide format.

PRIOR ACTS COVERAGE

The Company proposes to file the Prior Acts Coverage Rule for its Standard Claims Made Program. This rule outlines rating for prior acts coverage and clarifies that the advancement of the retroactive date can only be completed with not only the written acknowledgement of the insured, but also with the approval of the Company. This rule is consistent with the countrywide format.

RENEWAL RATING RULE

The Company wishes to file the Renewal Rating Rule for its Occurrence and Standard Claims Made Programs. This rule outlines the conditions on which a groups premium, which exceeds \$250,000, may be held constant from policy year to policy year. This rule conforms with our countrywide format.

RISK MANAGEMENT CREDIT RULE

The Company proposes to file a Risk Management Credit Rule for its Occurrence and Standard Claims Made Programs. This rule explains that a 10% credit is available to the policyholder for approved Risk Management courses, and follows the countrywide format.

SCHEDULE RATING PLAN

The Company proposes to file a Schedule Rating Plan rule for its Occurrence and Standard Claims Made Programs. The proposed rule allows for a rate modification for the recognition of unique risk characteristics not contemplated in the company's filed rate structure.

The proposed rule also provides additional clarity regarding the characteristics underlying each criteria as well as modifications necessary as a result of reduction in expenses. The rule conforms to the Medical Protective Company's countrywide template.

SHARED ENTITY VICARIOUS LIABILITY COVERAGE

The Company proposes to file a Shared Entity Vicarious Liability Coverage rating rule for its Occurrence & Standard Claims Made Programs. This rule outlines the methodology for adding an additional insured to the policy, for VL exposure only, on a shared limit basis. This rule conforms with the Company's countrywide format.

SLOT RATING RULE

The Company proposes to file a Slot Rating Rule for its Standard Claims Made Programs. This rule outlines and identifies that coverage for multi-healthcare provider groups is available, at the Company's option, on a slot basis rather than on an individual healthcare provider basis. The slot endorsement will identify the individuals and practice settings that are covered. This rule conforms to the countrywide format.

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

ILLINOIS - AREA 1
NURSE PRACTITIONERS PROGRAM
OCCURRENCE RATES

Class	100/300	200/600	250/750	500/1000	1000/3000	1000/6000	2000/4000
N1	565	609	627	680	848	883	1,015
N2	800	862	887	962	1,200	1,250	1,438
N3	1,033	1,114	1,146	1,243	1,550	1,615	1,856
N4	1,269	1,368	1,407	1,527	1,904	1,983	2,280
NS	176	190	195	212	264	275	316

IL-09-1

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STATE OF ILLINOIS
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SPRINGFIELD, ILLINOIS

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ILLINOIS - AREA 1

NURSE PRACTITIONERS PROGRAM

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	250/750	500/1000	1000/3000	1000/6000	2000/4000
N1	181	195	201	218	272	283	325
N2	256	276	284	308	384	400	460
N3	330	356	366	397	495	516	593
N4	406	438	450	488	609	635	730
NS							

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ILLINOIS - AREA 1

NURSE PRACTITIONERS PROGRAM
STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	250/750	500/1000	1000/3000	1000/6000	2000/4000
N1	322	347	357	387	483	503	579
N2	456	492	506	549	684	713	819
N3	589	635	653	709	884	921	1,058
N4	723	779	802	870	1,085	1,130	1,299
NS							

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ILLINOIS - AREA 1

NURSE PRACTITIONERS PROGRAM

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	250/750	500/1000	1000/3000	1000/6000	2000/4000
N1	435	469	482	523	653	680	782
N2	616	664	683	741	924	963	1,107
N3	796	858	883	958	1,194	1,244	1,430
N4	977	1,053	1,083	1,175	1,466	1,527	1,756
NS							

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ILLINOIS - AREA 1

NURSE PRACTITIONERS PROGRAM

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	250/750	500/1000	1000/3000	1000/6000	2000/4000
N1	474	511	526	570	711	741	852
N2	672	724	745	808	1,008	1,050	1,208
N3	868	936	963	1,044	1,302	1,357	1,560
N4	1,065	1,148	1,181	1,281	1,598	1,665	1,914
NS							

