THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

DIVISION OF INSURANCE
STATE OF ILLINOIS/DPR
FILED
APR 0 1 2006
SPRINGFIELD, ILLINOIS

Superseded 1-1-07

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A PERIOD OF 45 CONTINUOUS DAYS OR MORE, MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 75% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE DENTIST'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

MILITARY LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
NOV 01 2003
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE 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.

JUN 0 1 2003

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

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 - 50% / + 50%, 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:

1. <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.

JUN 01 2003

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES 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 INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. DENTAL STANDARDS, QUALITY AND CLAIMS REVIEW:
PRESENCE OF (1) COMMITTEES THAT MEET ON A ROUTINE BASIS TO REVIEW DENTAL 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 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.

JUN 01 2003

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

11. RECORD-KEEPING PRACTICES:
    DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

12. UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:
    DEMONSTRATING THE WILLINGNESS TO EXPEND THE TIME AND CAPITAL TO INCORPORATE THE LATEST ADVANCES IN DENTAL TREATMENTS AND EQUIPMENT INTO THE PRACTICE, 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.

THE
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Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

AN INSURED MAY QUALIFY FOR AN ACCELERATED EXTENSION CONTRACT, FOR NO ADDITIONAL PREMIUM, IF THE FOLLOWING UNDERWRITING REQUIREMENTS HAVE BEEN MET:

1) THE INSURED ANTICIPATES RETIREMENT FROM HIS OR HER PROFESSION IN LESS THAN FIVE YEARS.

2) THE INSURED HAS ATTAINED AGE 55.

3) THE INSURED IS A MEMBER OF A GROUP PRACTICE THAT HAS CLAIMS-MADE COVERAGE WITH THE COMPANY.

4) THE INSURED HAS LIMITED PRIOR ACTS EXPOSURE BASED UPON UNDERWRITING REVIEW.

THE TOTAL NUMBER OF INSUREDS, WITHIN A GROUP PRACTICE, THAT MAY QUALIFY FOR THE ACCELERATED EXTENSION CONTRACT MAY NOT EXCEED A RATIO OF 1 IN 3.

JUN 01 2003

THE
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FORT WAYNE, INDIANA 46885
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ILLINOIS

DENTISTS

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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

DIVISION OF INSURANCE
STATE OF ILLINOIS
FILED
APR 0 1 2006
SPRINGFIELD, ILLINOIS

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

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 EXPIRING STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT AND SCHEDULE RATING MODIFICATIONS.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

APR 0 1 2006

SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A PERIOD OF 45 CONTINUOUS DAYS OR MORE, MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 50% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE DENTIST'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

JUN 0 1 2003

THE
MEDICAL PROTECTIVE COMPANY
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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

MILITARY LEAVE OF ABSENCE CREDIT RULE

A DENTIST WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
NOV 0 1 2003
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

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.

JUN 0 1 2003

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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

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 - 50% / + 50%, 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:

1. <u>HISTORICAL LOSS EXPERIENCE:</u>
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JAN 0 1 2003

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

SCHEDULE RATING PLAN

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.

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ECONOMIC, SOCIETAL OR JURISDICTIONAL CHANGES OR TRENDS THAT WILL INFLUENCE THE FREQUENCY OR SEVERITY OF CLAIMS, OR THE UNUSUAL CIRCUMSTANCES OF A CLAIM(S) WHICH UNDERSTATE/OVERSTATE THE SEVERITY OF THE CLAIM(S).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES 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 INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

JUN 0 1 2003

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

SCHEDULE RATING PLAN

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. DENTAL STANDARDS, QUALITY AND CLAIMS REVIEW:
PRESENCE OF (1) COMMITTEES THAT MEET ON A ROUTINE BASIS TO REVIEW DENTAL 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 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.

JUN 01 2003

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

SCHEDULE RATING PLAN

11. RECORD-KEEPING PRACTICES:
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

12. UTILIZATION OF MONITORING EQUIPMENT, DIAGNOSTIC TESTS OR PROCEDURES:
DEMONSTRATING THE WILLINGNESS TO EXPEND THE TIME AND CAPITAL TO INCORPORATE THE LATEST ADVANCES IN DENTAL TREATMENTS AND EQUIPMENT INTO THE PRACTICE, 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.

JUN 01 2003

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE 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 BUT LESS THAN 10 YEARS, A 15% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

4. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	7% TO 20%	6% TO 16%	5% TO 15%	3% TO 12%	2% TO 11%
100	14% TO 34%	13% TO 26%	11% TO 24%	8% TO 19%	7% TO 16%
200		24% TO 42%	21% TO 38%	17% TO 30%	14% TO 25%
250			25% TO 44%	20% TO 34%	17% TO 28%
500				33% TO 51%	28% TO 42%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 01 2006
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	14% TO 32%	12% TO 25%	10% TO 22%	7% TO 18%	6% TO 15%
100	23% TO 49%	21% TO 38%	18% TO 34%	14% TO 26%	11% TO 22%
200		34% TO 57%	30% TO 52%	24% TO 39%	20% TO 32%
250			35% TO 59%	28% TO 45%	23% TO 36%
500				43% TO 65%	36% TO 52%

THE DEDUCTIBLE CREDITS ARE APPLICABLE TO PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 01 2006

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE, SHALL BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 75% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE PHYSICIAN'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 01 2003
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

MILITARY LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
NOV 0 1 2003
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
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ILLINOIS

PHYSICIANS & SURGEONS

OCCURENCE PROGRAM

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 01 2003
SPRINGFIELD, ILLINOIS

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.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

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 -50% / +50%, 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:

1. <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.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

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.

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.

The

Medical Protective Company

Fort Wayne, Indiana 46835

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

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.

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.

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

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.

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, 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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STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

AN INSURED MAY QUALIFY FOR AN ACCELERATED EXTENSION CONTRACT, FOR NO ADDITIONAL PREMIUM, IF THE FOLLOWING UNDERWRITING REQUIREMENTS HAVE BEEN MET:

1) THE INSURED ANTICIPATES RETIREMENT FROM HIS OR HER PROFESSION IN LESS THAN FIVE YEARS.

2) THE INSURED HAS ATTAINED AGE 55.

3) THE INSURED IS A MEMBER OF A GROUP PRACTICE THAT HAS CLAIMS-MADE COVERAGE WITH THE COMPANY.

4) THE INSURED HAS LIMITED PRIOR ACTS EXPOSURE BASED UPON UNDERWRITING REVIEW.

THE TOTAL NUMBER OF INSUREDS, WITHIN A GROUP PRACTICE, THAT MAY QUALIFY FOR THE ACCELERATED EXTENSION CONTRACT MAY NOT EXCEED A RATIO OF 1 IN 3.

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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 YEARS, 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 YEARS, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

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

4. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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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DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	7% TO 20%	6% TO 16%	5% TO 15%	3% TO 12%	2% TO 11%
100	14% TO 34%	13% TO 26%	11% TO 24%	8% TO 19%	7% TO 16%
200		24% TO 42%	21% TO 38%	17% TO 30%	14% TO 25%
250			25% TO 44%	20% TO 34%	17% TO 28%
500				33% TO 51%	28% TO 42%

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DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	14% TO 32%	12% TO 25%	10% TO 22%	7% TO 18%	6% TO 15%
100	23% TO 49%	21% TO 38%	18% TO 34%	14% TO 26%	11% TO 22%
200		34% TO 57%	30% TO 52%	24% TO 39%	20% TO 32%
250			35% TO 59%	28% TO 45%	23% TO 36%
500				43% TO 65%	36% TO 52%

THE DEDUCTIBLE CREDITS ARE APPLICABLE TO PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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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 AND SCHEDULE RATING MODIFICATIONS.

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LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE, MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 50% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE PHYSICIAN'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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MILITARY LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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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.

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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 -50% / +50%, 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:

1. <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.

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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.

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.

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SCHEDULE RATING PLAN

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.

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.

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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.

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, 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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OCCURRENCE PROGRAM

DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	7% TO 20%	6% TO 16%	5% TO 15%	3% TO 12%	2% TO 11%
100	14% TO 34%	13% TO 26%	11% TO 24%	8% TO 19%	7% TO 16%
200		24% TO 42%	21% TO 38%	17% TO 30%	14% TO 25%
250			25% TO 44%	20% TO 34%	17% TO 28%
500				33% TO 51%	28% TO 42%

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DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	14% TO 32%	12% TO 25%	10% TO 22%	7% TO 18%	6% TO 15%
100	23% TO 49%	21% TO 38%	18% TO 34%	14% TO 26%	11% TO 22%
200		34% TO 57%	30% TO 52%	24% TO 39%	20% TO 32%
250			35% TO 59%	28% TO 45%	23% TO 36%
500				43% TO 65%	36% TO 52%

THE DEDUCTIBLE CREDITS ARE APPLICABLE TO PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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ALLIED HEALTHCARE PROVIDERS

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LEAVE OF ABSENCE CREDIT RULE

AN ALLIED HEALTHCARE PROVIDER WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A PERIOD OF 45 DAYS OR MORE, SHALL BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 75% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE ALLIED HEALTHCARE PROVIDER'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME

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MILITARY LEAVE OF ABSENCE CREDIT RULE

AN ALLIED HEALTHCARE PROVIDER WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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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.

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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 -50% / +50%, 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:

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.

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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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

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6. NUMBER/TYPE OF PATIENT EXPOSURES:
SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. MEDICAL STANDARDS, QUALITY AND CLAIMS 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.

9. OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:
ADDITIONAL ACTIVITIES UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.

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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.

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.

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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DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	7% TO 20%	6% TO 16%	5% TO 15%	3% TO 12%	2% TO 11%
100	14% TO 34%	13% TO 26%	11% TO 24%	8% TO 19%	7% TO 16%
200		24% TO 42%	21% TO 38%	17% TO 30%	14% TO 25%
250			25% TO 44%	20% TO 34%	17% TO 28%
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DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (000'S)	100	200	250	500	1000
50	14% TO 32%	12% TO 25%	10% TO 22%	7% TO 18%	6% TO 15%
100	23% TO 49%	21% TO 38%	18% TO 34%	14% TO 26%	11% TO 22%
200		34% TO 57%	30% TO 52%	24% TO 39%	20% TO 32%
250			35% TO 59%	28% TO 45%	23% TO 36%
500				43% TO 65%	36% TO 52%

THE DEDUCTIBLE CREDITS ARE APPLICABLE TO PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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LEAVE OF ABSENCE CREDIT RULE

AN ALLIED HEALTHCARE PROVIDER WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A PERIOD OF 45 DAYS OR MORE, SHALL BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 75% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE ALLIED HEALTHCARE PROVIDER'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME.

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MILITARY LEAVE OF ABSENCE CREDIT RULE

AN ALLIED HEALTHCARE PROVIDER WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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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.

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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 -50% / +50%, 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:

1. <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.

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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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

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6. NUMBER/TYPE OF PATIENT EXPOSURES:
SIZE AND/OR DEMOGRAPHICS OF THE PATIENT POPULATION WHICH INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. MEDICAL STANDARDS, QUALITY AND CLAIMS 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.

9. OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:
ADDITIONAL ACTIVITIES UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.

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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.

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.

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.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the following health care providers:

Section

II. Corporations, Partnerships and Associations
III. Physicians and Surgeons
IV. Dentists
V. Allied Health Care Providers
VI. Health Care Facilities

B. This manual also specifies rules, rates, premiums, classifications and territories for the purpose of providing the following optional associated coverages to health care providers:

Section

VII. General Liability
VIII. Managed Care Entity Liability
IX. Pollution Liability

II. APPLICATION OF GENERAL RULES

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the respective Section or State Rate Pages.

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

III. POLICY TERM

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

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IV. LOCATION OF PRACTICE

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

V. PREMIUM COMPUTATION

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

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

VI. FACTORS OR MULTIPLIERS

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

VII. WHOLE DOLLAR RULE

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

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

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

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

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

C. The Company may waive an additional premium of $100 or less for coverages related to Healthcare facilities. This waiver only applies to cash exchange due on an endorsement effective date.

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IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. a policy is canceled at the Company's request;

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider and is shown on the appropriate State Rate Pages.

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

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate State Rate Pages.

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XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the State Rate Pages.

XIII. COVERAGE

Coverage may be provided on either an Occurrence or Claims-Made basis, unless noted otherwise in the respective section or State Rate Pages. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Occurrence or Standard Claims-Made, subject to availability and identified on the State Rate Pages.

XIV. BASIC LIMITS OF LIABILITY

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

XV. INCREASED LIMITS OF LIABILITY

A. Individual Limits of Liability

1. Increased Limits factors shall be those shown as applicable for the respective insureds and be used to develop the applicable premium.

B. Shared Limits of Liability

1. Limits of Liability may be increased on a shared limits basis excess of an individual limit per insured.

2. The rate for the shared excess limits shall be computed in the following manner:

   a. The rate for the individual limit of liability and the total limit of liability shall be calculated in accordance with the State Rate Pages. The total limit of liability is the sum of the individual per occurrence limit and the shared per occurrence limit.

   b. The initial shared limits rate is the difference between the total limits rate and the individual limits rate .

   c. The initial shared limits rate may be modified subject to the restrictions identified on the State Rate Pages, based on the following objective considerations:

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i. The number and distribution by classification of insureds.

ii. The amount of the shared limit and its relationship to the size and distribution of the group.

iii. The amount of the individual limit (attachment point) underlying the shared limit.

3. The minimum individual limit over which a shared excess limit may be provided is identified on the State Rate Pages.

4. Requests for total limits of liability (the sum of the individual per health care occurrence limit and the shared excess per health care occurrence limit) that exceed the maximum limit of liability identified on the State Rate Pages shall be referred to the Company and (a) rated.

XVI. PRIOR ACTS COVERAGE

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

XVII. EXTENDED REPORTING PERIOD COVERAGE (Claims-Made Coverage only)

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

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Experience, Part Time, Non -Discretionary Debit and Schedule Rating Modifications.

D. Premium must be paid, in accordance with state statutes, promptly when due.

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XVIII. GROUP PRACTICE

For the purpose of these rules, group practice shall be defined as a group of entities, physicians, dentists and/or allied health care providers rendering out-patient care who:

A. number 2 or more;

B. are organized as a legal entity;

C. share common facilities (including multiple locations) and support personnel.

XIX. MEMBERSHIP IN QUALIFIED ASSOCIATIONS

A. The unique characteristics of medical/dental practices and their membership in qualified professional associations shall make them eligible for premium modifications in addition to those available to all other groups.

B. Members of a qualified medical/dental group professional association shall be eligible for additional premium modifications.

1. Membership Credit

   a. A premium credit, identified on the State Rate Pages, shall be given to those insureds whose group is a member of a qualified association.

   b. A Qualified Association may include State Medical or Dental Societies.

2. Renewal Rate Rule

   a. If the group practice generates a manual premium in excess of $50,000, 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 and loss/claim free credit and non-discretionary credits will be applied in the usual manner.

   b. Only one consecutive renewal may receive application of this rule. The group practice may again qualify for this rule after the payment of one renewal premium based upon currently filed rates.

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XVII. Extended Reporting Period Coverage

C. 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 Expiring standard mature claims made rate, subject to expiring part time, Non-Discretionary Debit and schedule rating modifications.

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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 the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

2. Miscellaneous Entities

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

1. are organized as a legal entity;

2. maintain common facilities (including multiple locations) and support personnel; and

3. maintain medical/dental records of patients of the group as a historical record of patient care.

C. 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

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III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates (or premium per FTE/OPV rated policy) of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated on the State Rate Pages.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any modifications presented on the State Rate Pages.

3. 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 physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.

4. The premium for professional corporations, partnerships and associations may be subject to premium caps or flat rates as indicated on the State Rate Pages and may be reduced or eliminated as part of credits provided to multi-physician practices.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy or FTE/OPV rated policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

C. The premium for other entities shall be referred to the Home Office for the determination of premium and filing with the state insurance department.

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IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

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

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

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

2. Including the following types of entities:

   a. Urgicare Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center
   f. Home Health Agency
   g. Nursing Home
   h. Physical Fitness Center

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 risk 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.

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B. 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 SIR limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

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3. Large Group & Locum Tenens Group Rating - Corporations

   a. Corporation Coverage for Locum Tenens Groups or group comprised of 25 members or more may be collectively rated.

   b. Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association.

   c. The following premium modifications may be used: Part Time Practice, Risk Management Credit, Leave of Absence Credit, and/or Schedule Rating Modifications. Premium will be allocated to individuals within a Group, based on Underwriting evaluation.

   d. Locum Tenens Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

   e. For Corporation Coverage within the group, Extension Contract Rating premium is calculated by multiplying the mature allocated premium times the applicable claims made tail factor.

   f. Refer to the State Rate Pages for availability.

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A. **Classification**

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

2. Not otherwise identified as a Miscellaneous Entity.

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B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists – All Other Dental Specialties	10%	Available
Dentists – Oral Surgeons	1%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

2. **Miscellaneous Entities**

NOT AVAILABLE

3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.750	1.150	1.200
5 or more	1.820	1.750	1.200	1.250

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

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$25
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 35%
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

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2. Deductible Credits
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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.

3. Self-Insured Retention Credits

NOT AVAILABLE

4. **Group, Large Group & Temporary Staffing Agency Rating – Corporations**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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 Physicians/Surgeons.

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 physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical 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.

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B. Part Time Physicians

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 and membership association credits.

C. Physicians in Training

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

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

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

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

   Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

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

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   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.

D. Locum Tenens Physician –Physicians Substituting for MPCo Insured Physicians

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

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

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E. Locum Tenens Group Coverage

1. Coverage for Locum Tenens Groups is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. New Physician

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

   a. Residency;

   b. Fellowship program in their medical specialty;

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

   d. Medical school or specialty training program.

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

3. A reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

G. Physician Teaching Specialists

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

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

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

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

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

   c. No other credits are to apply concurrent with this rule except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

H. Physician's Leave of Absence

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

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

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

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

I. Physicians Military Leave of Absence

1. A physician who is on military leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a discount presented in the state rate pages. This will apply retroactively to the first day of the leave of absence. Only one application of this credit may be applied to an annual policy period.

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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.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit 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, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidelines.

   c. Years Part time will not be considered in the determination of years claim free.

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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.

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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 claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

   a. Premiums paid
   b. Number of claims
   c. Incurred losses
   d. 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 eight complete years from their initial medical-school graduation date, the total assigned claim points (as calculated from the Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

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Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 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 the insured's rate 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.

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G. Large Group Rating

a. A Group comprised of 25 members or more may be collectively rated.

b. Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association.

c. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, Risk Management, or Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

d. Locum Tenens Group Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

e. For Individual insureds within the group, Extension Contract Rating premium is calculated by multiplying the mature allocated premium times the applicable claims made tail factor.

f. Refer to the 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 losses attributed to the insured. (A loss shall be a

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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 coverage.

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 and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

3. The Enhanced Claims-Made base rate is subject to Claim Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

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

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purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit cannot be used in conjunction with this rating rule.

D. 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 physician basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each physician's number of hours of medical practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
2,100 - Residency Programs

2. For group practices, the minimum average FTE assigned to individual physicians is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

4. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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%

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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.

5. Premium modifications for new physician, part time, moonlighting, teaching, loss free credit or other similar credit cannot be used in conjunction with this rating rule.

E. 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 physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician 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 medical 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 physician, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and an Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

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2. Upon termination of coverage under this policy by reason of total disability or permanent retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. Insureds within a group may qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

   a. The insured anticipates permanent retirement from his or her profession in less than five years.

   b. The insured has attained age 55.

   c. The insured has claims-made coverage with the Company in a group practice.

   d. The insured has limited prior acts exposure based upon underwriting review.

   e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 3.

G. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the state rate pages.

H. 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, Risk Management or Deductible Credits.

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

Physician & Surgeons	$250

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

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

AVAILABLE

4. **Temporary Staffing Agency Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%

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6. **Physician Teaching Specialists**

   a. Training Activities

NOT AVAILABLE

   b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

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

Program	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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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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 Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 10	10%
10 or more	20%

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

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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.

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13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating 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	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code.

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

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

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

AVAILABLE

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

Refer to Quarterly Installment Option rule.

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

Credit
5%

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

Max AvailableCredit
50%

27. **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.

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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.

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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 and membership association credits.

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 a dentist's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program.

   a. The premium will be based upon the equivalent dental specialty rate and the average number of hours the insured practices per week.

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

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c. No other credits are to apply concurrent with this rule except risk management and membership credits.

d. The applicable modifications applicable to the manual rates are presented on the State Rate Pages.

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.

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;

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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. 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.

G. Dentist's Leave of Absence

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

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

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

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

H. Dentist Military Leave of Absence

1. A dentist who is on military leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a discount presented in the state rate pages. This will apply retroactively to the first day of the leave of absence. Only one application of this credit may be applied to an annual policy period.

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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.

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, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidelines.

   c. Years Part time will not be considered in the determination of years claim free.

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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.

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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:

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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.

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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 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

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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

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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. 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. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

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.

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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.

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3. Insureds within a group may qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

   a. The insured anticipates retirement from his or her profession in less than five years.

   b. The insured has attained age 55.

   c. The insured has claims-made coverage with the Company in a group practice.

   d. The insured has limited prior acts exposure based upon underwriting review.

   e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 3.

F. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the State Rate Pages.

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, Risk Management, Membership Association or Deductible Credits.

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

Dentists	$100

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

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

NOT AVAILABLE

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	$25

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

AVAILABLE

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

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

5. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

6. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	75%
Standard Claims Made	50%

7. **Dentists Military Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Dental Standards, Quality & Claim Review.	Presence of (1) committees that meet on a routine basis to review dental 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 undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification - 50% / + 50%	

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

Years Since Training	Credit
1	5%
2	5%
3	5%

10. **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%

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

12. **Self-Insured Retention Credits**

NOT AVAILABLE

13. **Experience Rating**

NOT AVAILABLE

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14. **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: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

15. **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.

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

19. **Renewal Rate Rule**

NOT AVAILABLE

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

REFER TO QUARTERLY INSTALLMENT OPTION RULE.

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

AVAILABLE

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

Credit
5%

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

AVAILABLE

24. **New to Company Credit Rule**
(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 25% of filed manual rates shall apply to the insureds first, second and third consecutive years of coverage. 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 three year credit program will be granted to an eligible insured during any period of time insured by the Company.

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25. 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.

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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 Allied Health Care Providers.

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 provider, shown on the State Rate Pages, in accordance with each provider's classification and class plan designation.

IV. CLASSIFICATIONS

A. Allied Health Care Providers

1. Each provider 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.

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B. Part Time Allied Health Care Providers

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. 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 the risk management credit.

C. Dental Hygienist Training

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

2. Coverage is available to students for activities directly related to their licensing.

   a. Coverage is available to students, on a short-term basis, for services rendered by the student during a dental hygiene externship prior to graduation and/or during the dental hygiene board exam pursuant to the student's professional licensing.

   b. The coverage for students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages. 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 hygiene board exam.

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D. Locum Tenens Allied Health Care Providers subsitituting for MPCo Insureds

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

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

E. Locum Tenens Group Coverage

1. Coverage for Locum Tenens Groups is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. Allied Health Care Provider's Leave of Absence

1. An allied health care provider who becomes disabled, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

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

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

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

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G. Military Leave of Absence

1. An Allied Health Care Provider who is on military leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a discount presented in the state rate pages. This will apply retroactively to the first day of the leave of absence. Only one application of this credit may be applied to an annual policy period.

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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 risk 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.

C. 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.

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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.

D. 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

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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.

3. The application of this modification precludes the use of all other rules based upon loss experience criteria.

E. Large Group Rating

1. A Group comprised of 25 members or more may be collectively rated.

2. Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, Risk Management, or Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Locum Tenens Group Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium is calculated by multiplying the mature allocated premium times the applicable claims made tail factor.

6. Refer to the State Rate Pages for availability.

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VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

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

B. 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 practitioner basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each practitioner's number of hours of service per year. The definition of one FTE is based on the following number of hours per year:

   2,500 - Group Practice

2. For group practices, the minimum average FTE assigned to individual practitioners is .05 (125 hours), subject to a total FTE per policy of no less than 1.0.

3. The premium developed by applying the applicable per practitioner rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the practitioner rates.

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4. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

C. 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 practitioner basis. Coverage is provided on a shared or individual practitioner limit basis.

2. The number of out-patient visits equivalent to a practitioner 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 3 visits per hour and a maximum rate of 6 visits per hour.

3. The applicable classification 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.

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5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. An insured, classified as 4B and above, shall qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

   a. The insured anticipates retirement from his or her profession in less than five years.

   b. The insured has attained age 55.

   c. The insured has claims-made coverage with the Company in a group practice.

   d. The insured has limited prior acts exposure based upon underwriting review.

   e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 10.

E. 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 or Risk Management Credits.

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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

Dental Assistant, Dental Hygienist.