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ILLINOIS - AREA 1
NURSE PRACTITIONERS PROGRAM
STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	250/750	500/1000	1000/3000	1000/6000	2000/4000
N1	559	603	620	672	839	874	1,005
N2	792	854	878	953	1,188	1,238	1,423
N3	1,023	1,103	1,135	1,231	1,535	1,599	1,838
N4	1,256	1,354	1,393	1,511	1,884	1,963	2,257
NS							

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SPRINGFIELD, ILLINOIS

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ILLINOIS

HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

OCCURRENCE PROGRAM

CLASS PLAN

CLASS N1

A NURSE PRACTITIONER SPECIALIZING IN ADULT, ADULT ONCOLOGY, FAMILY PLANNING, GERIATRIC, GYNECOLOGY OR WOMEN'S HEALTH CARE.

CLASS N2

A NURSE PRACTITIONER SPECIALIZING IN PSYCHIATRIC CARE.

CLASS N3

A NURSE PRACTITIONER SPECIALIZING IN ACUTE CRITICAL CARE, SCHOOL NURSE, FAMILY PRACTICE, PEDIATRIC OR NEONATAL CARE.

CLASS N4

A NURSE PRACTITIONER SPECIALIZING IN ACUTE CARE OBSTETRICS, OBSTETRICS/GYNECOLOGY OR PERINATAL CARE.

CLASS NS

STUDENTS CURRENTLY ATTENDING AN APPROVED NURSE PRACTITIONER PROGRAM.

**Coverage is not available for Midwives under this program.

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ILLINOIS

HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

STANDARD CLAIMS MADE PROGRAM

CLASS PLAN

CLASS N1

A NURSE PRACTITIONER SPECIALIZING IN ADULT, ADULT ONCOLOGY, FAMILY PLANNING, GERIATRIC, GYNECOLOGY OR WOMEN'S HEALTH CARE.

CLASS N2

A NURSE PRACTITIONER SPECIALIZING IN PSYCHIATRIC CARE.

CLASS N3

A NURSE PRACTITIONER SPECIALIZING IN ACUTE CRITICAL CARE, SCHOOL NURSE, FAMILY PRACTICE, OR PEDIATRIC OR NEONATAL CARE.

CLASS N4

A NURSE PRACTITIONER SPECIALIZING IN ACUTE CARE OBSTETRICS, OBSTETRICS/GYNECOLOGY OR PERINATAL CARE.

CLASS NS

STUDENTS CURRENTLY ATTENDING AN APPROVED NURSE PRACTITIONER PROGRAM.

**Coverage is not available for Midwives under this program.

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HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

STANDARD CLAIMS MADE PROGRAM

EXTENSION CONTRACT RATING FACTORS

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
LESS THAN 1	0.920
1	1.430
2	1.700
MATURE	1.870

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STATE OF ILLINOIS
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NURSE PRACTITIONER
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 LEAVE OF ABSENCE OR MILITARY LEAVE OF ABSENCE CREDITS.

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

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NURSE PRACTITIONER
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 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.

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HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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

2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL HEALTHCARE PROFESSIONAL IS .10 (200 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 HEALTHCARE PROFESSIONAL RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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ILLINOIS

HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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>
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

*THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATION FOR NEW TO PRACTICE AND RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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

FILED

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HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

OCCURRENCE PROGRAM

GROUP RATING RULE

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE HEALTHCARE PROFESSIONALS 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 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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HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

OCCURRENCE PROGRAM

GROUP RATING RULE

3. THE "INDIVIDUAL NET PREMIUMS" WILL EQUAL THE FILED RATE FOR THE INSURED. 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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ILLINOIS
HEALTHCARE PROFESSIONALS
NURSE PRACTITIONER
OCCURRENCE PROGRAM
LEAVE OF ABSENCE CREDIT RULE

A HEALTHCARE PROVIDER 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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Fort Wayne, Indiana 46835
Professional Protection Exclusively Since 1899

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HEALTHCARE PROFESSIONALS

NURSE PRACTITIONER

OCCURRENCE PROGRAM

MEMBERSHIP ASSOCIATION CREDIT

A PREMIUM CREDIT OF 10% SHALL BE GIVEN TO THOSE INSUREDS WHO ARE A MEMBER OF A DESIGNATED MEDICAL PROTECTIVE HEALTHCARE PROFESSIONAL ASSOCIATION.

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MILITARY LEAVE OF ABSENCE CREDIT RULE

A HEALTHCARE PROVIDER 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 RATING 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 CANCELLED AS OF THE INCEPTION DATE.

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NEW TO PRACTICE CREDIT

A PRACTITIONER IN THEIR FIRST YEAR OF PRACTICE, AFTER GRADUATION, WILL RECEIVE A 25% CREDIT APPLIED TO CURRENT FILED RATES.

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PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED HEALTHCARE PROFESSIONALS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION.

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 HEALTHCARE PROFESSIONALS.

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QUARTERLY INSTALLMENT OPTION

THE FOLLOWING INTEREST FREE INSTALLMENT PAYMENT PLANS ARE AVAILABLE, AT THE INSURED'S 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.

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RATING TERRITORIES

TERRITORY 1: ENTIRE STATE.

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RENEWAL RATING RULE

MEMBERS OF A QUALIFIED PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS.

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF \$250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING APPROVAL.

HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP 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 TEN PERCENT (10%) PREMIUM CREDIT FOR A RISK MANAGEMENT COURSE APPROVED FOR CREDIT BY THE MEDICAL PROTECTIVE COMPANY.

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SCHEDULE RATING PLAN

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR CERTAIN INSUREDS, OR GROUPS OF INSUREDS, WHO IN THE OPINION OF THE MEDICAL PROTECTIVE COMPANY, UNIQUELY QUALIFY FOR SUCH MODIFICATIONS BECAUSE OF FACTORS NOT CONTEMPLATED IN THE FILED RATE STRUCTURE OF THE COMPANY.

THE PREMIUM FOR A RISK MAY BE MODIFIED IN ACCORDANCE WITH 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 MODIFICATION SHALL BE BASED ON ONE OR MORE OF THE FOLLOWING CONSIDERATIONS:

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SCHEDULE RATING PLAN

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.

2. **CUMULATIVE YEARS OF PATIENT EXPERIENCE:**

THE INSURED(S) DEMONSTRATES A GREATER/LESS THAN STABLE LONGSTANDING PRACTICE AND/OR SIGNIFICANT DEGREE OF EXPERIENCE IN THEIR CURRENT AREA OF MEDICINE.

3. **CLASSIFICATION ANOMALIES:**

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.

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SCHEDULE RATING PLAN

4. **CLAIM ANOMALIES:**

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).

5. **MANAGEMENT CONTROL PROCEDURES:**

SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

6. **NUMBER / TYPE OF PATIENT EXPOSURES:**

SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH NEGATIVELY OR POSTIVELY INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

7. **ORGANIZATIONAL SIZE / STRUCTURE:**

A GROUP'S SIZE, PROCESSES AND/OR ROSTER OF INSUREDS ARE SUCH THAT THE COMPANY WILL INCUR GREATER OR LESSER COSTS IN ASSOCIATION WITH ITS SERVICE TO, OR COVERAGE OF, THE GROUP.

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SCHEDULE RATING PLAN

8. **HEALTHCARE STANDARDS, QUALITY AND CLAIMS REVIEW:**
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.
9. **OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:**
ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.
10. **TRAINING, ACCREDITATION AND CREDENTIALING:**
THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.
11. **RECORD KEEPING PRACTICES:**
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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SCHEDULE RATING PLAN

12. **UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:**

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, PROVIDING ABOVE OR BELOW AVERAGE PROCEDURES AS DEFINED IN UNDERWRITING GUIDELINES FOR A SPECIALTY, OR FAILURE TO MEET ACCEPTED STANDARDS OF CARE.