CLASS I-B

Cardiology Technologist, Clinical Laboratory Technologist, Counselor, Dietician, Electrocardiograph Technician, Electroneurodiagnostic Technologist, Licensed Practicing Nurse, Medical Laboratory Technician, Medical (Office) Assistant, Medical Records Technician, Nuclear Medicine Technologist, Ophthalmology Technician, Respiratory Therapy Assistant, Registered Nurse.

CLASS II

Audiologist/Speech Pathologist, Nurse Midwife Assistant, Occupational Therapist Assistant, Optician, Physical Therapy Assistant, Radiation Therapy Technologist, Social Worker, Surgical Technician, X-Ray Technician.

CLASS III

Optometrist, Paramedic/EMT, Pharmacist, Physical Therapist (Non-Owner).

CLASS IV

Case Manager, Occupational Therapist, Perfusionist, Physical Therapist (Owner), Psychologist, Respiratory Therapist.

CLASS V

Nurse Practitioner (Non-prescribing), Physician's Assistant (Non-prescribing).

CLASS VI

Nurse Surgical Assistant, Physician Surgical Assistant.
Nurse Practitioner (Prescribing), Physician's Assistant (Prescribing).

CLASS VII-A

Certified Registered Nurse Anesthetist, Registered Nurse Anesthetist.

CLASS VII-B

Nurse Midwife.

CLASS VIII-A

Podiatrist (No Surgery)

CLASS VIII-B

Podiatrist (Surgery).

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B. Manual Rates

1. Territory Definitions

Refer to Program Type for the Territory definition and description.

2. Occurrence Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

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3. Standard Claims Made Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. The Mature Standard Claims Made rate for is 0.920 of the corresponding Allied Health Care Provider Occurrence rate.

b. Allied Health Care Provider Claims Made Factors may be applied to the Mature Standard Claims Made base rate for the applicable year of claims made coverage.

c. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

4. Increased Limits Factors

Limits	Classes 1A-5	Classes 6-8B
100/300	1.000	1.000
200/600	1.220	1.260
500/1000	1.460	1.630
1000/1000	1.750	1.940
1000/3000	1.800	2.000
2000/2000	2.050	2.410
2000/4000	2.120	2.480
3000/3000	2.220	2.680
3000/5000	2.290	2.750

A minimum of 1000/3000 underlying limits required in order to purchase shared excess limits.

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5. Extended Reporting Period Coverage Factors

Years Retro. Date Precedes Expiration Date	Classes 1A-4	Classes 5-8B
1	0.750	0.700
2	1.000	1.000
3	1.100	1.150
4	1.150	1.200
5 or more	1.200	1.250

a. Factor applies to Mature Claims-Made Allied Health Care Provider rate.

6. Claims Made Factors

Years Since Retroactive Date	Class 1A-4	Classes 5-8B
0	0.60	0.45
1	0.80	0.70
2	0.90	0.85
3	0.95	0.90
4 or More	1.00	1.00

7. Shared Limits Modification

Modification
Up to 25%

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

Allied Health Care Provider	$50

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D. **Premium Modifications**

1. **Part Time Allied Health Care Provider**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-10	515	50%
11-20	1050	30%

Part Time Credits are available for AHCP Classes 4-8B Only.

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Dental Hygienist in Training**

NOT AVAILABLE

3. **Locum Tenens**

NOT AVAILABLE

4. **Locum Tenens Group Coverage**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **Leave of Absence**

NOT AVAILABLE

6. **Military Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Medical 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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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

Years Since Training	Credit
1	5%
2	5%
3	5%

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

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 20%	6% to 16%	5% to 15%	3% to 12%	2% to 11%
100	14% to 34%	13% to 26%	11% to 24%	8% to 19%	7% to 16%
200		24% to 42%	21% to 38%	17% to 30%	14% to 25%
250			25% to 44%	20% to 34%	17% to 28%
500				33% to 51%	28% to 42%
1000					39% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	14% to 32%	12% to 25%	10% to 22%	7% to 18%	6% to 15%
100	23% to 49%	21% to 38%	18% to 34%	14% to 26%	11% to 22%
200		34% to 57%	30% to 52%	24% to 39%	20% to 32%
250			35% to 59%	28% to 45%	23% to 36%
500				43% to 65%	36% to 52%
1000					49% to 69%

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.

10. **Self-Insured Retention Credits**

NOT AVAILABLE

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11. **Experience Rating**

NOT AVAILABLE

12. **Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

14. **Full-Time Equivalency Rating**

NOT AVAILABLE

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

AVAILABLE

16. **Accelerated Extension Contract Rating**

NOT AVAILABLE

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

AVAILABLE

18. **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.

THE
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FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 1

DENTISTS

OCCURRENCE RATES

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	2,412	2,750	3,160	3,618	4,100	4,366	4,559	4,679
1B	3,015	3,437	3,950	4,523	5,126	5,457	5,698	5,849
2A	7,236	8,249	9,479	10,854	12,301	13,097	13,676	14,038
2B	13,266	15,123	17,378	19,899	23,481	25,073	26,267	27,195
3	15,678	17,873	20,538	23,517	27,750	29,631	31,042	32,140

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MEDICAL PROTECTIVE COMPANY
SPRINGFIELD, ILLINOIS

Superseded 6-1-05

THE
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FORT WAYNE, INDIANA 46885

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ILLINOIS - AREA 2

DENTISTS

OCCURRENCE RATES

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	1,321	1,506	1,731	1,982	2,246	2,391	2,497	2,563
1B	1,651	1,882	2,163	2,477	2,807	2,988	3,120	3,203
2A	3,963	4,518	5,192	5,945	6,737	7,173	7,490	7,688
2B	7,266	8,283	9,518	10,899	12,861	13,733	14,387	14,895
3	8,587	9,789	11,249	12,881	15,199	16,229	17,002	17,603

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THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	521	594	683	782	886	943	985	1,011
1B	651	742	853	977	1,107	1,178	1,230	1,263
2A	1,563	1,782	2,048	2,345	2,657	2,829	2,954	3,032
2B	2,866	3,267	3,754	4,299	5,073	5,417	5,675	5,875
3	3,387	3,861	4,437	5,081	5,995	6,401	6,706	6,943

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THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	1,042	1,188	1,365	1,563	1,771	1,886	1,969	2,021
1B	1,303	1,485	1,707	1,955	2,215	2,358	2,463	2,528
2A	3,126	3,564	4,095	4,689	5,314	5,658	5,908	6,064
2B	5,732	6,534	7,509	8,598	10,146	10,833	11,349	11,751
3	6,774	7,722	8,874	10,161	11,990	12,803	13,413	13,887

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUN 01 2004
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	1,693	1,930	2,218	2,540	2,878	3,064	3,200	3,284
1B	2,117	2,413	2,773	3,176	3,599	3,832	4,001	4,107
2A	5,080	5,791	6,655	7,620	8,636	9,195	9,601	9,855
2B	9,314	10,618	12,201	13,971	16,486	17,603	18,442	19,094
3	11,007	12,548	14,419	16,511	19,482	20,803	21,794	22,564

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	1,976	2,253	2,589	2,964	3,359	3,577	3,735	3,833
1B	2,470	2,816	3,236	3,705	4,199	4,471	4,668	4,792
2A	5,927	6,757	7,764	8,891	10,076	10,728	11,202	11,498
2B	10,866	12,387	14,234	16,299	19,233	20,537	21,515	22,275
3	12,842	14,640	16,823	19,263	22,730	24,271	25,427	26,326

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Professional Protection Exclusively since 1899

ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	2,171	2,475	2,844	3,257	3,691	3,930	4,103	4,212
1B	2,714	3,094	3,555	4,071	4,614	4,912	5,129	5,265
2A	6,513	7,425	8,532	9,770	11,072	11,789	12,310	12,635
2B	11,941	13,613	15,643	17,912	21,136	22,568	23,643	24,479
3	14,112	16,088	18,487	21,168	24,978	26,672	27,942	28,930

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	285	325	373	428	485	516	539	553
1B	357	407	468	536	607	646	675	693
2A	856	976	1,121	1,284	1,455	1,549	1,618	1,661
2B	1,570	1,790	2,057	2,355	2,779	2,967	3,109	3,219
3	1,855	2,115	2,430	2,783	3,283	3,506	3,673	3,803

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Professional Protection Exclusively since 1899

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	571	651	748	857	971	1,034	1,079	1,108
1B	713	813	934	1,070	1,212	1,291	1,348	1,383
2A	1,712	1,952	2,243	2,568	2,910	3,099	3,236	3,321
2B	3,139	3,578	4,112	4,709	5,556	5,933	6,215	6,435
3	3,710	4,229	4,860	5,565	6,567	7,012	7,346	7,606

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STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

THE
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FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	927	1,057	1,214	1,391	1,576	1,678	1,752	1,798
1B	1,159	1,321	1,518	1,739	1,970	2,098	2,191	2,248
2A	2,782	3,171	3,644	4,173	4,729	5,035	5,258	5,397
2B	5,101	5,815	6,682	7,652	9,029	9,641	10,100	10,457
3	6,029	6,873	7,898	9,044	10,671	11,395	11,937	12,359

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Professional Protection Exclusively since 1899

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	1,082	1,233	1,417	1,623	1,839	1,958	2,045	2,099
1B	1,352	1,541	1,771	2,028	2,298	2,447	2,555	2,623
2A	3,246	3,700	4,252	4,869	5,518	5,875	6,135	6,297
2B	5,951	6,784	7,796	8,927	10,533	11,247	11,783	12,200
3	7,033	8,018	9,213	10,550	12,448	13,292	13,925	14,418

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS							
Class	**100/300**	**200/600**	**500/1000**	**1000/3000**	**2000/4000**	**3000/5000**	**4000/6000**	**5000/7000**
1A	1,189	1,355	1,558	1,784	2,021	2,152	2,247	2,307
1B	1,486	1,694	1,947	2,229	2,526	2,690	2,809	2,883
2A	3,567	4,066	4,673	5,351	6,064	6,456	6,742	6,920
2B	6,540	7,456	8,567	9,810	11,576	12,361	12,949	13,407
3	7,729	8,811	10,125	11,594	13,680	14,608	15,303	15,844

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

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

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

CLASS I B

Any Dentist performing implants involving osseointegration or minor surgical procedures.*

General Dentists or Specialists other than Oral Surgeons or dental anesthesiologists allowing (hosting) unconscious sedation outside of a hospital, but only if the sedation is administered by an oral surgeon, dental or medical anesthesiologist or CRNA.

*Procedures do not include the administration of a general anesthetic intended to cause unconsciousness unless administered in a hospital.

CLASS II A

Specialists in Dental Anesthesiology or Oral Pathology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery or any dentist performing major surgical procedures not included in class III (Administration of a general anesthetic intended to cause unconsciousness must be administered in a hospital).

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CLASS III

Specialist in Oral and Maxillofacial Surgery or any dentist who administers, personally or by an employed/contracted anesthesiologist any general anesthetic intended to cause unconsciousness if administered outside of a hospital setting, excluding "hosting" dentists under class IB. Any dentist performing major surgical procedures.

Procedures not otherwise classified.

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B. Manual Rates

1. Territory Definitions

Area 1	Cook County
Area 2	Remainder of State

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2. Occurrence Program

a. Area 1

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,412	2,750	3,160	3,618	4,100	4,366	4,559	4,679
1B	3,015	3,437	3,950	4,523	5,126	5,457	5,698	5,849
2A	7,236	8,249	9,479	10,854	12,301	13,097	13,676	14,038
2B	13,266	15,123	17,378	19,899	23,481	25,073	26,267	27,195
3	15,678	17,873	20,538	23,517	27,750	29,631	31,042	32,140

b. Area 2

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,321	1,506	1,731	1,982	2,246	2,391	2,497	2,563
1B	1,651	1,882	2,163	2,477	2,807	2,988	3,120	3,203
2A	3,963	4,518	5,192	5,945	6,737	7,173	7,490	7,688
2B	7,266	8,283	9,518	10,899	12,861	13,733	14,387	14,895
3	8,587	9,789	11,249	12,881	15,199	16,229	17,002	17,603

DIVISION OF INSURANCE
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3. Standard Claims Made Program

a. Area 1

0 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	521	594	683	782	886	943	985	1,011
1B	651	742	853	977	1,107	1,178	1,230	1,263
2A	1,563	1,782	2,048	2,345	2,657	2,829	2,954	3,032
2B	2,866	3,267	3,754	4,299	5,073	5,417	5,675	5,875
3	3,387	3,861	4,437	5,081	5,995	6,401	6,706	6,943

1 YEAR SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,042	1,188	1,365	1,563	1,771	1,886	1,969	2,021
1B	1,303	1,485	1,707	1,955	2,215	2,358	2,463	2,528
2A	3,126	3,564	4,095	4,689	5,314	5,658	5,908	6,064
2B	5,732	6,534	7,509	8,598	10,146	10,833	11,349	11,751
3	6,774	7,722	8,874	10,161	11,990	12,803	13,413	13,887

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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2 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,693	1,930	2,218	2,540	2,878	3,064	3,200	3,284
1B	2,117	2,413	2,773	3,176	3,599	3,832	4,001	4,107
2A	5,080	5,791	6,655	7,620	8,636	9,195	9,601	9,855
2B	9,314	10,618	12,201	13,971	16,486	17,603	18,442	19,094
3	11,007	12,548	14,419	16,511	19,482	20,803	21,794	22,564

3 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,976	2,253	2,589	2,964	3,359	3,577	3,735	3,833
1B	2,470	2,816	3,236	3,705	4,199	4,471	4,668	4,792
2A	5,927	6,757	7,764	8,891	10,076	10,728	11,202	11,498
2B	10,866	12,387	14,234	16,299	19,233	20,537	21,515	22,275
3	12,842	14,640	16,823	19,263	22,730	24,271	25,427	26,326

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

MATURE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,171	2,475	2,844	3,257	3,691	3,930	4,103	4,212
1B	2,714	3,094	3,555	4,071	4,614	4,912	5,129	5,265
2A	6,513	7,425	8,532	9,770	11,072	11,789	12,310	12,635
2B	11,941	13,613	15,643	17,912	21,136	22,568	23,643	24,479
3	14,112	16,088	18,487	21,168	24,978	26,672	27,942	28,930

b. Area 2

0 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	285	325	373	428	485	516	539	553
1B	357	407	468	536	607	646	675	693
2A	856	976	1,121	1,284	1,455	1,549	1,618	1,661
2B	1,570	1,790	2,057	2,355	2,779	2,967	3,109	3,219
3	1,855	2,115	2,430	2,783	3,283	3,506	3,673	3,803

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	571	651	748	857	971	1,034	1,079	1,108
1B	713	813	934	1,070	1,212	1,291	1,348	1,383
2A	1,712	1,952	2,243	2,568	2,910	3,099	3,236	3,321
2B	3,139	3,578	4,112	4,709	5,556	5,933	6,215	6,435
3	3,710	4,229	4,860	5,565	6,567	7,012	7,346	7,606

2 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	927	1,057	1,214	1,391	1,576	1,678	1,752	1,798
1B	1,159	1,321	1,518	1,739	1,970	2,098	2,191	2,248
2A	2,782	3,171	3,644	4,173	4,729	5,035	5,258	5,397
2B	5,101	5,815	6,682	7,652	9,029	9,641	10,100	10,457
3	6,029	6,873	7,898	9,044	10,671	11,395	11,937	12,359

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3 YEARS SINCE RETROACTIVE DATE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,082	1,233	1,417	1,623	1,839	1,958	2,045	2,099
1B	1,352	1,541	1,771	2,028	2,298	2,447	2,555	2,623
2A	3,246	3,700	4,252	4,869	5,518	5,875	6,135	6,297
2B	5,951	6,784	7,796	8,927	10,533	11,247	11,783	12,200
3	7,033	8,018	9,213	10,550	12,448	13,292	13,925	14,418

MATURE

	LIMITS							
Class	100/300	200/600	500/1000	1000/3000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,189	1,355	1,558	1,784	2,021	2,152	2,247	2,307
1B	1,486	1,694	1,947	2,229	2,526	2,690	2,809	2,883
2A	3,567	4,066	4,673	5,351	6,064	6,456	6,742	6,920
2B	6,540	7,456	8,567	9,810	11,576	12,361	12,949	13,407
3	7,729	8,811	10,125	11,594	13,680	14,608	15,303	15,844

DIVISION OF INSURANCE
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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	1.310	1.310
1000/3000	1.500	1.500
2000/4000	1.700	1.770
3000/5000	1.810	1.890
4000/6000	1.890	1.980
5000/7000	1.940	2.050

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

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6. Shared Limits Modification

Modification
Up to 25%

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Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK COUNTY

TERRITORY 2: REMAINDER OF STATE

MEDICAL PROTECTIVE CO
superseded
6-1-05

EFFECTIVE DATE JUN 0 1 1998

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK COUNTY

TERRITORY 2: REMAINDER OF STATE

EFFECTIVE DATE JUN 0 1 1998

HEALTH CARE FACILITIES

A. Classification

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 exposure.

Classification	ISO Code For Profit	ISO Code Not For Profit
Acute Care Beds	80611	80612
Bassinets	80611	80612
Maternity Beds	80611	80612
Neo Natal Beds	80611	80612
Psychiatric Beds	80997	80916
Chemical Dependency and Rehabilitation Beds	80601	80603
Long Term Care Beds	80923	80924
Inpatient Surgeries	N/A	N/A
Births	N/A	N/A
Outpatient Surgeries	80453	80453
ER Visits - Employed Physicians	80610	80617
ER Visits - Contracted Physicians with appropriate limits	80610	80617
Clinic Visits	80613	80614
Home Health Visits	N/A	N/A
Psychiatric Visits	80990	80917
Wellness Center Visits	N/A	N/A
All Other Outpatient Visits	80610	80617

Ancillary Services	ISO Code
Pharmacies	59181
Wellness and Fitness Centers	80614

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B. Manual Rates

1.

Territory Definitions	Relativity
Area 1 - Cook, Madison, St. Clair, & Will counties	3.00
Area 2 - Lake, Jackson, Vermillion, DuPage, Kane, & McHenry counties	1.75
Area 3 - Remainder of State	1.00

2. HPL Premium Basis

a. Occurrence Program

Acute Care Bed Rate at $200,000/$600,000: $1,290

b. Standard Claims-Made Program

Acute Care Bed Rate at $200,000/$600,000: $1,200

c. Classification Relativity Factors:

Classification	Relativity
Acute Care Beds	1.0000
Bassinets	1.0000
Maternity Beds	1.0000
Neo Natal Beds	1.2000
Psychiatric Beds	0.7500
Chemical Dependency and Rehabilitation Beds	0.2500
Long Term Care Beds	0.2000
Births	0.0400
Inpatient Surgeries	0.0180
Per 100 Visits:	
Outpatient Surgeries	0.4500
ER Visits - Employed Physicians	0.2000
ER Visits - Contracted Physicians with appropriate limits	0.2000
Clinic Visits	0.0500
Home Health Visits	0.0250
Psychiatric Visits	0.0380
Wellness Center Visits	0.0050
All Other Outpatient Visits	0.0500
Ancillary Services (Per (000's) annual revenue)	
Pharmacies	0.0010
Wellness and Fitness Centers	0.0010

3. Increased Limits Factors

Limits ($000)	Factor
200/600	1.000
1000/1000	1.440
1000/2000	1.584
1000/3000	1.600

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor PL Relativity
0	0.50
1	0.75
2	0.90
3	0.95
Mature	1.00
CM to Occ Relativity	0.93

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor PL Relativity
1	0.70
2	1.15
3	1.50
4	1.70
Mature	1.80

6. Prior Acts Nose Coverage

Years Retro. Date Precedes Inception Date	Factor Based on the Occurrence Rate
1	0.61
2	0.92
3	1.05
4	1.25
Mature	1.35

7. Additional limits of liability

Not Applicable

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8. PPL and Ancillary Premium Basis

a. Employed physician, surgeon and dentist modification

Limit of Liability	Factor
Separate	0.750
Shared	0.600

b. Residents (PGY-2 and above) modification

Limit of Liability	Factor
Separate	0.500
Shared	0.400

c. Ancillary Personnel (Shared Limit)

Personnel	Factor
CRNA	0.750
Nurse Midwife	0.750

d. Faculty/Teaching physician, surgeon and dentist modification

Limit of Liability	Factor
Separate	0.500
Shared	0.400

C. Policy Writing Minimum Premium

HCF	$10,000

Note: The minimum premium is reduced to $500 in those instances in which coverage is provided to an entity associated with an insured facility.

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D. Premium Modifications

1. Experience Rating Plan

TABLE OF ADJUSTED EXPECTED LOSS RATIOS AND CREDIBILITY

BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES**	AELR *	CREDIBILITY
10 - 11	22.53%	10.25%	49 - 50	46.93%	22.25%	88 - 89	58.35%	29.75%
11 - 12	23.55%	10.72%	50 - 51	47.33%	22.47%	89 - 90	58.55%	29.92%
12 - 13	24.52%	11.18%	51 - 52	47.73%	22.69%	90 - 91	58.74%	30.08%
13 - 14	25.45%	11.62%	52 - 53	48.12%	22.91%	91 - 92	58.93%	30.25%
14 - 15	26.35%	12.04%	53 - 54	48.51%	23.13%	92 - 93	59.11%	30.41%
15 - 16	27.22%	12.45%	54 - 55	48.88%	23.35%	93 - 94	59.29%	30.58%
16 - 17	28.05%	12.85%	55 - 56	49.25%	23.56%	94 - 95	59.47%	30.74%
17 - 18	28.86%	13.23%	56 - 57	49.62%	23.77%	95 - 96	59.65%	30.90%
18 - 19	29.65%	13.60%	57 - 58	49.98%	23.98%	96 - 97	59.82%	31.06%
19 - 20	30.41%	13.96%	58 - 59	50.33%	24.19%	97 - 98	59.98%	31.23%
20 - 21	31.15%	14.32%	59 - 60	50.67%	24.39%	98 - 99	60.15%	31.38%
21 - 22	31.88%	14.66%	60 - 61	51.01%	24.60%	99 - 100	60.31%	31.54%
22 - 23	32.58%	15.00%	61 - 62	51.35%	24.80%	100 - 105	60.77%	32.02%
23 - 24	33.27%	15.33%	62 - 63	51.67%	25.00%	105 - 110	61.49%	32.79%
24 - 25	33.94%	15.65%	63 - 64	51.99%	25.20%	110 - 115	62.14%	33.54%
25 - 26	34.59%	15.97%	64 - 65	52.31%	25.40%	115 - 120	62.72%	34.28%
26 - 27	35.23%	16.28%	65 - 66	52.62%	25.59%	120 - 125	63.25%	35.00%
27 - 28	35.85%	16.58%	66 - 67	52.92%	25.79%	125 - 130	63.73%	35.71%
28 - 29	36.47%	16.88%	67 - 68	53.22%	25.98%	130 - 135	64.17%	36.40%
29 - 30	37.07%	17.18%	68 - 69	53.51%	26.17%	135 - 140	64.57%	37.08%
30 - 31	37.65%	17.46%	69 - 70	53.80%	26.36%	140 - 145	64.93%	37.75%
31 - 32	38.23%	17.75%	70 - 71	54.08%	26.55%	145 - 150	65.25%	38.41%
32 - 33	38.79%	18.03%	71 - 72	54.36%	26.74%	150 - 160	65.69%	39.37%
33 - 34	39.35%	18.30%	72 - 73	54.63%	26.93%	160 - 170	66.18%	40.62%
34 - 35	39.89%	18.57%	73 - 74	54.90%	27.11%	170 - 180	66.60%	41.83%
35 - 36	40.42%	18.84%	74 - 75	55.16%	27.29%	180 - 190	66.94%	43.01%
36 - 37	40.94%	19.10%	75 - 76	55.42%	27.48%	190 - 200	67.24%	44.16%
37 - 38	41.45%	19.36%	76 - 77	55.67%	27.66%	200 - 225	67.65%	46.10%
38 - 39	41.96%	19.62%	77 - 78	55.92%	27.84%	225 - 250	68.08%	48.73%
39 - 40	42.45%	19.87%	78 - 79	56.16%	28.02%	250 - 275	68.37%	51.23%
40 - 41	42.94%	20.12%	79 - 80	56.40%	28.20%	275 - 300	68.59%	53.62%
41 - 42	43.41%	20.37%	80 - 81	56.63%	28.37%	300 - 400	68.92%	59.16%
42 - 43	43.88%	20.62%	81 - 82	56.86%	28.55%	400 - 500	69.15%	67.08%
43 - 44	44.34%	20.86%	82 - 83	57.09%	28.72%	500 - 600	69.25%	74.16%
44 - 45	44.79%	21.10%	83 - 84	57.31%	28.90%	600 - 700	69.31%	80.62%
45 - 46	45.23%	21.33%	84 - 85	57.52%	29.07%	700 - 800	69.34%	86.60%
46 - 47	45.67%	21.56%	85 - 86	57.74%	29.24%	800 - 900	69.35%	92.20%
47 - 48	46.09%	21.79%	86 - 87	57.95%	29.41%	900 - 1,000	69.37%	97.47%
48 - 49	46.51%	22.02%	87 - 88	58.15%	29.58%	1,000 +	69.40%	100.00%

NOTES :

* AELR is the adjusted expected loss ratio.