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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SHARED ENTITY VICARIOUS LIABILITY COVERAGE

A SCHEDULED HEALTHCARE PROFESSIONAL ENTITY MAY BE MADE AN ADDITIONAL INSURED ON A HEALTHCARE PROFESSIONAL'S PRIMARY INDIVIDUAL POLICY AT NO ADDITIONAL CHARGE. COVERAGE IS LIMITED TO VICARIOUS LIABILITY BASED SOLELY ON PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED BY THE NAMED INSURED NURSE PRACTITIONER.

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.

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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 WAIVE 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.
- 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 INSURED 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 LEAVE OF ABSENCE OR MILITARY LEAVE OF ABSENCE CREDITS.

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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 STANDARD 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.

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CONVERTIBLE COVERAGE RATING PLAN

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 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.

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STANDARD CLAIMS MADE 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 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.

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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 SCHEDULE RATING MODIFICATIONS.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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

2,000	GROUP PRACTICE
1,800	TRAINING/RESIDENCY PROGRAMS

FOR GROUP PRACTICES, THE MINIMUM AVERAGE FTE ASSIGNED TO ANY INDIVIDUAL HEALTHCARE PROFESSIONAL IS .10 (200 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 HEALTHCARE PROFESSIONAL RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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>
1-4	0.0%
5-9	-2.0%
10-14	-5.0%
15-24	-10.0%
25 +	-15.0%

*THE TABLE VALUE IS DETERMINED BY ROUNDING THE ACTUAL FTE PER POLICY USING THE .50 ROUNDING RULE.

PREMIUM MODIFICATION FOR NEW TO PRACTICE AND RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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

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GROUP RATING RULE

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE HEALTHCARE PROFESSIONALS 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 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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NURSE PRACTITIONER

STANDARD CLAIMS MADE PROGRAM

GROUP RATING RULE

3. THE "INDIVIDUAL NET PREMIUMS" WILL EQUAL THE FILED RATE FOR THE INSURED. HOWEVER, ONCE THE PREMIUM FOR THE GROUP HAS BEEN ESTABLISHED, THE COMPANY MAY ALLOCATE THAT PREMIUM AMONG THE INDIVIDUAL INSURED BASED UPON APPLICABLE UNDERWRITING CRITERIA.

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LEAVE OF ABSENCE CREDIT RULE

A HEALTHCARE PROVIDER 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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MEMBERSHIP ASSOCIATION CREDIT

A PREMIUM CREDIT OF 10% SHALL BE GIVEN TO THOSE INSUREDS WHO ARE A MEMBER OF A DESIGNATED MEDICAL PROTECTIVE HEALTHCARE PROFESSIONAL ASSOCIATION.

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MILITARY LEAVE OF ABSENCE CREDIT RULE

A HEALTHCARE PROVIDER 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 RATING 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 CANCELLED AS OF THE INCEPTION DATE.

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STANDARD CLAIMS MADE PROGRAM
NEW TO PRACTICE CREDIT

A PRACTITIONER IN THEIR FIRST YEAR OF PRACTICE, AFTER GRADUATION, WILL RECEIVE A 25% CREDIT APPLIED TO CURRENT FILED RATES.

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STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED HEALTHCARE PROFESSIONALS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION.

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 HEALTHCARE PROFESSIONALS.

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STANDARD CLAIMS MADE PROGRAM
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 THE APPROVAL BY THE COMPANY.

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STANDARD CLAIMS MADE PROGRAM

QUARTERLY INSTALLMENT OPTION

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.

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Edition Date: 07/01/09

SEP 08 2010

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STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: ENTIRE STATE.

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STANDARD CLAIMS MADE PROGRAM
RENEWAL RATING RULE

MEMBERS OF A QUALIFIED PROFESSIONAL GROUP/ASSOCIATION MAY QUALIFY FOR ADDITIONAL PREMIUM MODIFICATIONS.