** This is the average number of bed equivalent exposures for the latest five policy years.

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2. Schedule Rating Plan - Professional Liability

a. Risk Management Program

Considerations	Max. Credit	Max. Debit
Existence of a formal written risk management program with full time management position or committee	10%	10%
Employment of a full time patient advocate	5%	5%
The risk manager is a member of the Quality Assurance Committee	5%	5%
Existence of an effective medical audit system which includes surgical procedures and ties into the physician credentialing process	10%	10%
Existence of a formal risk management program for:		
Generic/Occurrence Screening	2%	2%
Incident Reporting	2%	2%
Infection Control Committee	2%	2%
Tissue Review Committee	2%	2%
A formal continuing education program for:		
Nursing Staff	5%	5%
Medical Staff	5%	5%
Allied Health Professionals	5%	5%
Administrative and medical staff commitment and involvement in risk management as exhibited by an established and enforced policy statement	15%	15%
Compliance with insurance company loss prevention recommendations, if any, relating to items other than above	10%	10%

b. Biomedical Equipment Program

Considerations	Max. Credit	Max. Debit
Existence of preventative maintenance and corrective maintenance program for equipment in the facility	5%	5%

c. JCAHO or Equivalent Accreditation

Considerations	Max. Credit	Max. Debit
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA) accreditation with no outstanding contingencies	10%	10%
Accreditation with commendation by one of the above accrediting organizations	10%	0%

d. Building and Physical Plant

Considerations	Max. Credit	Max. Debit
Compliance with National Fire Protection Association (NFPA) standards	10%	10%

e. Cooperation with Insurance Company Claims Department

Considerations	Max. Credit	Max. Debit
Adherence to clearly defined loss identification and reporting procedures	10%	10%

f. Maximum Modification: 50%

3. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.1%
10,000	9.6%	12.1%
25,000	16.4%	22.1%
50,000	25.6%	32.8%
100,000	36.2%	50.8%
250,000	57.6%	74.0%
300,000	60.2%	76.8%

Notes:

a) The deductible amount applies per health care occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

b) Deductibles may apply to indemnity only or to indemnity and defense costs.

c) Once a deductible is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower deductible.

d) Deductible amounts not shown will be interpolated using standard actuarial techniques.

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4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	54.6%
200,000	67.8%
250,000	74.4%
300,000	76.5%

Notes:

a) The SIR amount applies per health care occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

b) SIR's shall apply to indemnity and defense costs.

c) Once a SIR is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower SIR.

d) SIR amounts not shown will be interpolated using standard actuarial techniques.

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GENERAL LIABILITY

A. Classification

1. Applicable to the Occurrence and Standard Claims-Made Programs.
2. The classification plan shall consist of the types of health care providers for which coverage is provided.
   a. Corporations, Partnerships and Associations
   b. Physicians and Surgeons
   c. Dentists
   d. Allied Health Care Providers
   e. Health Care Facilities

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STATE OF ILLINOIS
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B. Manual Rates

1. Territory Definitions

Refer to Healthcare Facilities

2. Corporations, Partnerships and Associations

Reserved for future use.

3. Physicians and Surgeons

Reserved for future use.

4. Dentists

Reserved for future use.

5. Allied Health Care Providers

Reserved for future use.

6. Health Care Facilities

a. Standard General Liability

i.

Standard Premium Percentage	25.0%

Standard occurrence premium will be a percentage of the PL premium developed for beds, visits and ancillary services at the applicable limit.

ii. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor GL Relativity
0	0.89
1	0.95
2	0.99
3	1.00
Mature	1.00
CM to Occ Relativity	0.9615

iii. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor GL Relativity
1	0.55
2	0.95
3	1.15
4	1.25
Mature	1.25

iv.

GL Nose Coverage Factor Based on the Occurrence Rate	1.10

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b. Employee Benefit Liability - Claims Made Only

Limit	Charge
Basic	$1,000

Note: Employee Benefit Liability will be subject to the same increased limits factors and extended reporting endorsement factors as HPL.

C. Policy Writing Minimum Premium

	Add'l Coverage	Stand Alone
GL	$100	$2,500
EBL	$100	na

D. Premium Modifications

1. Corporations, Partnerships and Associations

   Reserved for future use.

2. Physicians and Surgeons

   Reserved for future use.

3. Dentists

   Reserved for future use.

4. Allied Health Care Providers

   Reserved for future use.

5. Health Care Facilities

   a. Exposure Modification

      i. Presence/absence of characteristics

Characteristics	Present	Absent
Daycare Center	10%	-10%
Restaurant	10%	-10%
Helicopter Landing Pad	5%	-5%
Retail Pharmacy	10%	-10%
Major Construction in the last or next 12 months	15%	-15%
Health and/or Fitness Center	10%	-10%
Habitational Risk (Apartments or Hotel)	15%	-15%
Special athletic or fund raising events that attract the general public	5%	-5%

      ii. Other characteristics of the underlying risk

Characteristics	Credit
Entire facility at Effective Date: 04/15/04	10%
Adequate Security	10%

      iii. Maximum Modification: 40%

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6. Schedule Rating Plan - General Liability

a. Risk Management Program

Considerations	Max. Credit	Max. Debit
Existence of a formal written risk management program with full time management position or committee	10%	10%
Employment of a full time patient advocate	5%	5%
The risk manager is a member of the Quality Assurance Committee	5%	5%
Existence of an effective medical audit system which includes surgical procedures and ties into the physician credentialing process	10%	10%
Existence of a formal risk management program for:		
Generic/Occurrence Screening	2%	2%
Incident Reporting	2%	2%
Infection Control Committee	2%	2%
Tissue Review Committee	2%	2%
A formal continuing education program for:		
Nursing Staff	5%	5%
Medical Staff	5%	5%
Allied Health Professionals	5%	5%
Administrative and medical staff commitment and involvement in risk management as exhibited by an established and enforced policy statement	15%	15%
Compliance with insurance company loss prevention recommendations, if any, relating to items other than above	10%	10%

b. Biomedical Equipment Program

Considerations	Max. Credit	Max. Debit
Existence of preventative maintenance and corrective maintenance program for equipment in the facility	5%	5%

c. JCAHO or Equivalent Accreditation

Considerations	Max. Credit	Max. Debit
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA) accreditation with no outstanding contingencies	10%	10%
Accreditation with commendation by one of the above accrediting organizations	10%	0%

d. Building and Physical Plant

Considerations	Max. Credit	Max. Debit
Compliance with National Fire Protection Association (NFPA) standards Effective Date: 04/15/04	10%	10%

e. Cooperation with Insurance Company Claims Department

Considerations	Max. Credit	Max. Debit
Adherence to clearly defined loss identification and reporting procedures	10%	10%

f. Maximum Modification: 50%

E. Miscellaneous General Liability Coverages

1. Corporations, Partnerships and Associations

Reserved for future use.

2. Physicians and Surgeons

Reserved for future use.

3. Dentists

Reserved for future use.

4. Allied Health Care Providers

Reserved for future use.

5. Health Care Facilities

a. Employer's Liability

Limit	Charge
Basic	n/a

b. Fire Damage Legal Liability

Per Occ. Limit	Charge
50,000	No add'l charge
100,000	$500
250,000	$1000

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c. Medical Payments

Per Person Limit	Bed Equivalent Exposures				
	Less than 100	101-250	251-500	501-1000	1001+
1,000	No add'l charge	No add'l charge	No add'l charge	No add'l charge	No add'l charge
2,500	$375	$1,075	$2,200	$4,375	$6,250
5,000	$675	$1,925	$3,950	$7,875	$11,250
10,000	$1200	$3,400	$7,000	$14,000	$20,000

d. Patients' Property Liability ($1,000 limit per person)

Insured's Deductible	Bed Equivalent Exposures				
	Less than 100	101-250	251-500	501-1000	1001+
$250 per person	$375	$1,075	$2,200	$4,375	$6,250
$500 per person	$150	$425	$875	$1,750	$2,500

MANAGED CARE ENTITY LIABILITY

A. Classification

1. Applicable to the Standard Claims-Made Program
2. The classification plan shall consist of HMO's and All Other Managed Care Entities.

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B. Manual Rates

1. Territory Definitions

Refer to Healthcare Facilities

2. Standard Claims Made Program

a. HMO's

	Area 1	Area 2	Area 3
Basic Limit Rates per 100 Enrollees	329.66	202.50	123.46

b. All Other

	Area 1	Area 2	Area 3
Basic Limit Rates per 100 Enrollees	188.38	115.71	70.55

3. Increased Limits Factors

Limits	Factor
200,000/600,000	1.000
1,000,000/1,000,000	1.440

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor
0	0.500
1	0.750
2	0.900
3	0.950
Mature	1.000

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor
1	0.700
2	1.150
3	1.500
4	1.700
Mature	1.800

C. Policy Writing Minimum Premium

MCE	$5,000

D. Premium Modifications

1. Schedule Rating Plan

a. Risk Management Program

Considerations	Max. Credit	Max. Debit
Formal written Risk Management Program	15%	15%
The existence of an effective management level risk management committee or position	5%	5%
Patient Advocate Policy: A mechanism exists for visitors, patients or their families to formally or informally communicate concerns regarding the MCE (i.e. satisfaction surveys)	4%	4%

b. Loss experience

Considerations	Max. Credit	Max. Debit
Loss Ratio	25%	25%
Frequency, severity of claims	25%	25%

c. Effectiveness in MCE Operations

Considerations	Max. Credit	Max. Debit
Years in Business:		
0 - 4 years	0%	20%
5 - 9 years	10%	10%
10+ years	20%	0%
All contracts, sales literature and brochures approved by legal counsel prior to use	15%	15%
Composition of Staff Employed vs. Contracted	15%	15%
Annual Credentialing of health care providers	15%	15%
Written Utilization Review Procedures	15%	15%
Existence of written Claim Denial Appeal process that is clearly spelled out to plan participants	15%	15%

d. MCE Operations for Others (E&O Coverage)

Characteristics	Max. Credit	Max. Debit
Claims Handling	5%	5%
Third Party Administration	5%	5%
Rehabilitation Services	5%	5%
Utilization Review	5%	5%
Peer Review/Credentialing	5%	5%
Electronic Data Processing or Computer Software	5%	5%
Loss Control or Safety Engineering	5%	5%
Premium Financing	5%	5%
Agency and Brokerage Operations	5%	5%
Insurance Consulting	5%	5%
Actuarial Services	5%	5%
Benefits Stop Loss Placement	5%	5%
Insurance Pool Management	5%	5%

e. Cooperation with Insurer's Loss Claim/Risk Management Department

Characteristics	Max. Credit	Max. Debit
Adherence to clearly defined Loss Identification/ Reporting procedures and compliance with formal risk management recommendations	10%	10%

f. Maximum Modification: 50%

POLLUTION LIABILITY

A. Classification

1. Applicable to the Standard Claims-Made Program.
2. The classification plan shall consist of the types of health care providers for which coverage is provided.
   a. Corporations, Partnerships and Associations
   b. Physicians and Surgeons
   c. Dentists
   d. Allied Health Care Providers
   e. Health Care Facilities

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B. Manual Rates

1. Territory Definitions

Refer to Healthcare Facilities

2. Premium Basis

a. Corporations, Partnerships and Associations

Reserved for future use.

b. Physicians and Surgeons

Reserved for future use.

c. Dentists

Reserved for future use.

d. Allied Health Care Providers

Reserved for future use

e. Health Care Facilities

i. Standard Claims Made Program

The Pollution basic limits premium will be 2.0% of the occurrence Health Care Facilities Professional Liability basic limits premium.

3. Increased Limits Factors

Limits	Factor
100,000/100,000	0.900
200,000/200,000	1.000
300,000/300,000	1.140

Notes:

a) Increased limits factors apply to the basic limits premium.
b) Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor (based on Occ.)
1	0.470
2	0.700
3	0.840
4	0.880
Mature	0.930

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5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor (based on CM)
1	0.700
2	1.150
3	1.500
4	1.700
Mature	1.800

C. Policy Writing Minimum Premium

POL	$500

D. Premium Modifications

1. Schedule Rating Plan

a. Risk Management/QA/Loss Control Program

Considerations	Max. Credit	Max. Debit
Existence of an environmental safety program	10%	10%
Required safety features in place (pollution controls)	10%	10%
Preventative equipment maintenance (oil tanks/gas cylinders) by outside contractors	10%	10%
Risk assessment previously conducted:		
Five or more years ago	0%	5%
Two or more years ago	5%	0%

b. Incinerators

Considerations	Max. Credit	Max. Debit
Incineration of medical waste for others	0%	25%

c. Disposal of Waste

Considerations	Max. Credit	Max. Debit
On site disposal of waste	0%	15%
Off site disposal of waste	15%	0%

d. Storage Tanks

Considerations	Max. Credit	Max. Debit
Above ground storage tanks filled with hazardous materials	10%	10%

e. Loss Activity

Considerations	Max. Credit	Max. Debit
Governmental sanctions or claims	25%	25%
Loss experience	25%	25%
Unreported claims, such as voluntary cleanup	10%	10%

f. Maximum Modification: 50%

2. Retention Amounts

Retention Amount		Credit Applicable to the 200/600 Limits Premium
Per Pollution Occurrence	Aggregate	
5,000	none	0.0%
10,000	none	12.1%
25,000	none	22.1%

Notes:

a) The coverage is claims made. Once a retention is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower retention.

b) Retention amounts include both indemnity and allocated loss adjustment expense.

c) Retention credits apply to the basic limits premium.

d) Retention amounts not shown will be interpolated using standard actuarial techniques.

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SPRINGFIELD

January 8, 2008

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843** 35-0506406
COMPANY FILE NO: 08-IL-110
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Maryville Medical Services
Policy # C47352

POLICY IN EFFECT: ***March 1, 2008 – March 1, 2009***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Maryville Medical Services, policy # C47352,* for your review and consideration. We request the effective date of this submission be **effective March 1, 2008 – March 1, 2009.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification and a self-addressed stamped envelope. As this risk was individually rated last year, the rule on file is applicable to the enclosed filing. 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

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Enclosures

1-0
MEM
RAT
glm
Jeh

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, James Kunce, FCAS, MAAA, SVP and Chief Actuary SVP & Actuary, 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, James Kunce, FCAS, MAAA, SVP and Chief Actuary, 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.

_____; SVP and Chief Actuary 01/07/08
Signature and Title of Authorized Insurance Company Officer Date

_____;FCAS, MAAA, SVP and Chief Actuary 01/07/08
Signature, Title and Designation of Authorized Actuary Date

Insurance Company FEIN 35-0506406 Filing Number 08-IL-110

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

08-IL-110

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/17/2007 Degree: MD Region: Midwest

Check One:

☐ Individual
☒ Group

1. INSURED: Maryville Medical Services (part of group 19607)
2. QUOTED PREMIUM: $7,300
3. MANUAL PREMIUM: $1,000
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2008
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2009
8. POLICY NUMBER(S): C47352
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of all of the CRNAs covered under the corporation. This is a separate corporation set up solely for CRNAs. Medical Protective's standard Allied corporate rate (minimum $1,000) does not contemplate for the risk of these CRNAs. $6636 * 11 * .10 = $7,300.

INDIVIDUAL RISK FILINGS WORKSHEET
PAGE 2
INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

The current filed Allied corporate rate simply has a minimum premium ($500) times a limit factor (2). The filed rate does not account for the specific risk covered. The risk of this corporation (11 CRNAs) falls outside of our standard allied corporate pricing.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2008. There are currently 5 anesthesiologists and 11 CRNAs insured with Medical Protective. There was a large CRNA PIC claim ($500K closed 10/2002) that clearly demonstrates the high risk of this specialty (for the corporate policy). The overall premium for the group (without the corp. premium) is approximately $195K.

This Individual Risk Filing is on the same basis as the previous policy period, but with updated base premium figures and the number of CRNAs.

Underwriter: Becky Joseph

Underwriting Supervisor Approval:

Date:

07-12-103

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/15/2006 Degree: MD Region: Midwest

Check One:

- ☐ Individual
- ☒ Group

1. INSURED: Maryville Medical Services (part of group 19607)
2. QUOTED PREMIUM: $5,375
3. MANUAL PREMIUM: $1,000
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2007
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2008
8. POLICY NUMBER(S): C47352
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of all of the CRNAs covered under the corporation. This is a separate corporation set up solely for CRNAs. Medical Protective's standard Allied corporate rate (minimum $1,000) does not contemplate for the risk of these CRNAs. $5972 * 9 * .10 = $5,375.

PREVIOUS YEAR'S FILING OF IND. RISK.

INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

The current filed Allied corporate rate simply has a minimum premium ($500) times a limit factor (2). The filed rate does not account for the specific risk covered. The risk of this corporation (9 CRNAs) falls outside of our standard allied corporate pricing.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2007. There are currently 5 anesthesiologists and 9 CRNAs. There were no MedPro claims during this first year. There was a large CRNA PIC claim ($500K closed 10/2002) that clearly demonstrates the high risk of this specialty (for the corporate policy). The overall premium for the group (without the corp. premium) is approximately $185K (manual non-discretionary). The premium would have been approximately $317K prior to the IL rate reduction (Territory 1, Madison County).

Underwriter: Becky Joseph

Underwriting Supervisor Approval: Melissa Bailey

Date: 12/15/06

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

INDIVIDUAL RISK RATING PLAN

CRNA TO ANESTHESIOLOGIST RATIO

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A CRNA TO ANESTHESIOLOGIST RATIO OF GREATER THAN 2 TO 1, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

MANUAL PAGES AS PREVIOUSLY FILED.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

INDIVIDUAL RISK RATING PLAN

CORPORATION VICARIOUS LIABILITY FOR PHYSICIANS NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A VICARIOUS LIABILITY EXPOSURE FOR PHYSICANS WHO ARE NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

RECEIVED
JAN - 9 2008
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

January 8, 2008

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843** 35-0506406
COMPANY FILE NO: 08-IL-109
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Maryville Physician Services
Policy # C47351

POLICY IN EFFECT: ***March 1, 2008 – March 1, 2009***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Maryville Physician Services, policy # C47351,* for your review and consideration. We request the effective date of this submission be **effective March 1, 2008 – March 1, 2009.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification 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 contact me. Thank you.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 01 2008
SPRINGFIELD, ILLINOIS

Sincerely,

Melissa Coker

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

Enclosures

1-0
MEM
RAT
gbn
JCh

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, James Kunce, FCAS, MAAA, SVP and Chief Actuary SVP & Actuary, 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, James Kunce, FCAS, MAAA, SVP and Chief Actuary, 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.

_____; SVP and Chief Actuary 01/07/08
Signature and Title of Authorized Insurance Company Officer Date

_____;FCAS, MAAA, SVP and Chief Actuary 01/07/08
Signature, Title and Designation of Authorized Actuary Date

Insurance Company FEIN 35-0506406 Filing Number 08-IL-109

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

08-1L-109

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/17/07 Degree: MD Region: Midwest

Check One:

☐ Individual
☒ Group

1. INSURED: Maryville Physician Services (part of group 19607)
2. QUOTED PREMIUM: $51,965
3. MANUAL PREMIUM: 17,305
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2008
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2009
8. POLICY NUMBER(S): C47351
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of the top 5 physicians covered under the corporation. All physicians covered under the corporation are not insured with Medical Protective. Therefore, the specialties of the top 5 were used, which include 3 general vascular surgeons, one plastic/hand surgeon and one OBGYN. The corporate cap will also not be applied. This corporate policy covers the physicians working at Maryville Physicians Services Inc. When we wrote this group in 2006, we were not aware of contracted physicians not insured with Medical Protective. Medical Protective's standard corporate rate does not contemplate for these non-insureds. An Individual Risk Filing was used for pricing beginning 3/1/07 and is again being used for the 3/1/08 policy year. The calculation is as follows: ($120,728 + 102,355 + 102,355 + 102,355 + 91,858) * .10 = $51,965.

INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

This risk falls outside of our standard corporate pricing as there are physicians that Medical Protective does not insure. This increases the vicarious liabilty exposure for the entity and this needs to be contemplated in the premium.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2008. There are currently 5 anesthesiologists and 11 CRNAs insured with Medical Protective. Through the information gathering process, we determined there are 10 other contracted physicians working for Maryville, 5 of which have a higher class than the 5 anesthesiologists we currently insure. The overall premium for the group (without the corp. premium) is approximately $195K. The additional $51,995 charged for the physician corporation is needed to appropriately price the corp. since MedPro has vicarious liability for physicians it does not insure.

This Individual Risk Filing is similar to the one filed for 3/1/07, with updated base premium.

* Rate on file from last year is still applicable.

Underwriter: Becky Joseph

Underwriting Supervisor Approval:

Date:

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/15/2006 Degree: MD Region: Midwest

Check One:
- ☐ Individual
- ☒ Group

1. INSURED: Maryville Physician Services (part of group 19607)
2. QUOTED PREMIUM: $49,230
3. MANUAL PREMIUM: 16,390
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2007
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2008
8. POLICY NUMBER(S): C47351
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of the top 5 physicians covered under the corporation. All physicians covered under the corporation are not insured with Medical Protective. Therefore, the specialties of the top 5 were used, which include 3 general vascular surgeons, one plastic surgeon and one OBGYN. The corporate cap would also not be applied. This corporate policy covers the physicians working at Maryville Physicians Services Inc. When we wrote this group, we were not aware of contracted physicians not insured with Medical Protective. Medical Protective's standard corporate rate does not contemplate for these non-insureds. ($114,375 + $96,968 + $96,968 + $96,968 + $87,024) * .10 = $49,230.

PREVIOUS YEAR'S FILING OF IND. RISK

12. WHY WAS THE RISK INDIVIDUALLY RATED?

This risk falls outside of our standard corporate pricing as there are physicians that Medical Protective does not insure. This increases the vicarious liabilty exposure for the entity and this needs to be contemplated in the premium.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2007. There are currently 5 anesthesiologists and 9 CRNAs. There were no MedPro claims during this first year. Through the information gathering process, we found out there are 9 other contracted physicians working for Maryville, 5 of which have a higher class than the 5 anesthesiologists we currently insure. I have discussed the pricing with the agent. She will attempt to get these contracted physicians covered through Medical Protective over the coming years. 2 more CRNAs are also expected to join the group 3/1/2007. The overall premium for the group (without the corp. premium) is approximately $185K (manual non-discretionary). The premium would have been approximately $317K prior to the IL rate reduction (Territory 1, Madison County). The additional $32,840 charged for the physician corporation is needed to appropriately price the corp.

Underwriter: Becky Joseph

Underwriting Supervisor Approval: Melissa Bailey

Date: 12/15/06

The

Medical Protective Company

Fort Wayne, Indiana 46835

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ILLINOIS

INDIVIDUAL RISK RATING PLAN

CRNA TO ANESTHESIOLOGIST RATIO

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A CRNA TO ANESTHESIOLOGIST RATIO OF GREATER THAN 2 TO 1, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

MANUAL PGS AS PREVIOUSLY FILED

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RECEIVED
JUN 27 2008
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

June 26, 2008

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUL 01 2008
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY - NAIC #11843**
COMPANY FILE NO: 08-IL-111
COMPANY FEIN NO: 35-0506406
RATE / RULE **ILLINOIS INDIVIDUAL RISK FILING**
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing - Wesley Y. Yapor
Individual Risk Rating Plan Rule, Dr. Wesley Y. Yapor

POLICY IN EFFECT: ***July 1, 2008 – July 1, 2009***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Wesley Y. Yapor, MD,* for your review and consideration. We request the effective date of this submission be effective **July 1, 2008 – July 1, 2009.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification and a self-addressed stamped envelope. As this risk was individually rated, the Individual Risk Rating Rule applicable to the above referenced risk is also enclosed. 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

Enclosures

I-O
MEM
RCL
Jeh

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, James Kunce, FCAS, MAAA, SVP and Chief Actuary SVP & Actuary, 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, James Kunce, FCAS, MAAA, SVP and Chief Actuary, 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.

; SVP and Chief Actuary — 6/26/08
Signature and Title of Authorized Insurance Company Officer — Date

;FCAS, MAAA, SVP and Chief Actuary — 6/26/08
Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 08-IL-111

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

IL IRF

08-IL-111

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 6/23/2008 Degree: MD Region: Midwest

Check One:
X Individual
Group

1. INSURED: Dr. Wesley Y. Yapor
2. QUOTED PREMIUM: $262,454 ($251,956 if Risk Management completed before 8/1/08)
3. MANUAL PREMIUM: $209,963
4. LIMITS: $1M/$3M
5. SELECT ONE: New Business
6. EFFECTIVE DATE (mm/dd/yyyy): 7/1/08
7. EXPIRATION DATE: (mm/dd/yyyy): 7/1/09
8. POLICY NUMBER(S): To Be Determined
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was determined by applying a +25% discretionary debit allowable under the filed Scheduled Rating Plan rule. +15% was attributable to historical loss experience and +10% was attributable to claim anomalies. A frequency pricing tool was used for this physician and demonstrates the frequency of his claims is very close to what is expected for a Neurosurgeon practicing in Cook County, IL. The variation in pricing relates to the filed Non-Discretionary Debit Plan rule. Based on the filing of this debit plan rule, Dr. Yapor would have had 12 "points" and qualified for a +200% debit applied to our base premium (premium would have been approximately $630,000). Due to the high frequency and severity specialty, in Cook County, IL, our filed non-discretionary rule would seem to overprice this particular risk. This physician handles high profile and complex cases, so high frequency is expected. Out of 11 claims filed during the past 10 years, seven closed with no indemnity payment, one closed with

indemnity payment and three are open claim matters. On the open claim matters, we obtained additional information that would indicate it is likely these too will close with no indemnity payment.

Based on our analysis, we feel comfortable that a +25% debit, instead of a +200% debit, adequately prices the risk.

12. WHY WAS THE RISK INDIVIDUALLY RATED?

This risk falls outside of our standard non-discretionary debit plan rule as this physician is a higher frequency and severity specialty, has a high profile practice and is practicing in Cook County. Medical Protective feels comfortable that a +25% debit prices the risk more appropriately than a +200% debit based on our current filing.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Underwriter: Becky Joseph

Underwriting Supervisor Approval: Melissa Bailey

Date: 6/12/08

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

INDIVIDUAL RISK RATING PLAN

DR. WESLEY Y. YAPOR
(POLICY NO. TBD)

DR. WESLEY Y. YAPOR'S RATE CONTAINS UNIQUE AND UNUSUAL RISK CHARACTERISTICS WHICH ARE NOT ADEQUATELY CONTEMPLATED IN THE COMPANY'S STANDARD RATE. THEREFORE, THIS INSURED'S PREMIUM WILL BE INDIVIDUALLY RISK RATED.

THE RATE WAS DERIVED BY APPLYING A 25% DEBIT FOR PRIOR CARRIER CLAIMS, WHICH PRODUCES A PREMIUM OF $262,454.

POLICY EFFECTIVE DATE: 07/01/08 – 07/01/09.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Wednesday, July 02, 2008 12:55 PM
To: Neuman, Gayle
Subject: MCAFEE E-MAIL SCAN ALERT!~FW: INDIVIDUAL RISK FILING #08-IL-111 (DR. WESLEY Y. YAPOR)

Attachments: Response Memo.doc; Rate page.pdf

Response Memo.doc (24 KB)

Rate page.pdf (25 KB)

Attachment file : IRF Rule Dr. Wesley Y. Yapor.doc
Scanner Detected: Suspicious Extensions (Virus)
Action taken : Moved (Clean failed because the virus could be new)

H i, Ms. Neuman,

Please find our response to your questions and the following attachments to respond to your email below. Should you need anything additional, please let me know.

Thank you,
Melissa Coker

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, June 30, 2008 2:05 PM
To: Coker, Melissa
Subject: Individual Risk Filing #08-IL-111

Ms. Coker,

We are in receipt of the above referenced filing submitted on June 26, 2008. Please address the following issues:

1. Although this is an individual risk filing, if another doctor met the exact same criteria, that doctor should also receive such discount. Therefore, including the doctor's name on the manual page is not reasonable.

2. Please provide an exact step-by-step illustration of the calculation of this premium. If this is new business, why is the insured being charged the mature rate for claims-made coverage? Additionally, explain the quoted premium vs. the premium if completed before 8/1/08. Medical Protective filed a scheduled rating plan with a maximum modification of +/-50%, so please explain the 200% debit.

We request receipt of your response by July 8, 2008.

Gayle Neuman

Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can

be accessed through the Department's website (http://www.idfpr.com/) by clicking on. insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

July 1, 2008

- Although this is an individual risk filing, if another doctor met the exact same criteria, that doctor should also receive such discount. Therefore, including the doctor's name on the manual page is not reasonable.

  Please find attached a revised rule.

- Please provide an exact step-by-step illustration of the calculation of this premium.

  262,454 = 209,963 * 1.25.

  209,963 is the manual premium for mature claims made, Cook county (area 1), class 8, 1m/3m limit (see attached filed rate page).

- If this is new business, why is the insured being charged the mature rate for claims-made coverage?

  This insured is being rated at a mature claims made rate as the insureds retroactive date is 01/01/89.

- Additionally, explain the quoted premium vs. the premium if completed before 8/1/08.

  If the insured completes Risk Management courses before 8/1/08, the premium will be adjusted accordingly.

- Medical Protective filed a scheduled rating plan with a maximum modification of +/-50%, so please explain the 200% debit.

  The Company has a Non-Discretionary Debit Rating Plan on file. Pursuant to this debit plan, this insured would normally receive a 200% debit. However, this filed debit plan does not contemplate territorial anomalies. As a result, the Company feels a 25% debit is actuarially sound.

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

ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,535	10,248	15,145	18,762	19,516
1B	10,046	13,663	20,192	25,015	26,019
1C	11,804	16,053	23,726	29,392	30,572
1D	12,859	17,488	25,847	32,019	33,305
2A	14,064	19,127	28,269	35,019	36,426
2B	16,576	22,543	33,318	41,274	42,932
2C	19,590	26,642	39,376	48,779	50,738
2D	22,101	30,057	44,423	55,031	57,242
3A	23,608	32,343	48,869	62,089	64,922
3B	26,120	35,784	54,068	68,696	71,830
4A	28,631	39,224	59,266	75,300	78,735
4B	31,143	42,666	64,466	81,906	85,643
5A	35,161	48,171	72,783	92,473	96,693
5B	39,179	53,675	81,101	103,041	107,742
6A	41,189	56,429	85,261	108,327	113,270
6B	46,212	63,310	95,659	121,538	127,083
7	53,244	72,944	110,215	140,032	146,421
8	76,350	104,600	158,045	200,801	209,963

EFFECTIVE DATE JAN 0 1 2007

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Tuesday, July 08, 2008 9:14 AM
To: Neuman, Gayle
Subject: INDIVIDUAL RISK FILING #08-IL-111
Attachments: Territorial Specialty Non Discretionary Debit Calculation Exception.doc

I apologize, please find the rule attached.

Please let me know if you need anything additional.
Melissa

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, July 07, 2008 12:06 PM
To: Coker, Melissa
Subject: RE: MCAFEE E-MAIL SCAN ALERT!~FW: INDIVIDUAL RISK FILING #08-IL-111 (DR. WESLEY Y. YAPOR)

Ms. Coker,

The revised rule page for the individual risk rating plan (wherein Dr. Yapor's name is deleted) was not attached.

Gayle Neuman
Division of Insurance

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Wednesday, July 02, 2008 12:55 PM
To: Neuman, Gayle
Subject: MCAFEE E-MAIL SCAN ALERT!~FW: INDIVIDUAL RISK FILING #08-IL-111 (DR. WESLEY Y. YAPOR)

Attachment file : IRF Rule Dr. Wesley Y. Yapor.doc
Scanner Detected: Suspicious Extensions (Virus)
Action taken : Moved (Clean failed because the virus could be new)

H i, Ms. Neuman,

Please find our response to your questions and the following attachments to respond to your email below. Should you need anything additional, please let me know.

Thank you,
Melissa Coker

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, June 30, 2008 2:05 PM
To: Coker, Melissa

Subject: Individual Risk Filing #08-IL-111

Ms. Coker,

We are in receipt of the above referenced filing submitted on June 26, 2008. Please address the following issues:

1. Although this is an individual risk filing, if another doctor met the exact same criteria, that doctor should also receive such discount. Therefore, including the doctor's name on the manual page is not reasonable.

2. Please provide an exact step-by-step illustration of the calculation of this premium. If this is new business, why is the insured being charged the mature rate for claims-made coverage? Additionally, explain the quoted premium vs. the premium if completed before 8/1/08. Medical Protective filed a scheduled rating plan with a maximum modification of +/-50%, so please explain the 200% debit.

We request receipt of your response by July 8, 2008.

Gayle Neuman

Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3

Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

<< File: Response Memo.doc >> << File: Rate page.pdf >>

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

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 MADE AGAINST THE INSURED DURING THE PAST 5 YEARS PURSUANT TO THE FOLLOWING SCHEDULE:

Closed 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 $100,00 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

HOWEVER, PROVIDERS WHO HAVE BEEN INSURED WITH THE COMPANY FOR LESS THAN FIVE COMPLETE YEARS WILL HAVE THEIR POINTS ADJUSTED PURSUANT TO THE FOLLOWING FORMULA:

Adjusted Points = (5 / # of Full Years of Experience) x Points

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE.

INFORMATION FROM MANUAL FOR REFERENCE

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

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

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. 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.

INFORMATION FROM MANUAL FOR REFERENCE

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885
Professional Protection Exclusively since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

PHYSICIANS AND SURGEONS

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.

INFORMATION FROM MANUAL FOR REFERENCE

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Friday, July 11, 2008 8:59 AM
To: Neuman, Gayle
Subject: RE: INDIVIDUAL RISK FILING #08-IL-111
Attachments: DOI Response No 2.pdf

Ms. Neuman,

Please find the information you requested attached. Please let me know if you need anything additional.

Thank you,
Melissa

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, July 09, 2008 3:20 PM
To: Coker, Melissa
Subject: RE: INDIVIDUAL RISK FILING #08-IL-111

The information should be specific to Dr. Yapor's account.

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Wednesday, July 09, 2008 2:19 PM
To: Neuman, Gayle
Subject: RE: INDIVIDUAL RISK FILING #08-IL-111

Ms. Neuman,
Do you need the information specific to Dr. Yapor's account, or in general?
Thanks,
Melissa

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, July 09, 2008 3:01 PM
To: Coker, Melissa
Subject: RE: INDIVIDUAL RISK FILING #08-IL-111

Ms. Coker,

Thank you for your e-mail response dated July 8, 2008.

In reviewing the non-discretionary debit plan, please provide a step-by-step of the calculation including the claim payout information, points assigned, points total, adjusted points total, and ISO coding.

Your response is requested by no later than July 15, 2008.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

Dr Yapor

Rating Variables	
Mature CM	
Cook County	
Class 8	
1m/3m Limit	
Manual Premium	$ 209,963

Per Filed Non Discretionary Debit Rule					
Date of Loss	Date Reported	Status	Date Closed	Indemnity Payment	Points Assigned
11/21/1999	12/18/2001	Closed	8/21/2003	0	1
1/24/2001	8/30/2002	Closed w pymnt	11/8/2006	$ 150,000	4
10/31/2000	11/18/2002	Closed	1/31/2006	0	1
3/1/2001	3/19/2003	Closed	6/25/2007	0	1
8/3/2002	5/7/2004	Closed	2/23/2006	0	1
1/23/2003	1/19/2005	Open		0	1
9/29/2003	3/4/2005	Open		0	1
6/5/2002	6/20/2006	Closed	2/27/2008	0	1
10/5/2004	12/21/2007	Open		0	1
				Total Points	12
				Total Debit %	200%
					$419,926

Final Premium PER FILING	$629,889

Date of Loss	Date Reported	Status	Date Closed	Indemnity Payment	Points Assigned
11/21/1999	12/18/2001	Closed	8/21/2003	0	
1/24/2001	8/30/2002	Closed w pymnt	11/8/2006	$ 150,000	4
10/31/2000	11/18/2002	Closed	1/31/2006	0	
8/3/2002	5/7/2004	Closed	2/23/2006	0	
1/23/2003	1/19/2005	Open		0	
9/29/2003	3/4/2005	Open		0	
6/5/2002	6/20/2006	Closed	2/27/2008	0	
10/5/2004	12/21/2007	Open		0	1
				Total Points	5
				Total Debit %	25%
					$52,491

Final Premium for Dr. Yapor	$262,454

There were several factors involved in deciding not to apply the filed 200% non-discretionary debit and instead price Dr. Yapor's policy based on 5 points / 25% debit. However, we primarily relied upon the following: 1) experience seemed to include high profile and complex cases...included claim with indemnity payment of $150,000 ~ 4 points. 2) Information from Dr. Yapor's defense attorney, on his pending claim matters impacted our decision to include the one open claim reported on 12/21/07 in the calculation. After evaluating these factors, the rate was determined by applying a +25% discretionary debit for the calculated 5 points under the filed Non-Discretionary Debit Rating Rule. We believe the premium, with the +25% debit, adequately prices the risk based on the individual risk characteristics of Dr. Yapor.

The Medical Protective Company

June 15, 2004

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
RECEIVED
JUN 16 2004
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
LINE 11 – MEDICAL MALPRACTICE
COMPANY FILING NO. 04-IL-63
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Base Rate Increase + 15.6%
Revise Partnership or Corporation Rating Rule
Revise Claim Free Credit Rule
Revise Extension Contract Rating Rule
Add Non-Discretionary Debit Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revised General Manual – Sections I, II, III and V
Revised State Rate Pages – Sections II, III and V

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

PROPOSED EFFECTIVE DATE: OCTOBER 1, 2004

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate and rule filing applicable to its Illinois Physicians & Surgeons and its Illinois Comprehensive Liability Coverage for Health Care Providers program. The company requests **October 1, 2004,** as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Physicians & Surgeons programs through a base rate increase of 15.6%. The accompanying Actuarial Memorandum provides support for the various changes including revised rules.

In addition, we have enclosed revised General Manual pages for Section I (*General Rules*), II (*Corporations, Partnerships & Associations*), III (*Physicians & Surgeons*) and V (*Allied Health Care Providers*) for the Company's Comprehensive Liability Coverage for Health Care Providers program. Additionally, corresponding Section III (*Physicians & Surgeons*) and V (*Allied Health Care Providers*) State Rate pages are enclosed. The rates and rules used for this program mirror those used for the Company's individual Physicians & Surgeon and Allied Health Care Providers Programs, and therefore are being included in this submission for manual purposes only to reflect the changes noted above.

Along with the Actuarial Memorandum, please find enclosed revised manual rule pages, the required forms, 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 contact me. Thank you.

Sincerely,

Melissa Coker

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3563
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Enclosure(s)

The Medical Protective Company

October 7, 2003

OCT 09 2003

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
LINE 11 – M EDICAL MALPRACTICE
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Increase		*+ 28.7 %*
Territory Relativity Changes		*+19.7 %*
Revised Increased Limit Factors	*(2m/4m)*	*+ 1.6 %*
Revised Excess Limit Factors		*+ 0.0 %*
Revised Class Plan		*- 2.9 %*
Revised Partnership or Corporation Rating Rule (Caps Only)		

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revised Rule Manual - Section II Corporations, Partnerships & Associations State Rate Pages
Revised Rule Manual – Section III Physicians & Surgeons State Rate Pages

PROPOSED EFFECTIVE DATE: January 1, 2004

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate and rule filing applicable to its Illinois Physicians & Surgeons and its Illinois Comprehensive Liability Coverage for Health Care Providers program. The company requests **January 1, 2004,** as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Physicians & Surgeons programs through a base rate increase, Territory Relativity Change, Revised Increased Limit Factors, Revised Excess Limit Factors, Class Plan Changes and rule revisions. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of 52.1%.

In addition, the Company has enclosed revised *Section II - Corporations, Partnerships & Associations* and *Section III - Physicians & Surgeons* state rate pages for the Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physician & Surgeon Program, and therefore are being included in this submission.

Along with the Explanatory Memorandum, please find enclosed revised manual rule pages, the required forms, 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 contact me. Thank you.

Sincerely,

Melissa Coker

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Property Casualty Actuary
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED
10/31/2003

Enclosure(s)

The Medical Protective Company

October 17, 2003

OCT 20 2003

John Gatlin, Supervisor, Property & Casualty Compliance Unit:
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY - NAIC #11843
LINE 11 – MEDICAL MALPRACTICE

PHYSICIANS & SURGEONS
DENTISTS
ALLIED HEALTH CARE PROVIDERS

Add Military Leave of Absence Credit Rule

PROPOSED EFFECTIVE DATE: November 1, 2003

Dear Mr. Gatlin:

The Medical Protective Company hereby submits for your review and consideration the enclosed rule filing applicable to our Physicians & Surgeons, Dentists, and Allied Health Care Providers Programs. We request November 1, 2003 as the effective date for this submission.

The new rule specifies that an insured may be eligible for a premium discount if on a military leave of absence. The language contained within the proposed rule is the countrywide format, and the introduction of this rule has no significant rate effect.

Along with the manual rule, please find enclosed required forms and a self-addressed stamped envelope. Upon completion of your review, 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.

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
NOV 01 2003
SPRINGFIELD, ILLINOIS

Sincerely,

Melissa Coker

Melissa Coker, Regulatory Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Enclosure(s)

The Medical Protective Company

RECEIVED
MAY 15 2003
Department of Insurance
Springfield

May 14, 2003

Illinois Department of Insurance
Attn: John Gatlin, Supervisor, Property & Casualty Compliance Unit
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 1 1 2003
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Revision to Physicians Rate Classes,May 1, 2003 Effective Date Filing

PROPOSED EFFECTIVE DATE CHANGE : From May 1, 2003 to May 11, 2003

Dear Mr. Gatlin:

On January 31, 2003, The Medical Protective Company submitted a rate filing in reference to our Physicians & Surgeons Occurrence and Standard Claims Made programs, which included revisions to the class plans, territories and rules, we had requested a proposed effective date of April 1, 2003. On February 20, 2003, in reference to the same filing, we requested to move back the proposed effective date from April 1, 2003 to May 1, 2003. After further consideration, we are requesting that the effective date be moved back, a final time from May 1, 2003 to **May 11, 2003**.

In addition, during a review of the recent Physicians & Surgeons filing approved by the Illinois Department of Insurance, it was discovered that there was a typo in the Physicians Rate Classes Standard Claims Made and Occurrence Program. The company wishes to provide updated manual pages reflecting the following modifications for clarification purposes.

- Class 2C has been modified to include "Physicians Not Otherwise Classified" instead of "Family Practice/General Practice"
- Class 3B has been modified to include "Family Practice/General Practice - Including Deliveries" instead of "Family Practice/General Practice with more than 125 deliveries"

Please find enclosed the modified manual pages 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,

Phillip J. Troyer | mdc

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

January 31, 2003

Hon. Nathaniel S. Shapo, Director of Insurance
Illinois Department of Insurance
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 01 2003
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Increase (+ 7.9 %)
Classification Changes (+ 19.6 %)
Revised Mature CM factor from .92 to .975 (+ 5.6 %)
Revised 1st Year CM Step Factor from .250 to .325
Territory Changes (5.1%)
- *Increased Area 1 factor from 1.820 to 2.100*
- *Area 2 county and factor revisions*
- *Area 3 county and factor revisions*
- *Area 4 county and factor revisions*
- *Area 5 county and factor revisions*

Revised Full Time Equivalency Rating Rule
Add Deferred Premium Payment Plan Rule
Add Membership Association Credit Rule
Revised Acc. Extension Contract Rating (Standard Claims Made Only)
Revised Extension Contract Rule (Standard Claims Made Only)
Revised Leave of Absence Credit Rule
Revised Locum Tenens
Revised Minimum Premium Rule ($250)
Revised Loss Free Credit
Revised New to Practice (50/30/0)
Revised P/C Rating Rule
Revised Part Time Practice (50/30/0)
Revised Prior Acts (Standard Claims Made Only)
Revised Risk Management
Revised Slot Rating Rule (Standard Claims Made Only)
Revised Solo Corp. Rule
Revised SRP (50%)
Withdraw Renewal Premium Increase Limitation Rule
Withdraw Retired Physicians Rating Rule (Occurrence Only)

ILLINOIS DI RECEIVED
2/25/2003

PROPOSED EFFECTIVE DATE: April 1, 2003

Dear Director Shapo:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Physicians & Surgeons programs. The company requests **April 01, 2003**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Physicians & Surgeons programs through a base rate increase and class plan changes. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of 43.2%.

Please find enclosed the required filing forms, filing fee 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,

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 0 1 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE:
AEROSPACE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHARMACOLOGY, PHYSIATRY, PHYSICIANS NOT OTHERWISE CLASSIFIED, PREVENTATIVE MEDICINE, AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:
ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PSYCHIATRY, AND RHEUMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:
DIABETES, FAMILY/GENERAL PRACTICE, NEPHROLOGY, AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: DERMATOLOGY AND OPHTHALMOLOGY.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE INTERNAL MEDICINE, AND PEDIATRICS.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, AND OTORHINOLARYNGOLOGY.

SURGICAL SPECIALISTS PERFORMING ANESTHESIOLOGY, OPHTHALMOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE HEMATOLOGY/ONCOLOGY, INFECTIOUS DISEASE, AND RADIOLOGY – DIAGNOSTIC.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE NEPHROLOGY, PATHOLOGY, PEDIATRICS, PSYCHIATRY - INCLUDING SHOCK THERAPY, PHYSICIANS NOT OTHERWISE CLASSIFIED, AND RADIOLOGY – THERAPY.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885
Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
RECEIVED
JAN 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, NEUROLOGY, AND PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: INFECTIOUS DISEASE, NEONATOLOGY, NEUROLOGY AND RADIOPAQUE DYE INJECTION.

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY SPECIALISTS PERFORMING RIGHT HEART CATHETERIZATION ONLY, CARDIOLOGY SPECIALISTS PERFORMING CATHETERIZATION INCLUDING LEFT HEART, GASTROENTEROLOGY, INTERNAL MEDICINE, INTENSIVE CARE AND RADIOLOGY – DIAGNOSTIC.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: ACUPUNCTURISTS, FAMILY/GENERAL PRACTICE, AND HEMATOLOGY/ONCOLOGY.

SURGICAL SPECIALISTS IN GASTROENTEROLOGY, AND GERIATRICS.

CLASS IIIB

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: AND FAMILY PRACTICE AND GENERAL PRACTICE – INCLUDING DELIVERIES.

SURGICAL SPECIALISTS IN COLON AND RECTAL SURGERY, FAMILY/GENERAL PRACTICE, OTORHINOLARYNGOLOGY (EXCLUDING PLASTIC), AND UROLOGY.

EMERGENCY MEDICINE - NO MAJOR SURGERY.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS IV-A

SURGICAL SPECIALISTS IN PLASTIC SURGERY (NO ELECTED COSMETIC), ORTHOPEDIC - HAND, AND ORTHOPEDIC - HEAD AND NECK.

CLASS IV-B

SURGICAL SPECIALISTS IN GYNECOLOGY, AND ORTHOPEDIC SURGERY (EXCLUDING SPINAL).

CLASS V-A

EMERGENCY MEDICINE - INCLUDING MAJOR SURGERY.

CLASS V-B

SURGICAL SPECIALISTS IN GENERAL SURGERY, PLASTIC SURGERY (NOT OTHERWISE CLASSIFIED), AND ORTHOPEDIC SURGERY (INCLUDING SPINAL).

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS VI

SURGICAL SPECIALISTS IN ABDOMINAL SURGERY.

CLASS VII

SURGICAL SPECIALISTS IN CARDIOVASCULAR SURGERY, TRAUMATIC SURGERY, THORACIC SURGERY, OBSTETRICS, AND OB/GYN AND VASCULAR SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: DUPAGE, JACKSON, KANE, LAKE, MCHENRY, AND VERMILLION COUNTIES .

TERRITORY 3: CHAMPAIGN, KANKAKEE, MACON, SANGAMON, AND WINNEBAGO COUNTIES.

TERRITORY 4: BUREAU, COLES, DEKALB, LASALLE, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 5: REMAINDER OF STATE.