IF THE GROUP PRACTICE/ASSOCIATION GENERATES A MANUAL PREMIUM IN EXCESS OF \$250,000 THE COMPANY MAY, IN CONSIDERATION OF THE UNDERLYING RISK, HOLD THE NEXT RENEWAL RATE(S) FOR THE INDIVIDUAL POLICYHOLDER(S) CONSTANT, SUBJECT TO UNDERWRITING APPROVAL.

HOWEVER, CHANGES IN CLASSIFICATION, LIMITS OF LIABILITY, CLAIMS-MADE STEP 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 TEN PERCENT (10%) PREMIUM CREDIT FOR A RISK MANAGEMENT COURSE APPROVED FOR CREDIT BY THE MEDICAL PROTECTIVE COMPANY.

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SCHEDULE RATING PLAN

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR CERTAIN INSUREDS, OR GROUPS OF INSUREDS, WHO IN THE OPINION OF THE MEDICAL PROTECTIVE COMPANY, UNIQUELY QUALIFY FOR SUCH MODIFICATIONS BECAUSE OF FACTORS NOT CONTEMPLATED IN THE FILED RATE STRUCTURE OF THE COMPANY.

THE PREMIUM FOR A RISK MAY BE MODIFIED IN ACCORDANCE WITH 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 MODIFICATION SHALL BE BASED ON ONE OR MORE OF THE FOLLOWING CONSIDERATIONS:

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SCHEDULE RATING PLAN

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.
2. **CUMULATIVE YEARS OF PATIENT EXPERIENCE:**
THE INSURED(S) DEMONSTRATES A GREATER/LESS THAN STABLE LONGSTANDING PRACTICE AND/OR SIGNIFICANT DEGREE OF EXPERIENCE IN THEIR CURRENT AREA OF MEDICINE.
3. **CLASSIFICATION ANOMALIES:**
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.

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SCHEDULE RATING PLAN

4. **CLAIM ANOMALIES:**

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).

5. **MANAGEMENT CONTROL PROCEDURES:**

SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

6. **NUMBER / TYPE OF PATIENT EXPOSURES:**

SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH NEGATIVELY OR POSTIVELY INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

7. **ORGANIZATIONAL SIZE / STRUCTURE:**

A GROUP'S SIZE, PROCESSES AND/OR ROSTER OF INSUREDS ARE SUCH THAT THE COMPANY WILL INCUR GREATER OR LESSER COSTS IN ASSOCIATION WITH ITS SERVICE TO, OR COVERAGE OF, THE GROUP.

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8. **HEALTHCARE STANDARDS, QUALITY AND CLAIMS REVIEW:**
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.
9. **OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:**
ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.
10. **TRAINING, ACCREDITATION AND CREDENTIALING:**
THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.
11. **RECORD KEEPING PRACTICES:**
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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SCHEDULE RATING PLAN

12. **UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:**

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, PROVIDING ABOVE OR BELOW AVERAGE PROCEDURES AS DEFINED IN UNDERWRITING GUIDELINES FOR A SPECIALTY, OR FAILURE TO MEET ACCEPTED STANDARDS OF CARE.

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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SHARED ENTITY VICARIOUS LIABILITY COVERAGE

A SCHEDULED HEALTHCARE PROFESSIONAL ENTITY MAY BE MADE AN ADDITIONAL INSURED ON A HEALTHCARE PROFESSIONAL'S PRIMARY INDIVIDUAL POLICY AT NO ADDITIONAL CHARGE. COVERAGE IS LIMITED TO VICARIOUS LIABILITY BASED SOLELY ON PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED BY THE NAMED INSURED NURSE PRACTITIONER.

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.

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SLOT RATING RULE

COVERAGE FOR MULTI-HEALTHCARE PROFESSIONAL GROUPS IS AVAILABLE, AT THE COMPANY'S OPTION, ON A SLOT BASIS RATHER THAN ON AN INDIVIDUAL HEALTHCARE PROFESSIONAL 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 INSURED 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 MODIFICATION FOR RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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