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	12,627	17,173	25,380	31,441	32,704
1B	16,836	22,897	33,840	41,922	43,605
1C	19,782	26,904	39,762	49,257	51,235
2A	24,412	33,200	49,068	60,786	63,227
2B	27,779	37,779	55,836	69,170	71,948
2C	32,830	44,649	65,988	81,747	85,030
2D	35,356	48,084	71 066	88,036	91,572
3A	42,090	57,663	87,126	110,697	115,748
3B	45,457	62,276	94,096	119,552	125,007
4A	53,875	73,809	111,521	141,691	148,156
4B	61,451	84,188	127,204	161,616	168,990
5A	67,344	92,261	139,402	177,115	185,196
5B	79,129	108,407	163,797	208,109	217,605
6	92,598	126,859	191,678	243,533	254,645
7	99,332	136,085	205,617	261,243	273,163
8	130,479	178,756	270,092	343,160	358,817

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PHYSICIANS AND SURGEONS

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	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,997	10,876	16,074	19,913	20,712
1B	10,663	14,502	21,433	26,551	27,617
1C	12,529	17,039	25,183	31,197	32,450
2A	15,461	21,027	31,077	38,498	40,044
2B	17,594	23,928	35,364	43,809	45,568
2C	20,793	28,278	41,794	51,775	53,854
2D	22,392	30,453	45,008	55,756	57,995
3A	26,658	36,521	55,182	70,111	73,310
3B	28,790	39,442	59,595	75,718	79,173
4A	34,122	46,747	70,633	89,741	93,836
4B	38,920	53,320	80,564	102,360	107,030
5A	42,652	58,433	88,290	112,175	117,293
5B	50,116	68,659	103,740	131,805	137,819
6	58,647	80,346	121,399	154,242	161,279
7	62,912	86,189	130,228	165,459	173,008
8	82,638	113,214	171,061	217,338	227,255

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	6,734	9,158	13,535	16,768	17,441
1B	8,979	12,211	18,048	22,358	23,256
1C	10,550	14,348	21,206	26,270	27,325
2A	13,020	17,707	26,170	32,420	33,722
2B	14,815	20,148	29,778	36,889	38,371
2C	17,509	23,812	35,193	43,597	45,348
2D	18,856	25,644	37,901	46,951	48,837
3A	22,448	30,754	46,467	59,038	61,732
3B	24,243	33,213	50,183	63,759	66,668
4A	28,733	39,364	59,477	75,568	79,016
4B	32,773	44,899	67,840	86,193	90,126
5A	35,916	49,205	74,346	94,459	98,769
5B	42,201	57,815	87,356	110,989	116,053
6	49,385	67,657	102,227	129,883	135,809
7	52,976	72,577	109,660	139,327	145,684
8	69,587	95,334	144,045	183,014	191,364

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PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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INCREASED LIMITS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

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EXCESS LIMITS FACTORS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
1M/1M xs 1M/3M	1.280	1.320	1.320
2M/2M xs 1M/3M	1.473	1.502	1.502
3M/3M xs 1M/3M	1.556	1.592	1.592
4M/4M xs 1M/3M	1.615	1.660	1.660
5M/5M xs 1M/3M	1.661	1.727	1.727
6M/6M xs 1M/3M	1.706	1.778	1.778
7M/7M xs 1M/3M	1.751	1.825	1.825
8M/8M xs 1M/3M	1.790	1.866	1.866
9M/9M xs 1M/3M	1.829	1.895	1.895

Note: For aggregate limits not listed above, refer to company.

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OCCURRENCE 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 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

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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.

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FULL TIME EQUIVALENCY RATING RULE

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

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

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

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

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FULL TIME EQUIVALENCY RATING RULE (CONT.)

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

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
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 NEW TO PRACTICE, PART TIME PRACTICE, OR LOSS FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE, SHALL BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 75% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE PHYSICIAN'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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LOCUM TENENS

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

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

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LOSS FREE CREDIT

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IF NO LOSS HAS BEEN ATTRIBUTED TO AN INSURED, THE INSURED WILL BE ELIGIBLE FOR PREMIUM CREDITS ON THE FOLLOWING SCHEDULE:

1. IF INSURED BY THE COMPANY AND LOSS 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 LOSS FREE FOR 5 YEARS BUT LESS THAN 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND LOSS FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% SHALL BE APPLIED TO THE NEXT POLICY RENEWAL.

A LOSS 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS LOSS FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE LOSS FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH STANDARD GUIDELINES APPLICABLE TO THE COMPANY'S INSUREDS.

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MEMBERSHIP ASSOCIATION CREDIT RULE

THE UNIQUE CHARACTERISTICS OF A MEDICAL 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 5% 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 PHYSICIAN WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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MINIMUM PREMIUM REQUIREMENT RULE

ALL POLICIES ARE SUBJECT TO A MINIMUM PREMIUM OF $250. 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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NEW TO PRACTICE CREDIT

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A "NEW" PHYSICIAN SHALL BE A PHYSICIAN WHO HAS RECENTLY COMPLETED ONE OF THE FOLLOWING PROGRAMS AND WILL BEGIN A FULL TIME PRACTICE FOR THE FIRST TIME:

A) RESIDENCY;
B) FELLOWSHIP PROGRAM IN THEIR MEDICAL SPECIALITY;
C) FULFILLMENT OF A MILITARY OBLIGATION IN REMUNERATION FOR MEDICAL SCHOOL TUITION;
D) MEDICAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

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

CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR AND CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR FOLLOWING COMPLETION OF THEIR MEDICAL TRAINING PROGRAM.

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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 MADE AGAINST THE INSURED DURING THE PAST 5 YEARS PURSUANT TO THE FOLLOWING SCHEDULE:

Closed 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 $100,00 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

HOWEVER, PROVIDERS WHO HAVE BEEN INSURED WITH THE COMPANY FOR LESS THAN FIVE COMPLETE YEARS WILL HAVE THEIR POINTS ADJUSTED PURSUANT TO THE FOLLOWING FORMULA:

Adjusted Points = (5 / # of Full Years of Experience) x Points

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE.

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NON-DISCRETIONARY DEBIT PLAN

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

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. 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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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.

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

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THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

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 PHYSICIANS.

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PART TIME PRACTICE RULE

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

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 RISK MANAGEMENT AND/OR MEMBERSHIP ASSOCIATION.

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RENEWAL PREMIUM INCREASE LIMITATION

THE RENEWAL PREMIUM SHALL BE BASED UPON THE RATES IN EFFECT ON THE RENEWAL OR ANNIVERSARY DATE PROVIDED. HOWEVER, WITH RESPECT TO ANY INDIVIDUAL POLICY OR RISK RECEIVING A PREMIUM INCREASE, THAT PORTION OF THE PREMIUM INCREASE SPECIFICALLY CAUSED BY FILED CHANGES IN THE BASE RATE, INCREASED LIMIT FACTORS, CLAIMS MADE STEP FACTORS, TERRITORY FACTORS AND CLASS RELATIVITIES SHALL BE LESS THAN 30%. AT EACH SUBSEQUENT RENEWAL, THE BASE RATE, INCREASED LIMIT FACTOR, CLAIMS MADE STEP FACTOR, TERRITORY FACTOR AND CLASS RELATIVITY FOR AN AFFECTED INSURED WILL CONTINUE TO INCREASE (SUBJECT AGAIN TO A MAXIMUM COMBINED INCREASE OF LESS THAN 30%) UNTIL HIS/HER RATE MATCHES THOSE CURRENTLY APPROVED FOR USE IN THE STATE.

EFFECTIVE DATE JAN 01 1999

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RETIRED PHYSICIANS RATING RULE

IF PERMANENTLY RETIRED FROM THE PRACTICE OF MEDICINE, A PHYSICIAN MAY QUALIFY FOR $100,000/$300,000 LIMITS OCCURRENCE COVERAGE AT AN ANNUAL RATE OF $200 FOR THE FOLLOWING ACTIVITIES:

1) PRESCRIPTION WRITING FOR SELF AND IMMEDIATE FAMILY MEMBERS ONLY.

2) SERVICE ON OR EXECUTING THE DIRECTIVES OF A FORMAL ACCREDITATION, PEER REVIEW OR CREDENTIALING COMMITTEE OR HEARING PANEL.

THE PERFORMANCE OF ANY CLINICAL ACTIVITIES WILL REQUIRE THE PHYSICIAN TO BE RE-RATED IN ACCORDANCE WITH THE APPROPRIATE SPECIALTY.

NO OTHER CREDITS MAY APPLY CONCURRENTLY WITH THIS RULE.

EFFECTIVE DATE JAN 0 1 1999

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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.

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SCHEDULE RATING PLAN

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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 -50% / +50%, 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:

1. <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.

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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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES 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 INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

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SCHEDULE RATING PLAN

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. MEDICAL STANDARDS, QUALITY AND CLAIMS 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.

9. OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:
ADDITIONAL ACTIVITIES 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.

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SCHEDULE RATING PLAN

11. RECORD-KEEPING PRACTICES:
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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.

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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SOLO CORPORATION COVERAGE

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

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

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE:
AEROSPACE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHARMACOLOGY, PHYSIATRY, PHYSICIANS NOT OTHERWISE CLASSIFIED, PREVENTATIVE MEDICINE, AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:
ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PSYCHIATRY, AND RHEUMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:
DIABETES, FAMILY/GENERAL PRACTICE, NEPHROLOGY, AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: DERMATOLOGY AND OPHTHALMOLOGY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE INTERNAL MEDICINE, AND PEDIATRICS.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, AND OTORHINOLARYNGOLOGY.

SURGICAL SPECIALISTS PERFORMING ANESTHESIOLOGY, OPHTHALMOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE HEMATOLOGY/ONCOLOGY, INFECTIOUS DISEASE, AND RADIOLOGY – DIAGNOSTIC.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE NEPHROLOGY, PATHOLOGY, PEDIATRICS, PSYCHIATRY - INCLUDING SHOCK THERAPY, PHYSICIANS NOT OTHERWISE CLASSIFIED, AND RADIOLOGY – THERAPY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, NEUROLOGY, AND PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: INFECTIOUS DISEASE, NEONATOLOGY, NEUROLOGY AND RADIOPAQUE DYE INJECTION.

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY SPECIALISTS PERFORMING RIGHT HEART CATHETERIZATION ONLY, CARDIOLOGY SPECIALISTS PERFORMING CATHETERIZATION INCLUDING LEFT HEART, GASTROENTEROLOGY, INTERNAL MEDICINE, INTENSIVE CARE AND RADIOLOGY – DIAGNOSTIC.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: ACUPUNCTURISTS, FAMILY/GENERAL PRACTICE, AND HEMATOLOGY/ONCOLOGY.

SURGICAL SPECIALISTS IN GASTROENTEROLOGY, AND GERIATRICS.

CLASS IIIB

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: AND FAMILY PRACTICE AND GENERAL PRACTICE – INCLUDING DELIVERIES.

SURGICAL SPECIALISTS IN COLON AND RECTAL SURGERY, FAMILY/GENERAL PRACTICE, OTORHINOLARYNGOLOGY (EXCLUDING PLASTIC), AND UROLOGY.

EMERGENCY MEDICINE - NO MAJOR SURGERY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IV-A

SURGICAL SPECIALISTS IN PLASTIC SURGERY (NO ELECTED COSMETIC), ORTHOPEDIC - HAND, AND ORTHOPEDIC - HEAD AND NECK.

CLASS IV-B

SURGICAL SPECIALISTS IN GYNECOLOGY, AND ORTHOPEDIC SURGERY (EXCLUDING SPINAL).

CLASS V-A

EMERGENCY MEDICINE - INCLUDING MAJOR SURGERY.

CLASS V-B

SURGICAL SPECIALISTS IN GENERAL SURGERY, PLASTIC SURGERY (NOT OTHERWISE CLASSIFIED), AND ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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PHYSICIANS RATE CLASSES (CONT.)

CLASS VI

SURGICAL SPECIALISTS IN ABDOMINAL SURGERY.

CLASS VII

SURGICAL SPECIALISTS IN CARDIOVASCULAR SURGERY, TRAUMATIC SURGERY, THORACIC SURGERY, OBSTETRICS, AND OB/GYN AND VASCULAR SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: DUPAGE, JACKSON, KANE, LAKE, MCHENRY, AND VERMILLION COUNTIES .

TERRITORY 3: CHAMPAIGN, KANKAKEE, MACON, SANGAMON, AND WINNEBAGO COUNTIES.

TERRITORY 4: BUREAU, COLES, DEKALB, LASALLE, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 5: REMAINDER OF STATE.

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,001	5,441	8,042	9,962	10,363
1B	5,335	7,256	10,723	13,284	13,818
1C	6,269	8,526	12,601	15,610	16,237
2A	7,736	10,521	15,549	19,263	20,036
2B	8,803	11,972	17,694	21,919	22,800
2C	10,404	14,149	20,912	25,906	26,946
2D	11,204	15,237	22,520	27,898	29,018
3A	13,338	18,273	27,610	35,079	36,680
3B	14,405	19,735	29,818	37,885	39,614
4A	17,073	23,390	35,341	44,902	46,951
4B	19,473	26,678	40,309	51,214	53,551
5A	21,341	29,237	44,176	56,127	58,688
5B	25,075	34,353	51,905	65,947	68,956
6	29,344	40,201	60,742	77,175	80,696
7	31,478	43,125	65,159	82,787	86,565
8	41,348	56,647	85,590	108,745	113,707

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,540	7,534	11,135	13,795	14,349
1B	7,387	10,046	14,848	18,394	19,132
1C	8,680	11,805	17,447	21,613	22,481
2A	10,711	14,567	21,529	26,670	27,741
2B	12,189	16,577	24,500	30,351	31,570
2C	14,405	19,591	28,954	35,868	37,309
2D	15,513	21,098	31,181	38,627	40,179
3A	18,468	25,301	38,229	48,571	50,787
3B	19,945	27,325	41,286	52,455	54,849
4A	23,639	32,385	48,933	62,171	65,007
4B	26,963	36,939	55,813	70,913	74,148
5A	29,549	40,482	61,166	77,714	81,260
5B	34,720	47,566	71,870	91,314	95,480
6	40,630	55,663	84,104	106,857	111,733
7	43,584	59,710	90,219	114,626	119,856
8	57,251	78,434	118,510	150,570	157,440

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	9,234	12,558	18,560	22,993	23,916
1B	12,312	16,744	24,747	30,657	31,888
1C	14,467	19,675	29,079	36,023	37,470
2A	17,852	24,279	35,883	44,451	46,237
2B	20,315	27,628	40,833	50,584	52,616
2C	24,008	32,651	48,256	59,780	62,181
2D	25,856	35,164	51,971	64,381	66,967
3A	30,780	42,169	63,715	80,951	84,645
3B	33,242	45,542	68,811	87,426	91,416
4A	39,398	53,975	81,554	103,617	108,345
4B	44,939	61,566	93,024	118,190	123,582
5A	49,248	67,470	101,943	129,522	135,432
5B	57,866	79,276	119,783	152,188	159,132
6	67,716	92,771	140,172	178,093	186,219
7	72,641	99,518	150,367	191,046	199,763
8	95,418	130,723	197,515	250,949	262,400

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STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	11,081	15,070	22,273	27,592	28,700
1B	14,774	20,093	29,696	36,787	38,265
1C	17,360	23,610	34,894	43,226	44,962
2A	21,423	29,135	43,060	53,343	55,486
2B	24,377	33,153	48,998	60,699	63,136
2C	28,810	39,182	57,908	71,737	74,618
2D	31,027	42,197	62,364	77,257	80,360
3A	36,936	50,602	76,458	97,142	101,574
3B	39,891	54,651	82,574	104,913	109,700
4A	47,278	64,771	97,865	124,341	130,015
4B	53,926	73,879	111,627	141,825	148,297
5A	59,098	80,964	122,333	155,428	162,520
5B	69,440	95,133	143,741	182,627	190,960
6	81,259	111,325	168,206	213,711	223,462
7	87,169	119,422	180,440	229,254	239,715
8	114,502	156,868	237,019	301,140	314,881

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	12,312	16,744	24,747	30,657	31,888
1B	16,416	22,326	32,996	40,876	42,517
1C	19,289	26,233	38,771	48,030	49,959
2A	23,803	32,372	47,844	59,269	61,650
2B	27,086	36,837	54,443	67,444	70,153
2C	32,011	43,535	64,342	79,707	82,908
2D	34,474	46,885	69,293	85,840	89,288
3A	41,040	56,225	84,953	107,935	112,860
3B	44,323	60,723	91,749	116,569	121,888
4A	52,531	71,967	108,739	138,157	144,460
4B	59,918	82,088	124,030	157,584	164,775
5A	65,664	89,960	135,924	172,696	180,576
5B	77,155	105,702	159,711	202,918	212,176
6	90,288	123,695	186,896	237,457	248,292
7	96,854	132,690	200,488	254,726	266,349
8	127,224	174,297	263,354	334,599	349,866

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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ILLINOIS - AREA 2

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,534	3,446	5,093	6,310	6,563
1B	3,379	4,595	6,792	8,414	8,752
1C	3,970	5,399	7,980	9,885	10,282
2A	4,900	6,664	9,849	12,201	12,691
2B	5,575	7,582	11,206	13,882	14,439
2C	6,589	8,961	13,244	16,407	17,066
2D	7,096	9,651	14,263	17,669	18,379
3A	8,448	11,574	17,487	22,218	23,232
3B	9,123	12,499	18,885	23,993	25,088
4A	10,813	14,814	22,383	28,438	29,736
4B	12,333	16,896	25,529	32,436	33,916
5A	13,516	18,517	27,978	35,547	37,169
5B	15,881	21,757	32,874	41,767	43,673
6	18,585	25,461	38,471	48,879	51,109
7	19,936	27,312	41,268	52,432	54,824
8	26,188	35,878	54,209	68,874	72,017

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,509	4,772	7,053	8,737	9,088
1B	4,679	6,363	9,405	11,651	12,119
1C	5,497	7,476	11,049	13,688	14,237
2A	6,784	9,226	13,636	16,892	17,571
2B	7,720	10,499	15,517	19,223	19,995
2C	9,123	12,407	18,337	22,716	23,629
2D	9,825	13,362	19,748	24,464	25,447
3A	11,697	16,025	24,213	30,763	32,167
3B	12,632	17,306	26,148	33,222	34,738
4A	14,972	20,512	30,992	39,376	41,173
4B	17,077	23,395	35,349	44,913	46,962
5A	18,715	25,640	38,740	49,220	51,466
5B	21,990	30,126	45,519	57,834	60,473
6	25,733	35,254	53,267	67,678	70,766
7	27,604	37,817	57,140	72,599	75,911
8	36,260	49,676	75,058	95,364	99,715

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,849	7,955	11,756	14,564	15,149
1B	7,798	10,605	15,674	19,417	20,197
1C	9,162	12,460	18,416	22,813	23,730
2A	11,307	15,378	22,727	28,154	29,285
2B	12,866	17,498	25,861	32,036	33,323
2C	15,206	20,680	30,564	37,863	39,384
2D	16,376	22,271	32,916	40,776	42,414
3A	19,495	26,708	40,355	51,272	53,611
3B	21,054	28,844	43,582	55,372	57,899
4A	24,953	34,186	51,653	65,626	68,621
4B	28,462	38,993	58,916	74,855	78,271
5A	31,191	42,732	64,565	82,032	85,775
5B	36,650	50,211	75,866	96,390	100,788
6	42,888	58,757	88,778	112,795	117,942
7	46,007	63,030	95,234	120,998	126,519
8	60,433	82,793	125,096	158,939	166,191

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,018	9,544	14,106	17,475	18,177
1B	9,357	12,726	18,808	23,299	24,235
1C	10,994	14,952	22,098	27,375	28,474
2A	13,568	18,452	27,272	33,784	35,141
2B	15,440	20,998	31,034	38,446	39,990
2C	18,247	24,816	36,676	45,435	47,260
2D	19,651	26,725	39,499	48,931	50,896
3A	23,394	32,050	48,426	61,526	64,334
3B	25,265	34,613	52,299	66,447	69,479
4A	29,943	41,022	61,982	78,750	82,343
4B	34,154	46,791	70,699	89,825	93,924
5A	37,429	51,278	77,478	98,438	102,930
5B	43,979	60,251	91,037	115,665	120,942
6	51,466	70,508	106,535	135,356	141,532
7	55,208	75,635	114,281	145,197	151,822
8	72,519	99,351	150,114	190,725	199,427

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SPRINGFIELD, ILLINOIS

MATURE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,798	10,605	15,674	19,417	20,197
1B	10,397	14,140	20,898	25,889	26,928
1C	12,216	16,614	24,554	30,418	31,639
2A	15,076	20,503	30,303	37,539	39,047
2B	17,155	23,331	34,482	42,716	44,431
2C	20,274	27,573	40,751	50,482	52,510
2D	21,834	29,694	43,886	54,367	56,550
3A	25,993	35,610	53,806	68,362	71,481
3B	28,072	38,459	58,109	73,829	77,198
4A	33,270	45,580	68,869	87,500	91,493
4B	37,949	51,990	78,554	99,806	104,360
5A	41,588	56,976	86,087	109,376	114,367
5B	48,866	66,946	101,153	128,518	134,382
6	57,184	78,342	118,371	150,394	157,256
7	61,342	84,039	126,978	161,329	168,691
8	80,577	110,390	166,794	211,918	221,587

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,134	2,902	4,289	5,314	5,527
1B	2,845	3,869	5,718	7,084	7,369
1C	3,343	4,546	6,719	8,324	8,658
2A	4,126	5,611	8,293	10,274	10,686
2B	4,695	6,385	9,437	11,691	12,160
2C	5,548	7,545	11,151	13,815	14,369
2D	5,975	8,126	12,010	14,878	15,475
3A	7,114	9,746	14,726	18,710	19,564
3B	7,683	10,526	15,904	20,206	21,128
4A	9,105	12,474	18,847	23,946	25,039
4B	10,386	14,229	21,499	27,315	28,562
5A	11,382	15,593	23,561	29,935	31,301
5B	13,373	18,321	27,682	35,171	36,776
6	15,650	21,441	32,396	41,160	43,038
7	16,788	23,000	34,751	44,152	46,167
8	22,052	30,211	45,648	57,997	60,643

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,955	4,019	5,940	7,358	7,653
1B	3,940	5,358	7,919	9,811	10,205
1C	4,629	6,295	9,304	11,526	11,989
2A	5,713	7,770	11,483	14,225	14,797
2B	6,501	8,841	13,067	16,187	16,838
2C	7,682	10,448	15,441	19,128	19,896
2D	8,274	11,253	16,631	20,602	21,430
3A	9,850	13,495	20,390	25,906	27,088
3B	10,638	14,574	22,021	27,978	29,255
4A	12,607	17,272	26,096	33,156	34,669
4B	14,380	19,701	29,767	37,819	39,545
5A	15,759	21,590	32,621	41,446	43,337
5B	18,517	25,368	38,330	48,700	50,922
6	21,669	29,687	44,855	56,989	59,590
7	23,245	31,846	48,117	61,134	63,924
8	30,533	41,830	63,203	80,302	83,966

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PHYSICIANS AND SURGEONS

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2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,925	6,698	9,899	12,263	12,756
1B	6,566	8,930	13,198	16,349	17,006
1C	7,715	10,492	15,507	19,210	19,982
2A	9,521	12,949	19,137	23,707	24,659
2B	10,835	14,736	21,778	26,979	28,063
2C	12,804	17,413	25,736	31,882	33,162
2D	13,790	18,754	27,718	34,337	35,716
3A	16,416	22,490	33,981	43,174	45,144
3B	17,729	24,289	36,699	46,627	48,755
4A	21,012	28,786	43,495	55,262	57,783
4B	23,967	32,835	49,612	63,033	65,909
5A	26,265	35,983	54,369	69,077	72,229
5B	30,862	42,281	63,884	81,167	84,871
6	36,115	49,478	74,758	94,982	99,316
7	38,741	53,075	80,194	101,889	106,538
8	50,888	69,717	105,338	133,835	139,942

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	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,909	8,036	11,877	14,713	15,304
1B	7,880	10,717	15,839	19,621	20,409
1C	9,258	12,591	18,609	23,052	23,978
2A	11,426	15,539	22,966	28,451	29,593
2B	13,001	17,681	26,132	32,372	33,673
2C	15,365	20,896	30,884	38,259	39,795
2D	16,547	22,504	33,259	41,202	42,857
3A	19,699	26,988	40,777	51,808	54,172
3B	21,275	29,147	44,039	55,953	58,506
4A	25,214	34,543	52,193	66,313	69,339
4B	28,760	39,401	59,533	75,639	79,090
5A	31,518	43,180	65,242	82,892	86,675
5B	37,034	50,737	76,660	97,399	101,844
6	43,338	59,373	89,710	113,979	119,180
7	46,490	63,691	96,234	122,269	127,848
8	61,066	83,660	126,407	160,604	167,932

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,566	8,930	13,198	16,349	17,006
1B	8,755	11,907	17,598	21,800	22,675
1C	10,287	13,990	20,677	25,615	26,643
2A	12,695	17,265	25,517	31,611	32,880
2B	14,446	19,647	29,036	35,971	37,415
2C	17,072	23,218	34,315	42,509	44,216
2D	18,386	25,005	36,956	45,781	47,620
3A	21,888	29,987	45,308	57,565	60,192
3B	23,639	32,385	48,933	62,171	65,007
4A	28,016	38,382	57,993	73,682	77,044
4B	31,956	43,780	66,149	84,044	87,879
5A	35,020	47,977	72,491	92,103	96,305
5B	41,149	56,374	85,178	108,222	113,160
6	48,153	65,970	99,677	126,642	132,421
7	51,655	70,767	106,926	135,853	142,051
8	67,851	92,956	140,452	178,448	186,590

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

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STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

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STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

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STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46885

Professional Protection Exclusively since 1899

ILLINOIS - AREA 5

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

DIVISION OF INSURANCE
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	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE

INCREASED LIMITS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE

EXCESS LIMITS FACTORS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
1M/1M xs 1M/3M	1.280	1.320	1.320
2M/2M xs 1M/3M	1.473	1.502	1.502
3M/3M xs 1M/3M	1.556	1.592	1.592
4M/4M xs 1M/3M	1.615	1.660	1.660
5M/5M xs 1M/3M	1.661	1.727	1.727
6M/6M xs 1M/3M	1.706	1.778	1.778
7M/7M xs 1M/3M	1.751	1.825	1.825
8M/8M xs 1M/3M	1.790	1.866	1.866
9M/9M xs 1M/3M	1.829	1.895	1.895

Note: For aggregate limits not listed above, refer to company.

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE

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CLAIMS-MADE FACTORS

YEARS SINCE RETROACTIVE DATE	FACTOR
0	0.325
1	0.450
2	0.750
3	0.900
4 OR MORE	1.000
MATURE CLAIMS-MADE TO OCCURRENCE FACTOR	0.975

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE

EXTENSION CONTRACT FACTORS

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

EFFECTIVE DATE JAN 0 1 1999

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STANDARD CLAIMS MADE PROGRAM

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ACCELERATED EXTENSION CONTRACT RULE

AN INSURED MAY QUALIFY FOR AN ACCELERATED EXTENSION CONTRACT, FOR NO ADDITIONAL PREMIUM, IF THE FOLLOWING UNDERWRITING REQUIREMENTS HAVE BEEN MET:

1) THE INSURED ANTICIPATES RETIREMENT FROM HIS OR HER PROFESSION IN LESS THAN FIVE YEARS.

2) THE INSURED HAS ATTAINED AGE 55.

3) THE INSURED IS A MEMBER OF A GROUP PRACTICE THAT HAS CLAIMS-MADE COVERAGE WITH THE COMPANY.

4) THE INSURED HAS LIMITED PRIOR ACTS EXPOSURE BASED UPON UNDERWRITING REVIEW.

THE TOTAL NUMBER OF INSUREDS, WITHIN A GROUP PRACTICE, THAT MAY QUALIFY FOR THE ACCELERATED EXTENSION CONTRACT MAY NOT EXCEED A RATIO OF 1 IN 3.

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PHYSICIANS AND SURGEONS

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 YEARS, 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 10 YEARS, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

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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 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.

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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 AND SCHEDULE RATING MODIFICATIONS.

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STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

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

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

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

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

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

FULL TIME EQUIVALENCY RATING RULE (CONT.)

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

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
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 NEW TO PRACTICE, PART TIME PRACTICE, OR LOSS FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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STANDARD CLAIMS MADE PROGRAM

LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN WHO BECOMES DISABLED OR IS ON LEAVE OF ABSENCE FOR A CONTINUOUS PERIOD OF 45 DAYS OR MORE, MAY BE ELIGIBLE FOR RESTRICTED COVERAGE AT A DISCOUNT OF 50% OF THE APPLICABLE RATE FOR THE PERIOD OF DISABILITY OR LEAVE OF ABSENCE. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF DISABILITY OR LEAVE OF ABSENCE. LEAVE OF ABSENCE MAY INCLUDE TIME TO ENHANCE THE PHYSICIAN'S EDUCATION, BUT DOES NOT INCLUDE VACATION TIME. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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STANDARD CLAIMS MADE PROGRAM

LOCUM TENENS

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

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

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STANDARD CLAIMS MADE PROGRAM

LOSS FREE CREDIT

IF NO LOSS HAS BEEN ATTRIBUTED TO AN INSURED, THE INSURED WILL BE ELIGIBLE FOR PREMIUM CREDITS ON THE FOLLOWING SCHEDULE:

1. IF INSURED BY THE COMPANY AND LOSS 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 LOSS FREE FOR 5 YEARS BUT LESS THAN 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND LOSS FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% SHALL BE APPLIED TO THE NEXT POLICY RENEWAL.

A LOSS 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS LOSS FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE LOSS FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH STANDARD GUIDELINES APPLICABLE TO THE COMPANY'S INSUREDS.

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STANDARD CLAIMS MADE PROGRAM

MEMBERSHIP ASSOCIATION CREDIT RULE

THE UNIQUE CHARACTERISTICS OF A MEDICAL 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 5% 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 PHYSICIAN WHO IS ON A MILITARY 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. THIS WILL APPLY RETROACTIVELY TO THE FIRST DAY OF THE LEAVE OF ABSENCE. ONLY ONE APPLICATION OF THIS CREDIT MAY BE APPLIED TO AN ANNUAL POLICY PERIOD.

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MINIMUM PREMIUM REQUIREMENT RULE

ALL POLICIES ARE SUBJECT TO A MINIMUM PREMIUM OF $250. 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

NEW TO PRACTICE CREDIT

A "NEW" PHYSICIAN SHALL BE A PHYSICIAN WHO HAS RECENTLY COMPLETED ONE OF THE FOLLOWING PROGRAMS AND WILL BEGIN A FULL TIME PRACTICE FOR THE FIRST TIME:

A) RESIDENCY;
B) FELLOWSHIP PROGRAM IN THEIR MEDICAL SPECIALITY;
C) FULFILLMENT OF A MILITARY OBLIGATION IN REMUNERATION FOR MEDICAL SCHOOL TUITION;
D) MEDICAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

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

CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR AND CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR MEDICAL 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 MADE AGAINST THE INSURED DURING THE PAST 5 YEARS PURSUANT TO THE FOLLOWING SCHEDULE:

Closed 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 $100,00 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

HOWEVER, PROVIDERS WHO HAVE BEEN INSURED WITH THE COMPANY FOR LESS THAN FIVE COMPLETE YEARS WILL HAVE THEIR POINTS ADJUSTED PURSUANT TO THE FOLLOWING FORMULA:

Adjusted Points = (5 / # of Full Years of Experience) x Points

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE.

THE
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STANDARD CLAIMS MADE PROGRAM

NON-DISCRETIONARY DEBIT PLAN

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

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. 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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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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PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

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 PHYSICIANS.

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

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 RISK MANAGEMENT AND/OR MEMBERSHIP ASSOCIATION.

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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 THE APPROVAL OF THE COMPANY.

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RENEWAL PREMIUM INCREASE LIMITATION

THE RENEWAL PREMIUM SHALL BE BASED UPON THE RATES IN EFFECT ON THE RENEWAL OR ANNIVERSARY DATE PROVIDED. HOWEVER, WITH RESPECT TO ANY INDIVIDUAL POLICY OR RISK RECEIVING A PREMIUM INCREASE, THAT PORTION OF THE PREMIUM INCREASE SPECIFICALLY CAUSED BY FILED CHANGES IN THE BASE RATE, INCREASED LIMIT FACTORS, CLAIMS MADE STEP FACTORS, TERRITORY FACTORS AND CLASS RELATIVITIES SHALL BE LESS THAN 30%. AT EACH SUBSEQUENT RENEWAL, THE BASE RATE, INCREASED LIMIT FACTOR, CLAIMS MADE STEP FACTOR, TERRITORY FACTOR AND CLASS RELATIVITY FOR AN AFFECTED INSURED WILL CONTINUE TO INCREASE (SUBJECT AGAIN TO A MAXIMUM COMBINED INCREASE OF LESS THAN 30%) UNTIL HIS/HER RATE MATCHES THOSE CURRENTLY APPROVED FOR USE IN THE STATE.

EFFECTIVE DATE JAN 0 1 1999

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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.

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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 -50% / +50%, 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:

1. <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.

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SCHEDULE RATING PLAN

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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES 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 INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

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7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. MEDICAL STANDARDS, QUALITY AND CLAIMS 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.

9. OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:
ADDITIONAL ACTIVITIES 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.

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SCHEDULE RATING PLAN

11. RECORD-KEEPING PRACTICES:
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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.

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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SLOT RATING RULE

COVERAGE FOR MULTI-PHYSICIAN GROUPS IS AVAILABLE, AT THE COMPANY'S OPTION, ON A SLOT BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. THE SLOT ENDORSEMENT WILL IDENTIFY THE INDIVIDUALS AND PRACTICE SETTINGS THAT ARE COVERED. COVERAGE WILL BE PROVIDED ON A SHARED LIMIT BASIS FOR THOSE INSUREDS MOVING THROUGH THE SLOT OR POSITION.

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 LOSS FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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SOLO CORPORATION COVERAGE

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

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

Last Update: August 21, 2001

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Standard Claims Made Program

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WITHDRAWN FORMS
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Medical Professional Liability Insurance Application

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State Statutory Requirement

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 Physicians/Surgeons.

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 physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical 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.

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B. Part Time Physicians

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 and membership association credits.

C. Physicians in Training

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

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

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

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

   Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

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

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   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.

D. Locum Tenens Physician

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

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

E. New Physician

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

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a. Residency;

b. Fellowship program in their medical specialty;

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

d. Medical school or specialty training program.

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

3. A reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

F. Physician Teaching Specialists

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

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

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

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

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.

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G. Physician's Leave of Absence

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

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

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

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

H. Military Leave of Absence

1. A dentist who is on military leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a discount presented in the state rate pages. This will apply retroactively to the first day of the leave of absence. Only on application of this credit may be applied to an annual policy period.

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 risk 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.

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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.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit 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, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidlines.

   c. Years Part time will not be considered in the determination of years claim free.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Deductibles shall be offered to qualified insureds.

   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.

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iii. The maximum premium credit is limited to 75% 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 claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

a. Premiums paid
b. Number of claims
c. Incurred losses
d. 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.

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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 made against the insured during the past 5 years pursuant to the Schedule A, located in the State Rate Pages.

However, Providers who have been insured with the Company for less than five years will have their points adjusted pursuant to the following formula:

Adjusted Points = (5 / # of Full Years of Experience) x Points

Insureds with Less than one year of experience shall be assumed to have one year of experience.

A debit shall then be applied to the insured's rate based upon Schedule B, located 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.

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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 losses attributed to the insured. (A loss 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 coverage.

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 and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

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3. The Enhanced Claims-Made base rate is subject to Loss Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

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

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit cannot be used in conjunction with this rating rule.

D. 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 physician basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each physician's number of hours of medical practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
2,100 - Residency Programs

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2. For group practices, the minimum average FTE assigned to individual physicians is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

4. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

5. Premium modifications for new physician, part time, moonlighting, teaching, loss free credit or other similar credit cannot be used in conjunction with this rating rule.

E. 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 physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician 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.

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3. The applicable medical 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 physician, part time, moonlighting, teaching, loss free credit, or other similar credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and an Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability or permanent retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. Insureds within a group may qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

   a. The insured anticipates permanent retirement from his or her profession in less than five years.

   b. The insured has attained age 55.

   c. The insured has claims-made coverage with the Company in a group practice.

   d. The insured has limited prior acts exposure based upon underwriting review.

   e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 3.

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G. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the state rate pages.

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PHYSICIANS & SURGEONS

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.

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CLASS IA

Non-Surgical Specialists to include:
Aerospace, Allergy, Dermatology, Forensic Medicine, Nuclear, Nutrition, Occupational Medicine, Ophthalmology, Pharmacology, Physiatry, Physicians Not Otherwise Classified, Preventative Medicine, and Public Health.

CLASS IB

Non-Surgical Specialists to include:
Endocrinology, Geriatrics, Gynecology, Otorhinolaryngology, Pathology, Psychiatry, and Rheumatology.

CLASS IC

Non-Surgical Specialists to include:
Diabetes, Family/General Practice, Nephrology, and Urgent Care.

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Dermatology and Ophthalmology.

CLASS IIA

Non-Surgical Specialists to include Internal Medicine, and Pediatrics.

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Cardiology (Including Swan-Ganz), Endocrinology, Geriatrics, Gynecology, and Otorhinolaryngology.

Surgical specialists performing Anesthesiology, Ophthalmology and Pain Management.

CLASS IIB

Non-Surgical Specialists to include Hematology/Oncology, Infectious Disease, and Radiology – Diagnostic.

Specialists performing minor surgery or assisting in major surgery on their own patients to include Nephrology, Pathology, Pediatrics, Psychiatry - including Shock Therapy, physicians not otherwise classified, and Radiology – Therapy.

CLASS IIC

Non-Surgical Specialists to include: Gastroenterology, Neurology, and Pulmonary Disease.

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Infectious Disease, Neonatology, Neurology and Radiopaque Dye Injection.

CLASS IID

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Cardiology specialists performing right heart catheterization only, Cardiology specialists performing catheterization including left heart, Gastroenterology, Internal Medicine, Intensive Care and Radiology – diagnostic.

CLASS IIIA

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Acupuncturists, Family/General Practice, and Hematology/Oncology.

Surgical specialists in Gastroenterology, and Geriatrics.

CLASS IIIB

Specialists performing minor surgery or assisting in major surgery on their own patients to include: and Family Practice and General Practice – including deliveries.

Surgical specialists in Colon and Rectal Surgery, Family/General Practice, Otorhinolaryngology (excluding plastic), and Urology.

Emergency Medicine - no major surgery.

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CLASS IV-A

Surgical specialists in Plastic Surgery (no elected cosmetic), Orthopedic - Hand, and Orthopedic - Head and Neck.

CLASS IV-B

Surgical Specialists in Gynecology, and Orthopedic Surgery (excluding spinal).

CLASS V-A

Emergency Medicine - including major surgery.

CLASS V-B

Surgical Specialists in General Surgery, Plastic Surgery (not otherwise classified), and Orthopedic Surgery (including spinal).

CLASS VI

Surgical Specialists in Abdominal Surgery.

CLASS VII

Surgical specialists in Cardiovascular Surgery, Traumatic Surgery, Thoracic Surgery, Obstetrics, and OB/GYN and Vascular Surgery.

CLASS VIII

Surgical specialists in Neurological Surgery.

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B. Manual Rates

1. Territory Definitions

Area 1	Cook, Madison, St. Clair, and Will Counties
Area 2	DuPage, Jackson, Kane, Lake, McHenry and Vermilion Counties
Area 3	Champaign, Kankakee, Macon, Sangamon, and Winnebago Counties
Area 4	Bureau, Coles DeKalb, LaSalle, Ogle and Randolph Counties
Area 5	Remainder of State

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2. Occurrence Program

a. Area 1

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	12,627	17,173	25,380	31,441	32,704
1B	16,836	22,897	33,840	41,922	43,605
1C	19,782	26,904	39,762	49,257	51,235
2A	24,412	33,200	49,068	60,786	63,227
2B	27,779	37,779	55,836	69,170	71,948
2C	32,830	44,649	65,988	81,747	85,030
2D	35,356	48,084	71,066	88,036	91,572
3A	42,090	57,663	87,126	110,697	115,748
3B	45,457	62,276	94,096	119,552	125,007
4A	53,875	73,809	111,521	141,691	148,156
4B	61,451	84,188	127,204	161,616	168,990
5A	67,344	92,261	139,402	177,115	185,196
5B	79,129	108,407	163,797	208,109	217,605
6	92,598	126,859	191,678	243,533	254,645
7	99,332	136,085	205,617	261,243	273,163
8	130,479	178,756	270,092	343,160	358,817

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b. Area 2

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,997	10,876	16,074	19,913	20,712
1B	10,663	14,502	21,433	26,551	27,617
1C	12,529	17,039	25,183	31,197	32,450
2A	15,461	21,027	31,077	38,498	40,044
2B	17,594	23,928	35,364	43,809	45,568
2C	20,793	28,278	41,794	51,775	53,854
2D	22,392	30,453	45,008	55,756	57,995
3A	26,658	36,521	55,182	70,111	73,310
3B	28,790	39,442	59,595	75,718	79,173
4A	34,122	46,747	70,633	89,741	93,836
4B	38,920	53,320	80,564	102,360	107,030
5A	42,652	58,433	88,290	112,175	117,293
5B	50,116	68,659	103,740	131,805	137,819
6	58,647	80,346	121,399	154,242	161,279
7	62,912	86,189	130,228	165,459	173,008
8	82,638	113,214	171,061	217,338	227,255

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c. Area 3

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,734	9,158	13,535	16,768	17,441
1B	8,979	12,211	18,048	22,358	23,256
1C	10,550	14,348	21,206	26,270	27,325
2A	13,020	17,707	26,170	32,420	33,722
2B	14,815	20,148	29,778	36,889	38,371
2C	17,509	23,812	35,193	43,597	45,348
2D	18,856	25,644	37,901	46,951	48,837
3A	22,448	30,754	46,467	59,038	61,732
3B	24,243	33,213	50,183	63,759	66,668
4A	28,733	39,364	59,477	75,568	79,016
4B	32,773	44,899	67,840	86,193	90,126
5A	35,916	49,205	74,346	94,459	98,769
5B	42,201	57,815	87,356	110,989	116,053
6	49,385	67,657	102,227	129,883	135,809
7	52,976	72,577	109,660	139,327	145,684
8	69,587	95,334	144,045	183,014	191,364

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d. Area 4

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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e. Area 5

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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3. Standard Claims-Made Programs

a. Area 1

0 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,001	5,441	8,042	9,962	10,363
1B	5,335	7,256	10,723	13,284	13,818
1C	6,269	8,526	12,601	15,610	16,237
2A	7,736	10,521	15,549	19,263	20,036
2B	8,803	11,972	17,694	21,919	22,800
2C	10,404	14,149	20,912	25,906	26,946
2D	11,204	15,237	22,520	27,898	29,018
3A	13,338	18,273	27,610	35,079	36,680
3B	14,405	19,735	29,818	37,885	39,614
4A	17,073	23,390	35,341	44,902	46,951
4B	19,473	26,678	40,309	51,214	53,551
5A	21,341	29,237	44,176	56,127	58,688
5B	25,075	34,353	51,905	65,947	68,956
6	29,344	40,201	60,742	77,175	80,696
7	31,478	43,125	65,159	82,787	86,565
8	41,348	56,647	85,590	108,745	113,707

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1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,540	7,534	11,135	13,795	14,349
1B	7,387	10,046	14,848	18,394	19,132
1C	8,680	11,805	17,447	21,613	22,481
2A	10,711	14,567	21,529	26,670	27,741
2B	12,189	16,577	24,500	30,351	31,570
2C	14,405	19,591	28,954	35,868	37,309
2D	15,513	21,098	31,181	38,627	40,179
3A	18,468	25,301	38,229	48,571	50,787
3B	19,945	27,325	41,286	52,455	54,849
4A	23,639	32,385	48,933	62,171	65,007
4B	26,963	36,939	55,813	70,913	74,148
5A	29,549	40,482	61,166	77,714	81,260
5B	34,720	47,566	71,870	91,314	95,480
6	40,630	55,663	84,104	106,857	111,733
7	43,584	59,710	90,219	114,626	119,856
8	57,251	78,434	118,510	150,570	157,440

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2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	9,234	12,558	18,560	22,993	23,916
1B	12,312	16,744	24,747	30,657	31,888
1C	14,467	19,675	29,079	36,023	37,470
2A	17,852	24,279	35,883	44,451	46,237
2B	20,315	27,628	40,833	50,584	52,616
2C	24,008	32,651	48,256	59,780	62,181
2D	25,856	35,164	51,971	64,381	66,967
3A	30,780	42,169	63,715	80,951	84,645
3B	33,242	45,542	68,811	87,426	91,416
4A	39,398	53,975	81,554	103,617	108,345
4B	44,939	61,566	93,024	118,190	123,582
5A	49,248	67,470	101,943	129,522	135,432
5B	57,866	79,276	119,783	152,188	159,132
6	67,716	92,771	140,172	178,093	186,219
7	72,641	99,518	150,367	191,046	199,763
8	95,418	130,723	197,515	250,949	262,400

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Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	12,312	16,744	24,747	30,657	31,888
1B	16,416	22,326	32,996	40,876	42,517
1C	19,289	26,233	38,771	48,030	49,959
2A	23,803	32,372	47,844	59,269	61,650
2B	27,086	36,837	54,443	67,444	70,153
2C	32,011	43,535	64,342	79,707	82,908
2D	34,474	46,885	69,293	85,840	89,288
3A	41,040	56,225	84,953	107,935	112,860
3B	44,323	60,723	91,749	116,569	121,888
4A	52,531	71,967	108,739	138,157	144,460
4B	59,918	82,088	124,030	157,584	164,775
5A	65,664	89,960	135,924	172,696	180,576
5B	77,155	105,702	159,711	202,918	212,176
6	90,288	123,695	186,896	237,457	248,292
7	96,854	132,690	200,488	254,726	266,349
8	127,224	174,297	263,354	334,599	349,866

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b. Area 2

0 Years Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,534	3,446	5,093	6,310	6,563
1B	3,379	4,595	6,792	8,414	8,752
1C	3,970	5,399	7,980	9,885	10,282
2A	4,900	6,664	9,849	12,201	12,691
2B	5,575	7,582	11,206	13,882	14,439
2C	6,589	8,961	13,244	16,407	17,066
2D	7,096	9,651	14,263	17,669	18,379
3A	8,448	11,574	17,487	22,218	23,232
3B	9,123	12,499	18,885	23,993	25,088
4A	10,813	14,814	22,383	28,438	29,736
4B	12,333	16,896	25,529	32,436	33,916
5A	13,516	18,517	27,978	35,547	37,169
5B	15,881	21,757	32,874	41,767	43,673
6	18,585	25,461	38,471	48,879	51,109
7	19,936	27,312	41,268	52,432	54,824
8	26,188	35,878	54,209	68,874	72,017

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1 Year Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,509	4,772	7,053	8,737	9,088
1B	4,679	6,363	9,405	11,651	12,119
1C	5,497	7,476	11,049	13,688	14,237
2A	6,784	9,226	13,636	16,892	17,571
2B	7,720	10,499	15,517	19,223	19,995
2C	9,123	12,407	18,337	22,716	23,629
2D	9,825	13,362	19,748	24,464	25,447
3A	11,697	16,025	24,213	30,763	32,167
3B	12,632	17,306	26,148	33,222	34,738
4A	14,972	20,512	30,992	39,376	41,173
4B	17,077	23,395	35,349	44,913	46,962
5A	18,715	25,640	38,740	49,220	51,466
5B	21,990	30,126	45,519	57,834	60,473
6	25,733	35,254	53,267	67,678	70,766
7	27,604	37,817	57,140	72,599	75,911
8	36,260	49,676	75,058	95,364	99,715

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,849	7,955	11,756	14,564	15,149
1B	7,798	10,605	15,674	19,417	20,197
1C	9,162	12,460	18,416	22,813	23,730
2A	11,307	15,378	22,727	28,154	29,285
2B	12,866	17,498	25,861	32,036	33,323
2C	15,206	20,680	30,564	37,863	39,384
2D	16,376	22,271	32,916	40,776	42,414
3A	19,495	26,708	40,355	51,272	53,611
3B	21,054	28,844	43,582	55,372	57,899
4A	24,953	34,186	51,653	65,626	68,621
4B	28,462	38,993	58,916	74,855	78,271
5A	31,191	42,732	64,565	82,032	85,775
5B	36,650	50,211	75,866	96,390	100,788
6	42,888	58,757	88,778	112,795	117,942
7	46,007	63,030	95,234	120,998	126,519
8	60,433	82,793	125,096	158,939	166,191

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	7,018	9,544	14,106	17,475	18,177
1B	9,357	12,726	18,808	23,299	24,235
1C	10,994	14,952	22,098	27,375	28,474
2A	13,568	18,452	27,272	33,784	35,141
2B	15,440	20,998	31,034	38,446	39,990
2C	18,247	24,816	36,676	45,435	47,260
2D	19,651	26,725	39,499	48,931	50,896
3A	23,394	32,050	48,426	61,526	64,334
3B	25,265	34,613	52,299	66,447	69,479
4A	29,943	41,022	61,982	78,750	82,343
4B	34,154	46,791	70,699	89,825	93,924
5A	37,429	51,278	77,478	98,438	102,930
5B	43,979	60,251	91,037	115,665	120,942
6	51,466	70,508	106,535	135,356	141,532
7	55,208	75,635	114,281	145,197	151,822
8	72,519	99,351	150,114	190,725	199,427

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,798	10,605	15,674	19,417	20,197
1B	10,397	14,140	20,898	25,889	26,928
1C	12,216	16,614	24,554	30,418	31,639
2A	15,076	20,503	30,303	37,539	39,047
2B	17,155	23,331	34,482	42,716	44,431
2C	20,274	27,573	40,751	50,482	52,510
2D	21,834	29,694	43,886	54,367	56,550
3A	25,993	35,610	53,806	68,362	71,481
3B	28,072	38,459	58,109	73,829	77,198
4A	33,270	45,580	68,869	87,500	91,493
4B	37,949	51,990	78,554	99,806	104,360
5A	41,588	56,976	86,087	109,376	114,367
5B	48,866	66,946	101,153	128,518	134,382
6	57,184	78,342	118,371	150,394	157,256
7	61,342	84,039	126,978	161,329	168,691
8	80,577	110,390	166,794	211,918	221,587

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

c. Area 3

0 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,134	2,902	4,289	5,314	5,527
1B	2,845	3,869	5,718	7,084	7,369
1C	3,343	4,546	6,719	8,324	8,658
2A	4,126	5,611	8,293	10,274	10,686
2B	4,695	6,385	9,437	11,691	12,160
2C	5,548	7,545	11,151	13,815	14,369
2D	5,975	8,126	12,010	14,878	15,475
3A	7,114	9,746	14,726	18,710	19,564
3B	7,683	10,526	15,904	20,206	21,128
4A	9,105	12,474	18,847	23,946	25,039
4B	10,386	14,229	21,499	27,315	28,562
5A	11,382	15,593	23,561	29,935	31,301
5B	13,373	18,321	27,682	35,171	36,776
6	15,650	21,441	32,396	41,160	43,038
7	16,788	23,000	34,751	44,152	46,167
8	22,052	30,211	45,648	57,997	60,643

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,955	4,019	5,940	7,358	7,653
1B	3,940	5,358	7,919	9,811	10,205
1C	4,629	6,295	9,304	11,526	11,989
2A	5,713	7,770	11,483	14,225	14,797
2B	6,501	8,841	13,067	16,187	16,838
2C	7,682	10,448	15,441	19,128	19,896
2D	8,274	11,253	16,631	20,602	21,430
3A	9,850	13,495	20,390	25,906	27,088
3B	10,638	14,574	22,021	27,978	29,255
4A	12,607	17,272	26,096	33,156	34,669
4B	14,380	19,701	29,767	37,819	39,545
5A	15,759	21,590	32,621	41,446	43,337
5B	18,517	25,368	38,330	48,700	50,922
6	21,669	29,687	44,855	56,989	59,590
7	23,245	31,846	48,117	61,134	63,924
8	30,533	41,830	63,203	80,302	83,966

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,925	6,698	9,899	12,263	12,756
1B	6,566	8,930	13,198	16,349	17,006
1C	7,715	10,492	15,507	19,210	19,982
2A	9,521	12,949	19,137	23,707	24,659
2B	10,835	14,736	21,778	26,979	28,063
2C	12,804	17,413	25,736	31,882	33,162
2D	13,790	18,754	27,718	34,337	35,716
3A	16,416	22,490	33,981	43,174	45,144
3B	17,729	24,289	36,699	46,627	48,755
4A	21,012	28,786	43,495	55,262	57,783
4B	23,967	32,835	49,612	63,033	65,909
5A	26,265	35,983	54,369	69,077	72,229
5B	30,862	42,281	63,884	81,167	84,871
6	36,115	49,478	74,758	94,982	99,316
7	38,741	53,075	80,194	101,889	106,538
8	50,888	69,717	105,338	133,835	139,942

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,909	8,036	11,877	14,713	15,304
1B	7,880	10,717	15,839	19,621	20,409
1C	9,258	12,591	18,609	23,052	23,978
2A	11,426	15,539	22,966	28,451	29,593
2B	13,001	17,681	26,132	32,372	33,673
2C	15,365	20,896	30,884	38,259	39,795
2D	16,547	22,504	33,259	41,202	42,857
3A	19,699	26,988	40,777	51,808	54,172
3B	21,275	29,147	44,039	55,953	58,506
4A	25,214	34,543	52,193	66,313	69,339
4B	28,760	39,401	59,533	75,639	79,090
5A	31,518	43,180	65,242	82,892	86,675
5B	37,034	50,737	76,660	97,399	101,844
6	43,338	59,373	89,710	113,979	119,180
7	46,490	63,691	96,234	122,269	127,848
8	61,066	83,660	126,407	160,604	167,932

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,566	8,930	13,198	16,349	17,006
1B	8,755	11,907	17,598	21,800	22,675
1C	10,287	13,990	20,677	25,615	26,643
2A	12,695	17,265	25,517	31,611	32,880
2B	14,446	19,647	29,036	35,971	37,415
2C	17,072	23,218	34,315	42,509	44,216
2D	18,386	25,005	36,956	45,781	47,620
3A	21,888	29,987	45,308	57,565	60,192
3B	23,639	32,385	48,933	62,171	65,007
4A	28,016	38,382	57,993	73,682	77,044
4B	31,956	43,780	66,149	84,044	87,879
5A	35,020	47,977	72,491	92,103	96,305
5B	41,149	56,374	85,178	108,222	113,160
6	48,153	65,970	99,677	126,642	132,421
7	51,655	70,767	106,926	135,853	142,051
8	67,851	92,956	140,452	178,448	186,590

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

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0 Years Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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SPRINGFIELD, ILLINOIS

1 Year Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

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0 Years Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

4. Increased Limits Factors

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8-8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

* A minimum of 1000/3000 underlying limits required

5. Excess Limits Factors

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8-8
1M/1M xs 1M/3M	1.280	1.320	1.320
2M/2M xs 1M/3M	1.473	1.502	1.502
3M/3M xs 1M/3M	1.556	1.592	1.592
4M/4M xs 1M/3M	1.615	1.660	1.660
5M/5M xs 1M/3M	1.661	1.727	1.727
6M/6M xs 1M/3M	1.706	1.778	1.778
7M/7M xs 1M/3M	1.751	1.825	1.825
8M/8M xs 1M/3M	1.790	1.866	1.866
9M/9M xs 1M/3M	1.829	1.895	1.895

Note: For aggregate limits not listed above, refer to company.

6. Extended Reporting Period Coverage Factors

Years Since Retroactive Date	Standard Claims-Made Factor *	Enhanced Factor *
1	0.900	N/A
2	1.500	N/A
3	1.700	N/A
4 OR MORE	1.820	N/A

* Factors are applicable to mature claims-made rate

7. Shared Limits Modification

Modification
Up to 25%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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6. Extended Reporting Period Coverage Factors

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

7. Shared Limits Modification

Modification
Up to 25%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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C. **Policy Writing Minimum Premium**
(Occurrence & Standard Claims Made Programs)

Physician & Surgeons	$250

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

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

AVAILABLE

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

Years New to Practice	Credit
1st	50%
2nd	30%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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5. **Physician Teaching Specialists**

   a. Training Activities

NOT AVAILABLE

   b. Teaching Specialists

NOT AVAILABLE

6. **Physicians Leave of Absence**

Program	Credit
Occurrence	75%
Standard Claims Made	50%

7. **Physicians Military Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

DIVISION OF INSURANCE
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8. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Medical 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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

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

Year	Credit
1	5%
2	5%
3	5%

10. **Claim Free Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 10	10%
10 or more	20%

11. **Deductible Credits**

NOT AVAILABLE

12. **Self-Insured Retention Credits**

NOT AVAILABLE

13. **Experience Rating**

NOT AVAILABLE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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OCT 01 2004
SPRINGFIELD, ILLINOIS

14. **Non-Discretionary Debit Rating Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Closed 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 $100,00 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	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code.

15. **Convertible Coverage Rating Plan**

NOT AVAILABLE

16. **Enhanced Claims Made Rating**

NOT AVAILABLE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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OCT 01 2004
SPRINGFIELD, ILLINOIS

17. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

19. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Renewal Rate Rule**

NOT AVAILABLE

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

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.

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

Credit
5%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
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JUL 01 2008
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July 1, 2008

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
WITHDRAWN
JUL 08 2008
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 08-IL-113
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Chicago Lake Shore

POLICY IN EFFECT: ***July 1, 2008 – July 1, 2009***

Dear Ms. Neuman:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Chicago Lake Shore,* for your review and consideration. We request the effective date of this submission be effective **July 1, 2008 – July 1, 2009.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification 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 contact me. Thank you.

Sincerely,

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

Enclosures

FO
MCM
RVL

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Tuesday, July 01, 2008 3:20 PM
To: Neuman, Gayle
Subject: The Medical Protective Company, Individual Risk Filing, Company Filing # 08-IL-113
Attachments: cover letter.pdf; actuarial certification.pdf; indiv risk applicatin_lake shore.pdf; rule.pdf

Hi, Ms. Neuman,

Thank you for discussing the attached filing with Dave Sherman and I today. We appreciate you allowing us to the send in the individual risk filing via email in order to meet the 7/1/08 effective date. Please find attached the cover letter, actuarial certification, individual risk application and the applicable rule assocated with the individual risk filing for filing purposes.

<<cover letter.pdf>> <<actuarial certification.pdf>> <<indiv risk applicatin_lake shore.pdf>> <<rule.pdf>>

Please let me know if you should have any questions regarding this filing.
Sincerely,
Melissa Coker

Melissa Coker, Paralegal
Legal Department
Medical Protective

The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835
Phone: 260-486-0838
Fax: 260-486-0733
Email: melissa.coker@medpro.com
web: www.medicalprotective.com

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, James Kunce, FCAS, MAAA, SVP and Chief Actuary SVP & Actuary, 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, James Kunce, FCAS, MAAA, SVP and Chief Actuary, 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.

_____; SVP and Chief Actuary — 07/01/08
Signature and Title of Authorized Insurance Company Officer — Date

_____;FCAS, MAAA, SVP and Chief Actuary — 07/01/08
Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 08-IL-113

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date 07/01/2008: Degree: MD Region: MW - IL

Check One:
Individual
Group **X**

1. INSURED: Chicago Lake Shore Associates LTD.
2. QUOTED PREMIUM: $20,000
3. MANUAL PREMIUM: Not applicable – no rate filed for requested limit
4. LIMITS: $1M/$8M
5. SELECT ONE:
6. EFFECTIVE DATE: 07/01/2008
7. EXPIRATION DATE: 07/01/2009
8. POLICY NUMBER(S): To Be Determined
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes **X** No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

    The premium charge for the aggregate limit was based on a charge for each additional $1M of aggregate limit in excess of the standard $1M/$3M limit for corporation coverage. The cumulative charge for the additional $5M aggregate limit was determined to be $20,000, which is approximately double the underlying corporation premium charge and approximately 2.4% of the underlying physician premium.

12. WHY WAS THE RISK INDIVIDUALLY RATED?

    The limit requested for the corporation coverage, $1M/$8M, was not available under the Company's current rates and rules.

13. SPECIAL INFORMATION RELATED TO THE RISK:

None

14. ADDITIONAL COMMENTS:

None

Underwriter: Norma Jean Hansen

Underwriting Supervisor Approval:

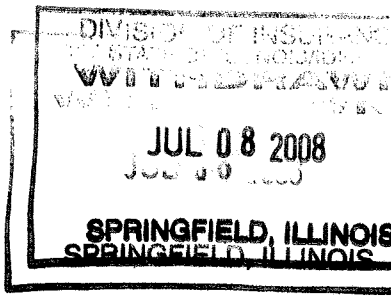
Date: 07/01/2008

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899



ILLINOIS

INDIVIDUAL RISK RATING PLAN

PARTNERSHIP/CORPORATION RATING FOR ADDITIONAL AGGREGATE LIMITS

IN THOSE INSTANCES IN WHICH INSURED GROUPS REQUEST AGGREGATE LIMITS FOR THE PARTNERSHIP/CORPORATION COVERAGE THAT EXCEEDS THREE TIMES THE PER INCIDENT LIMIT, THE COMPANY MAY PROVIDE ADDITIONAL AGGREGATE LIMITS, UP TO A MAXIMUM OF $10M, SUBJECT TO UNDERWRITING REVIEW. THE INSURED PARTNERSHIP/CORPORATION PREMIUM WILL BE INDIVIDUALLY RISK RATED, SUBJECT TO THE FOLLOWING PARAMETERS:

THE FINAL RATE WILL BE DERIVED BY UTILIZING A 7.5% TO 15% RATING FACTOR FOR THE FIRST $1M OF AGGREGATE LIMITS. THE RATING FACTOR FOR EACH SUCCESSIVE $1M LIMIT SHALL BE DETERMINED AS 90% OF THE RATING FACTOR FOR THE PREVIOUS $1M LIMIT. THESE RATING FACTORS WILL BE MULTIPLICATIVELY COMBINED TO DERIVE A FINAL RATE THAT WILL BE APPLIED TO THE MANUAL PARTNERSHIP/CORPORATION PREMIUM, AT THE STANDARD LIMIT, TO DEVELOP THE ADDITIONAL PREMIUM FOR THE AGGREGATE LIMIT.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Tuesday, July 08, 2008 9:06 AM
To: Neuman, Gayle
Subject: RE: Individual Risk Filing #08-IL-113 - Chicago Lake Shore

Hi, Ms. Neuman,

I just wanted to let you know that the account has advised that they have decided to go with another carrier. At this time, we wish to withdraw the individual risk filing from review. I thank you for your time regarding the filing.

Sincerely,
Melissa Coker

Melissa Coker, Paralegal
Legal Department
Medical Protective

The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835
Phone: 260-486-0838
Fax: 260-486-0733
Email: melissa.coker@medpro.com
web: www.medicalprotective.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, July 02, 2008 9:29 AM
To: Coker, Melissa
Subject: Individual Risk Filing #08-IL-113 - Chicago Lake Shore

Ms. Coker,

We are in receipt of the above referenced filing received on July 1, 2008. Please address the following issues:

1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If a stat agency is used, please indicate which one?

2. Please provide an exact step-by-step illustration of the calculation of this premium. Provide the rate for the proposed insured with a $1M/$3M limit.

3. On the manual page provided, it indicates the final rate will be derived by utilizing a 7.5% to 15% rating factor. Explain how you will determine who gets a 7.5% factor and who gets a 15% factor?

We request receipt of your response by July 11, 2008.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance

Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

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JAN - 9 2008
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

January 8, 2008

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843** 35-0506406
COMPANY FILE NO: 08-IL-109
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Maryville Physician Services
Policy # C47351

POLICY IN EFFECT: ***March 1, 2008 – March 1, 2009***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Maryville Physician Services, policy # C47351,* for your review and consideration. We request the effective date of this submission be **effective March 1, 2008 – March 1, 2009.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

Enclosures

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gln
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INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/17/07 Degree: MD Region: Midwest

Check One:

- ☐ Individual
- ☒ Group

1. INSURED: Maryville Physician Services (part of group 19607)
2. QUOTED PREMIUM: $51,965
3. MANUAL PREMIUM: 17,305
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2008
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2009
8. POLICY NUMBER(S): C47351
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of the top 5 physicians covered under the corporation. All physicians covered under the corporation are not insured with Medical Protective. Therefore, the specialties of the top 5 were used, which include 3 general vascular surgeons, one plastic/hand surgeon and one OBGYN. The corporate cap will also not be applied. This corporate policy covers the physicians working at Maryville Physicians Services Inc. When we wrote this group in 2006, we were not aware of contracted physicians not insured with Medical Protective. Medical Protective's standard corporate rate does not contemplate for these non-insureds. An Individual Risk Filing was used for pricing beginning 3/1/07 and is again being used for the 3/1/08 policy year. The calculation is as follows: ($120,728 + 102,355 + 102,355 + 102,355 + 91,858) * .10 = $51,965.

INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

This risk falls outside of our standard corporate pricing as there are physicians that Medical Protective does not insure. This increases the vicarious liabilty exposure for the entity and this needs to be contemplated in the premium.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2008. There are currently 5 anesthesiologists and 11 CRNAs insured with Medical Protective. Through the information gathering process, we determined there are 10 other contracted physicians working for Maryville, 5 of which have a higher class than the 5 anesthesiologists we currently insure. The overall premium for the group (without the corp. premium) is approximately $195K. The additional $51,995 charged for the physician corporation is needed to appropriately price the corp. since MedPro has vicarious liability for physicians it does not insure.

This Individual Risk Filing is similar to the one filed for 3/1/07, with updated base premium.

* Rate on file from last year is still appropriate.

Underwriter: Becky Joseph

Underwriting Supervisor Approval:

Date:

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JAN - 9 2008
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

January 8, 2008

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

35-0506406

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 08-IL-110
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Maryville Medical Services
Policy # C47352

POLICY IN EFFECT: ***March 1, 2008 – March 1, 2009***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Maryville Medical Services, policy # C47352,* for your review and consideration. We request the effective date of this submission be **effective March 1, 2008 – March 1, 2009.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification and a self-addressed stamped envelope. As this risk was individually rated last year, the rule on file is applicable to the enclosed filing. 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

Enclosures

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/17/2007 Degree: MD Region: Midwest

Check One:

- ☐ Individual
- ☒ Group

1. INSURED: Maryville Medical Services (part of group 19607)
2. QUOTED PREMIUM: $7,300
3. MANUAL PREMIUM: $1,000
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2008
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2009
8. POLICY NUMBER(S): C47352
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of all of the CRNAs covered under the corporation. This is a separate corporation set up solely for CRNAs. Medical Protective's standard Allied corporate rate (minimum $1,000) does not contemplate for the risk of these CRNAs. $6636 * 11 * .10 = $7,300.

INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

The current filed Allied corporate rate simply has a minimum premium ($500) times a limit factor (2). The filed rate does not account for the specific risk covered. The risk of this corporation (11 CRNAs) falls outside of our standard allied corporate pricing.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2008. There are currently 5 anesthesiologists and 11 CRNAs insured with Medical Protective. There was a large CRNA PIC claim ($500K closed 10/2002) that clearly demonstrates the high risk of this specialty (for the corporate policy). The overall premium for the group (without the corp. premium) is approximately $195K.

This Individual Risk Filing is on the same basis as the previous policy period, but with updated base premium figures and the number of CRNAs.

Underwriter: Becky Joseph

Underwriting Supervisor Approval:

Date:

MEDICAL PROTECTIVE
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RECEIVED
FEB 28 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

February 27, 2006

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 01 2007
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 07-IL-102
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Maryville Physician Services
Policy # C47351

POLICY IN EFFECT: ***March 1, 2007 – March 1, 2008***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Maryville Physician Services, policy # C47351,* for your review and consideration. We request the effective date of this submission be **effective March 1, 2007 – March 1, 2008.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

Enclosures

I-O
MEM
BOL
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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, James Kunce, FCAS, MAAA, SVP and Chief Actuary SVP & Actuary, 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, James Kunce, FCAS, MAAA, SVP and Chief Actuary, 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.

; SVP and Chief Actuary 02/27/07
Signature and Title of Authorized Insurance Company Officer Date

;FCAS, MAAA, SVP and Chief Actuary 02/27/07
Signature, Title and Designation of Authorized Actuary Date

Insurance Company FEIN 35-0506406 Filing Number 07-IL-102

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

07-IL-102

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/15/2006 Degree: MD Region: Midwest

Check One:

- ☐ Individual
- ☒ Group

1. INSURED: Maryville Physician Services (part of group 19607)
2. QUOTED PREMIUM: $49,230
3. MANUAL PREMIUM: 16,390
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2007
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2008
8. POLICY NUMBER(S): C47351
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of the top 5 physicians covered under the corporation. All physicians covered under the corporation are not insured with Medical Protective. Therefore, the specialties of the top 5 were used, which include 3 general vascular surgeons, one plastic surgeon and one OBGYN. The corporate cap would also not be applied. This corporate policy covers the physicians working at Maryville Physicians Services Inc. When we wrote this group, we were not aware of contracted physicians not insured with Medical Protective. Medical Protective's standard corporate rate does not contemplate for these non-insureds. ($114,375 + $96,968 + $96,968 + $96,968 + $87,024) * .10 = $49,230.

12. WHY WAS THE RISK INDIVIDUALLY RATED?

This risk falls outside of our standard corporate pricing as there are physicians that Medical Protective does not insure. This increases the vicarious liabilty exposure for the entity and this needs to be contemplated in the premium.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2007. There are currently 5 anesthesiologists and 9 CRNAs. There were no MedPro claims during this first year. Through the information gathering process, we found out there are 9 other contracted physicians working for Maryville, 5 of which have a higher class than the 5 anesthesiologists we currently insure. I have discussed the pricing with the agent. She will attempt to get these contracted physicians covered through Medical Protective over the coming years. 2 more CRNAs are also expected to join the group 3/1/2007. The overall premium for the group (without the corp. premium) is approximately $185K (manual non-discretionary). The premium would have been approximately $317K prior to the IL rate reduction (Territory 1, Madison County). The additional $32,840 charged for the physician corporation is needed to appropriately price the corp.

Underwriter: Becky Joseph

Underwriting Supervisor Approval: Melissa Bailey

Date: 12/15/06

MEDICAL PROTECTIVE
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RECEIVED
FEB 28 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

February 27, 2006

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 01 2007
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 07-IL-~~102~~ 103
COMPANY FEIN NO: 35-0506406
ILLINOIS INDIVIDUAL RISK FILING
ILLINOIS PHYSICIANS & SURGEONS
Application for an Individual Risk Filing – Maryville Medical Services
Policy # C47352

POLICY IN EFFECT: ***March 1, 2007 – March 1, 2008***

Dear Mr. Gatlin:

Please find enclosed an Application for an Individual Risk Filing, applicable to *Maryville Medical Services, policy # C47352,* for your review and consideration. We request the effective date of this submission be **effective March 1, 2007 – March 1, 2008.**

Along with Individual Risk Filing Worksheet which provides a detail of how the rate was derived and why the risk was individually rated, please find the actuarial certification 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

Enclosures

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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, James Kunce, FCAS, MAAA, SVP and Chief Actuary SVP & Actuary, 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, James Kunce, FCAS, MAAA, SVP and Chief Actuary, 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.

_____; SVP and Chief Actuary — 02/27/07
Signature and Title of Authorized Insurance Company Officer — Date

_____; FCAS, MAAA, SVP and Chief Actuary — 02/27/07
Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 07-IL-103

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

07-12-103

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/15/2006 Degree: MD Region: Midwest

Check One:

☐ Individual
☒ Group

1. INSURED: Maryville Medical Services (part of group 19607)
2. QUOTED PREMIUM: $5,375
3. MANUAL PREMIUM: $1,000
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2007
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2008
8. POLICY NUMBER(S): C47352
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of all of the CRNAs covered under the corporation. This is a separate corporation set up solely for CRNAs. Medical Protective's standard Allied corporate rate (minimum $1,000) does not contemplate for the risk of these CRNAs. $5972 * 9 * .10 = $5,375.

INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

The current filed Allied corporate rate simply has a minimum premium ($500) times a limit factor (2). The filed rate does not account for the specific risk covered. The risk of this corporation (9 CRNAs) falls outside of our standard allied corporate pricing.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2007. There are currently 5 anesthesiologists and 9 CRNAs. There were no MedPro claims during this first year. There was a large CRNA PIC claim ($500K closed 10/2002) that clearly demonstrates the high risk of this specialty (for the corporate policy). The overall premium for the group (without the corp. premium) is approximately $185K (manual non-discretionary). The premium would have been approximately $317K prior to the IL rate reduction (Territory 1, Madison County).

Underwriter: Becky Joseph

Underwriting Supervisor Approval: Melissa Bailey

Date: 12/15/06

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DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 09 2007
SPRINGFIELD, ILLINOIS

RECEIVED
MAR - 9 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 0 9 2007
SPRINGFIELD, ILLINOIS

March 7, 2007

Gayle Neuman, Property & 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: 07-IL-104
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS, DENTISTS and ALLIEDS
OCCURRENCE and STANDARD CLAIMS MADE
Individual Risk Rating Rule Plan

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
State Rate Pages, Section II, III, IV and V

EFFECTIVE DATE: ***March 1, 2007*** NO

Dear Ms. Neuman:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to its Illinois Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Coverage for Health Care Providers programs. The company requests **March 1, 2007**, as the effective date for this submission.

This rule will identify the standards by which our company reviews the variations in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

Please find enclosed the required filing forms, actuarial certification 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 contact me. Thank you.

Sincerely,

Melissa Coker

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

Enclosures

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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, __, Jim D. Kunce, 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.

SVP — 3/7/07

Signature and Title of Authorized Insurance Company Officer — Date

SVP — 3/7/07

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 06-IL-104

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

PHYSICIANS & SURGEONS

OCCURRENCE PROGRAM

INDIVIDUAL RISK RATING PLAN

ACCOUNTS FOR WHICH THE FILED RATES AND RULES DO NOT ADEQUATELY CONTEMPLATE THE UNIQUE AND UNUSUAL CHARACTERISTICS OF THE RISK WILL BE INDIVIDUALLY RISK RATED. PROPER DOCUMENTATION AS TO THE DETERMINATION OF SUCH RATE WILL BE SUBMITTED TO THE ILLINOIS DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION, PURSUANT TO SECTION 155.18(B)(4). SUCH DOCUMENTATION MAY INCLUDE AN ASSESSMENT OF THE VARIATION IN RISK THAT EXISTS DUE TO CONSIDERATIONS SUCH AS SIZE, LOCATION OR GEOGRAPHIC DISPERSION, COVERAGE REQUIREMENTS, HISTORICAL EXPERIENCE, MANAGEMENT, AND MEDICAL PRACTICE STRUCTURE OR OTHER UNUSUAL CHARACTERISTICS. THE RATING PARAMETERS IDENTIFIED IN THE INDIVIDUAL RISK RATING SUBMITTED TO THE DEPARTMENT SHALL APPLY TO ALL RISKS THAT SUBSTANTIALLY MEET THE SAME CRITERIA.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

PHYSICIANS & SURGEONS

STANDARD CLAIMS MADE PROGRAM

INDIVIDUAL RISK RATING PLAN

ACCOUNTS FOR WHICH THE FILED RATES AND RULES DO NOT ADEQUATELY CONTEMPLATE THE UNIQUE AND UNUSUAL CHARACTERISTICS OF THE RISK WILL BE INDIVIDUALLY RISK RATED. PROPER DOCUMENTATION AS TO THE DETERMINATION OF SUCH RATE WILL BE SUBMITTED TO THE ILLINOIS DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION, PURSUANT TO SECTION 155.18(B)(4). SUCH DOCUMENTATION MAY INCLUDE AN ASSESSMENT OF THE VARIATION IN RISK THAT EXISTS DUE TO CONSIDERATIONS SUCH AS SIZE, LOCATION OR GEOGRAPHIC DISPERSION, COVERAGE REQUIREMENTS, HISTORICAL EXPERIENCE, MANAGEMENT, AND MEDICAL PRACTICE STRUCTURE OR OTHER UNUSUAL CHARACTERISTICS. THE RATING PARAMETERS IDENTIFIED IN THE INDIVIDUAL RISK RATING SUBMITTED TO THE DEPARTMENT SHALL APPLY TO ALL RISKS THAT SUBSTANTIALLY MEET THE SAME CRITERIA.

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Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

INDIVIDUAL RISK RATING PLAN

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The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

INDIVIDUAL RISK RATING PLAN

ACCOUNTS FOR WHICH THE FILED RATES AND RULES DO NOT ADEQUATELY CONTEMPLATE THE UNIQUE AND UNUSUAL CHARACTERISTICS OF THE RISK WILL BE INDIVIDUALLY RISK RATED. PROPER DOCUMENTATION AS TO THE DETERMINATION OF SUCH RATE WILL BE SUBMITTED TO THE ILLINOIS DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION, PURSUANT TO SECTION 155.18(B)(4). SUCH DOCUMENTATION MAY INCLUDE AN ASSESSMENT OF THE VARIATION IN RISK THAT EXISTS DUE TO CONSIDERATIONS SUCH AS SIZE, LOCATION OR GEOGRAPHIC DISPERSION, COVERAGE REQUIREMENTS, HISTORICAL EXPERIENCE, MANAGEMENT, AND MEDICAL PRACTICE STRUCTURE OR OTHER UNUSUAL CHARACTERISTICS. THE RATING PARAMETERS IDENTIFIED IN THE INDIVIDUAL RISK RATING SUBMITTED TO THE DEPARTMENT SHALL APPLY TO ALL RISKS THAT SUBSTANTIALLY MEET THE SAME CRITERIA.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

ALLIED HEALTHCARE PROVIDERS

OCCURRENCE PROGRAM

INDIVIDUAL RISK RATING PLAN

ACCOUNTS FOR WHICH THE FILED RATES AND RULES DO NOT ADEQUATELY CONTEMPLATE THE UNIQUE AND UNUSUAL CHARACTERISTICS OF THE RISK WILL BE INDIVIDUALLY RISK RATED. PROPER DOCUMENTATION AS TO THE DETERMINATION OF SUCH RATE WILL BE SUBMITTED TO THE ILLINOIS DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION, PURSUANT TO SECTION 155.18(B)(4). SUCH DOCUMENTATION MAY INCLUDE AN ASSESSMENT OF THE VARIATION IN RISK THAT EXISTS DUE TO CONSIDERATIONS SUCH AS SIZE, LOCATION OR GEOGRAPHIC DISPERSION, COVERAGE REQUIREMENTS, HISTORICAL EXPERIENCE, MANAGEMENT, AND MEDICAL PRACTICE STRUCTURE OR OTHER UNUSUAL CHARACTERISTICS. THE RATING PARAMETERS IDENTIFIED IN THE INDIVIDUAL RISK RATING SUBMITTED TO THE DEPARTMENT SHALL APPLY TO ALL RISKS THAT SUBSTANTIALLY MEET THE SAME CRITERIA.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

INDIVIDUAL RISK RATING PLAN

ACCOUNTS FOR WHICH THE FILED RATES AND RULES DO NOT ADEQUATELY CONTEMPLATE THE UNIQUE AND UNUSUAL CHARACTERISTICS OF THE RISK WILL BE INDIVIDUALLY RISK RATED. PROPER DOCUMENTATION AS TO THE DETERMINATION OF SUCH RATE WILL BE SUBMITTED TO THE ILLINOIS DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION, PURSUANT TO SECTION 155.18(B)(4). SUCH DOCUMENTATION MAY INCLUDE AN ASSESSMENT OF THE VARIATION IN RISK THAT EXISTS DUE TO CONSIDERATIONS SUCH AS SIZE, LOCATION OR GEOGRAPHIC DISPERSION, COVERAGE REQUIREMENTS, HISTORICAL EXPERIENCE, MANAGEMENT, AND MEDICAL PRACTICE STRUCTURE OR OTHER UNUSUAL CHARACTERISTICS. THE RATING PARAMETERS IDENTIFIED IN THE INDIVIDUAL RISK RATING SUBMITTED TO THE DEPARTMENT SHALL APPLY TO ALL RISKS THAT SUBSTANTIALLY MEET THE SAME CRITERIA.

5. **Individual Risk Rating Plan**
(Occurrence & Standard Claims Made Programs)

Accounts for which the filed rates and rules do not adequately contemplate the unique and unusual characteristics of the risk will be Individually Risk Rated. Proper documentation as to the determination of such rate will be submitted to the Illinois Department of Financial & Professional Regulation, pursuant to Section 155.18(B)(4). Such documentation may include an assessment of the variation in risk that exists due to considerations such as size, location or geographic dispersion, coverage requirements, historical experience, management, and medical practice structure or other unusual characteristics. The rating parameters identified in the Individual Risk Rating submitted to the Department shall apply to all risks that substantially meet the same criteria.

27. **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.

28. **Individual Risk Rating Plan**
(Occurrence & Standard Claims Made Programs)

Accounts for which the filed rates and rules do not adequately contemplate the unique and unusual characteristics of the risk will be Individually Risk Rated. Proper documentation as to the determination of such rate will be submitted to the Illinois Department of Financial & Professional Regulation, pursuant to Section 155.18(B)(4). Such documentation may include an assessment of the variation in risk that exists due to considerations such as size, location or geographic dispersion, coverage requirements, historical experience, management, and medical practice structure or other unusual characteristics. The rating parameters identified in the Individual Risk Rating submitted to the Department shall apply to all risks that substantially meet the same criteria.

25. 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.

26. **Individual Risk Rating Plan**
(Occurrence & Standard Claims Made Programs)

Accounts for which the filed rates and rules do not adequately contemplate the unique and unusual characteristics of the risk will be Individually Risk Rated. Proper documentation as to the determination of such rate will be submitted to the Illinois Department of Financial & Professional Regulation, pursuant to Section 155.18(B)(4). Such documentation may include an assessment of the variation in risk that exists due to considerations such as size, location or geographic dispersion, coverage requirements, historical experience, management, and medical practice structure or other unusual characteristics. The rating parameters identified in the Individual Risk Rating submitted to the Department shall apply to all risks that substantially meet the same criteria.

19. **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.

20. **Individual Risk Rating Plan**
(Occurrence & Standard Claims Made Programs)

Accounts for which the filed rates and rules do not adequately contemplate the unique and unusual characteristics of the risk will be Individually Risk Rated. Proper documentation as to the determination of such rate will be submitted to the Illinois Department of Financial & Professional Regulation, pursuant to Section 155.18(B)(4). Such documentation may include an assessment of the variation in risk that exists due to considerations such as size, location or geographic dispersion, coverage requirements, historical experience, management, and medical practice structure or other unusual characteristics. The rating parameters identified in the Individual Risk Rating submitted to the Department shall apply to all risks that substantially meet the same criteria.

Contact Person:
Gayle Neuman
217-524-6497
Gayle.Neuman@illinois.gov

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
_X__MEDICAL MALPRACTICE	**11.0000**	***This checklist is for rate/rule filings only. See separate form checklist.
___Claims Made	11.10000	
_X__Occurrence	11.2000	

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_X_Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation,

Review Standards Requirements Column		bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	Certificate No. 546900-51
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page	Not Applicable

		1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including all rates. b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	The Company's Statistical Agent is ISO. This filing does not modify the existing base rate for Physicians & Surgeons, and thus there is no rate effect as a result.

EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code 929	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty Compliance Section, except as otherwise provided in Section 155.18.	March 1, 2007
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	N/A
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Enclosed
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed.	Refer to enclosed Cover letter for relevant information. This is a new product filing, and does not supersede an existing filing. Actuarial Certification is enclosed.

		• List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the	N/A – no rate effect to current insureds.

		information is "exact" or "estimated."	
PAYMENT PLANS			
Quarterly premium payment installment plan required as prescribed by the Director.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	Current Rules and procedures comply with requirements
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Current Rules and procedures comply with requirements.
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed	Current Rules and procedures comply with requirements

		rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals: • Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which must be priced as a factor of one of the following:*** o the last 12 months' premium. o the premium in effect at policy issuance. o the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.*** • Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first. ***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must:	Current rules and procedures comply with requirements.

		• Offer free 5-year extended reporting period (tail coverage) or • Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	N/A
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Rate applicable to currently filed rates.
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Current Rules and procedures comply with requirements.
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and	

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	N/A
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	Enclosed
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	The Companys statistical agent is ISO.
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any	215 ILCS 5/155.18 50 IL Adm. Code	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The	Enclosed.

rate filing, as well as any rule filing that affects the ultimate premium.	929	explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	N/A
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	N/A – Existing rates are not being changed
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	N/A
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	N/A
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	N/A
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	N/A
Loss Adjustment Expenses			

Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	N/A
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	N/A
Other Actuarial Information Required			

Insurers must include the information described in this section.	215 ILCS 5/155.18
	
	50 IL Adm. Code 929
		Insurers shall also include the following information:
		
		• All actuarial support/justification for all rates being changed, including but not limited to changes in:
		  ○ Base rates;
		  ○ Territory definitions;
		  ○ Territory factor changes;
		  ○ Classification factor changes;
		  ○ Classification definition changes;
		  ○ Changes to schedule credits/debits, etc.
		
		• Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed.
			N/A

		• Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	N/A

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Friday, March 09, 2007 3:13 PM
To: Neuman, Gayle
Subject: FW: Filing #07-IL-102 and #07-IL-103

Ms Neuman,

Thank you for your e-mail of March 1st. Since we have been unable to reach you by telephone, please allow this e-mail to respond to your question below.

As you already know, as of March 1st our rate and rule manual did not contain a rule regarding IRFs. We have since made a new rule filing (company file number 07-IL-104) that allows us to file an IRF when an insured's unique characteristics place the risk outside our normal rate classification. Given the difficulty in predefining what unique characteristic will place such a risk outside the norm, we have used language broad enough to serve our prospective insureds while providing the Department with sufficient documentation to review and understand the individually filed risk. Such documentation will include the Company's standard IRF worksheet which identifies why the risk was individually rated, as well as any additional information.
If you need any additional information please contact me.

Sincerely,
Melissa Coker
260-486-0838
melissa.coker@medpro.com

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, March 01, 2007 3:33 PM
To: Coker, Melissa
Subject: Filing #07-IL-102 and #07-IL-103

Ms. Coker,

Section 155.18(b)(4) of the Illinois Insurance Code allows insurers to modify classification rates to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probably effect upon losses or expenses. Such modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations and shall apply to all risks under the same or substantially the same circumstances or conditions.

Before we can review your request to individually rate XXXX risk, please indicate where, in your current rate/rule manual, you list the standards by which you measure the variations in hazards or expense provisions in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating. Such standards are required in the law, prior to individually rating any risk, to ensure that an insurer is not applying its rates in an unfairly discriminatory manner.

We request receipt of your response by March 9, 2007.

Gayle Neuman

Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

State of Illinois
Financial and Professional Regulation
Division of Insurance
Report of *Ex Parte* Communication

Name of employee making report: Gayle Neuman

Job Title of employee making report: Insurance Analyst

Date of communication: 3/15/07 + 4/27/07

Date of First Notice (if applicable): n/a

Mode of communication (e.g. in person, telephone, fax, e-mail, mail): telephone

On whose behalf communication is made: Medical Protective

Person(s) with whom communication occurred: Melissa Coker and Dave Shermand

Summary of Nature and Substance of communication: Individual risk filings

What action, if any, the person(s) requested: –

Responses made to communication: –

Other Pertinent Information: –

Please attach any and all documents to this form including e-mails, faxes, papers or other documents.

The company indicated they wanted to maintain flexibility. I explained they must comply with law that indicates they must list each factor that could cause a risk to be individually rated - size, location, etc.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, April 26, 2007 2:59 PM
To: Neuman, Gayle
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

10:30 your time we will give you a call, that will work fine.

Thanks you for your time!

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, April 26, 2007 1:52 PM
To: Coker, Melissa
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

I will only be in the office on Friday until 11:00. So, we could try between 10:30 and 11:00???

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Thursday, April 26, 2007 11:40 AM
To: Neuman, Gayle
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Do you have time available to discuss this further? We still have a few questions that we wanted to run by you? Would you be available tomorrow between 11 - 11:30?

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, April 26, 2007 12:36 PM
To: Coker, Melissa
Subject: FW: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

I spoke with your and Dave Sherman on March 15, 2007 regarding the individual risk rating issue. Please provide a response on this issue by no later than May 1, 2007.

From: Neuman, Gayle
Sent: Thursday, March 15, 2007 11:33 AM
To: 'Coker, Melissa'
Subject: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

We are in receipt of the above referenced filing submitted by your letter dated March 7, 2007.

First, the filing cannot be effective March 1, 2007 as it was not received until March 9, 2007. Please advise.

Upon reviewing the manual pages submitted, we do not see where the filing defines the criteria for which a risk would be individually rated. The filing needs to indicate the factors involved that decide the risk is outside the

perimeter for its size, location or geographic dispersion, coverage requirements, historical experience, management, medical practice structure or other unusual characteristics.

Your response is requested by March 26, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Wednesday, May 02, 2007 3:19 PM
To: Neuman, Gayle
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104
Attachments: 2302_001.pdf

Gayle,

Thank you for speaking with Dave Shermand and I yesterday and allowing us more time to finalize the rules for your review. We believe we have modified the rules to meet the request. However if you need any additional changes made or have any questions, please let me know.

Sincerely,
Melissa Coker

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, April 26, 2007 1:52 PM
To: Coker, Melissa
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

I will only be in the office on Friday until 11:00. So, we could try between 10:30 and 11:00???

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Thursday, April 26, 2007 11:40 AM
To: Neuman, Gayle
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Do you have time available to discuss this further? We still have a few questions that we wanted to run by you? Would you be available tomorrow between 11 - 11:30?

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, April 26, 2007 12:36 PM
To: Coker, Melissa
Subject: FW: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

I spoke with your and Dave Sherman on March 15, 2007 regarding the individual risk rating issue. Please provide a response on this issue by no later than May 1, 2007.

From: Neuman, Gayle
Sent: Thursday, March 15, 2007 11:33 AM
To: 'Coker, Melissa'
Subject: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

We are in receipt of the above referenced filing submitted by your letter dated March 7, 2007.

First, the filing cannot be effective March 1, 2007 as it was not received until March 9, 2007. Please advise.

Upon reviewing the manual pages submitted, we do not see where the filing defines the criteria for which a risk would be individually rated. The filing needs to indicate the factors involved that decide the risk is outside the perimeter for its size, location or geographic dispersion, coverage requirements, historical experience, management, medical practice structure or other unusual characteristics.

Your response is requested by March 26, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

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Neuman, Gayle

From: Neuman, Gayle
Sent: Thursday, June 07, 2007 11:14 AM
To: 'Coker, Melissa'
Subject: FW: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

We request receipt of your response to the attached e-mail by June 11, 2007.

From: Neuman, Gayle
Sent: Tuesday, May 22, 2007 8:10 AM
To: 'Coker, Melissa'
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

We are still reviewing this issue. Please address the following questions:

In regard to the "CRNA to Anesthesiologist Ratio", this plan should indicate the credit/debit that will be received with this scenario. Since the issue at hand showed the insured's discount was 90%, that should be the discount applied to all that meet this criteria and therefore included on the manual page.

The CRNA premium is 25% of the Anesthesiology rate. The scenario discribed indicates there was a large CRNA claim that "demonstrates the high risk of this specialty". The information provided seems to contradict the reason for giving the insured a discount.

In regard to the "Corporation Vicarious Liability for Physicians Not Individually Insured by Medical Protective", the manual page should indicate the additional amount that will be charged will be calculated by adding 10% of the sum of the top 5 physicians. However on page 1 of the IRF Worksheet, they indicate $49,230 will be charged, and on page 2 it indicates $32,840. Please explain the difference.

Your prompt attention is appreciated.

Gayle Neuman

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Monday, May 21, 2007 4:43 PM
To: Neuman, Gayle
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Gayle,
Can you advise if the rule and IRF have been approved at this time?
Thank you for your time.

Sincerely,
Melissa Coker

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Tuesday, June 12, 2007 2:59 PM
To: Neuman, Gayle
Subject: FW: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104
Attachments: IRF - C47352 Maryville Medical Services (CRNAs).doc

Ms. Neuman,

I apologize, I just realized you had requested the response on the 11th, not the 12th. I apologize for the delay.

In review of your questions and in speaking with our Underwriting Department, we offer the following information in response.

You indicate that you would except to see claims support charging more, however our underwriter manager would expect to see the opposite. As we are charging more because CRNA's present a higher exposure from a macro point of view then that of a typical allied healthcare provider. We also don't often see this high of CRNA to Anesthesiologist ratio. We priced it by taking 10% of the sum of all the CRNAs covered under the corporation. $5972 *.9 (9 CRNAs) *.10=$5,375

In regards to your questions raised in paragraph two, it appears that you are looking for claim support and we do address the prior claim experience in the IRF form, which I have re-attached for your review.

In regards to your question in the last paragraph, we are not sure of your question? As the minimum premium for the allied corporation pulled was $1,000 and that doesn't support the exposure we have with all of the CRNA's under one corporation. There were two separate IRF's submitted for two different entities under one group. One entity has physicians and CRNA's and one is an Allied corporation. If you can help clarify your question stated in this last paragraph, we will provide the information you are needing to continue your review.

Please let me know if you need any additional information, and again, I apologize for the delay in response.

Melissa

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, June 07, 2007 12:14 PM
To: Coker, Melissa
Subject: FW: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

We request receipt of your response to the attached e-mail by June 11, 2007.

From: Neuman, Gayle
Sent: Tuesday, May 22, 2007 8:10 AM
To: 'Coker, Melissa'
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Ms. Coker,

We are still reviewing this issue. Please address the following questions:

In regard to the "CRNA to Anesthesiologist Ratio", this plan should indicate the credit/debit that will be received with this scenario. Since the issue at hand showed the insured's discount was 90%, that should be the discount applied to all that meet this criteria and therefore included on the manual page.

The CRNA premium is 25% of the Anesthesiology rate. The scenario discribed indicates there was a large CRNA claim that "demonstrates the high risk of this specialty". The information provided seems to contradict the reason for giving the insured a discount.

In regard to the "Corporation Vicarious Liability for Physicians Not Individually Insured by Medical Protective", the manual page should indicate the additional amount that will be charged will be calculated by adding 10% of the sum of the top 5 physicians. However on page 1 of the IRF Worksheet, they indicate $49,230 will be charged, and on page 2 it indicates $32,840. Please explain the difference.

Your prompt attention is appreciated.

Gayle Neuman

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Monday, May 21, 2007 4:43 PM
To: Neuman, Gayle
Subject: RE: Medical Protective - Individual Risk Rating Rule Plan - Filing #07-IL-104

Gayle,
Can you advise if the rule and IRF have been approved at this time?
Thank you for your time.

Sincerely,
Melissa Coker

INDIVIDUAL RISK FILING (IRF) WORKSHEET

(Complete this form and submit with all Individual Risk Filings)

Date (mm/dd/yyyy): 12/15/2006 Degree: MD Region: Midwest

Check One:

☐ Individual
☒ Group

1. INSURED: Maryville Medical Services (part of group 19607)
2. QUOTED PREMIUM: $5,375
3. MANUAL PREMIUM: $1,000
4. LIMITS: $1M/$3M
5. SELECT ONE: Renewal
6. EFFECTIVE DATE (mm/dd/yyyy): 03/01/2007
7. EXPIRATION DATE: (mm/dd/yyyy): 03/01/2008
8. POLICY NUMBER(S): C47352
9. ARE ANY OF THE FORMS/ENDORSEMENTS INCLUDED WITH THE FILING NOT CURRENTLY FILED AND APPROVED WITH THE DEPARTMENT OF INSURANCE?

   ☐ Yes ☒ No

10. IF YES, WHICH SUBMITTED FORMS ARE NOT APPROVED? (attach)

11. HOW WAS THE RATE DERIVED?

The rate was derived by taking 10% of the sum of all of the CRNAs covered under the corporation. This is a separate corporation set up solely for CRNAs. Medical Protective's standard Allied corporate rate (minimum $1,000) does not contemplate for the risk of these CRNAs. $5972 * 9 * .10 = $5,375.

INSURED: C47352 - Maryville Medical Services

12. WHY WAS THE RISK INDIVIDUALLY RATED?

The current filed Allied corporate rate simply has a minimum premium ($500) times a limit factor (2). The filed rate does not account for the specific risk covered. The risk of this corporation (9 CRNAs) falls outside of our standard allied corporate pricing.

13. SPECIAL INFORMATION RELATED TO THE RISK:

14. ADDITIONAL COMMENTS:

Maryville Physicians Services, Inc. (group 19607) has been with MedPro since 3/1/2006 and is being renewed 3/1/2007. There are currently 5 anesthesiologists and 9 CRNAs. There were no MedPro claims during this first year. There was a large CRNA PIC claim ($500K closed 10/2002) that clearly demonstrates the high risk of this specialty (for the corporate policy). The overall premium for the group (without the corp. premium) is approximately $185K (manual non-discretionary). The premium would have been approximately $317K prior to the IL rate reduction (Territory 1, Madison County).

Underwriter: Becky Joseph

Underwriting Supervisor Approval: Melissa Bailey

Date: 12/15/06

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, July 26, 2007 1:29 PM
To: Neuman, Gayle
Subject: RE: Filing #07-IL-104 - Individual Risk Rating Rule Plan

Ms. Neuman,

After review of your email of 7/19 and the original filing submitted on 3/7, we would like to withdraw the *"Dentists" and "Allied Healthcare Providers" in addition to "Occurrence Program" and "Standard Claims Made Program". Additionally, "Illinois - State Rate Pages".* As you explained in the last telephone conference with yourself, Dave Sherman and I - because of the specific information needed for the rule in connection with the Physicians & Surgeons individual risk filings we made, we would most likely need to file a new rule with each individual risk filing submission.

The two new pages submitted on 5/2 replace the pages submitted to you originally on 3/7 and should be placed in the Physicians & Surgeons manual section. I apologize for any confusion.

Please let me know should you have any additional questions.

Melissa

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, July 24, 2007 3:24 PM
To: Coker, Melissa
Subject: FW: Filing #07-IL-104 - Individual Risk Rating Rule Plan

Ms. Coker,

We request your response to the attached e-mail by July 27, 2007.

From: Neuman, Gayle
Sent: Thursday, July 19, 2007 10:34 AM
To: 'Coker, Melissa'
Subject: Filing #07-IL-104 - Individual Risk Rating Rule Plan

Ms. Coker,

The manual pages provided with your March 7, 2007 submission were labeled as "Physicians & Surgeons", "Dentists" and "Allied Healthcare Providers" in addition to "Occurrence Program" and "Standard Claims Made Program". Additionally, "Illinois - State Rate Pages" were included. However, On May 2, 2007, you sent an e-mail that included the attachment of two new manual pages. I am unsure as to the placement of such pages - are these two forms to replace the 10 manual pages originally submitted? Under what manual section should they be filed? Please clarify.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

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Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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Neuman, Gayle

From: Neuman, Gayle
Sent: Friday, September 07, 2007 9:25 AM
To: 'Coker, Melissa'
Subject: Filings #07-IL-102, #07-IL-103, and #07-IL-104 - Individual Risk Issue

Ms. Coker,

These filings have been reviewed and stamped "filed". A copy is in the mail to you.

Perhaps in your next filing submission, the manual pages resulting from this filing could be cleaned up. Pursuant to your 7/26/07 e-mail, you indicated the two new pages should be submitted under the Physicians & Surgeons manual section. I placed the two pages in the manual under each section although the pages do not reflect "Physician & Surgeon", "Occurrence Program", or "Claims Made Program". Additionally, no pages were specified for the Illinois State Rate Pages.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

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MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUL 0 1 2007
SPRINGFIELD, ILLINOIS

May 29, 2007

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
JUN 0 1 2007
SPRINGFIELD. ILLINOIS

John Gatlin, Director of 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: 07-IL-105
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Classification Revision (Add Cosmetic Surgery)

OVERALL RATE IMPACT: 0.0%

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revise State Rate Pages Section III – Physicians & Surgeons

PROPOSED EFFECTIVE DATE: JULY 1, 2007

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration our classification filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date of July 1, 2007 for this filing. The accompanying Actuarial Memorandum provides detailed support for the changes, which will result in an overall premium change of 0.0% in the state of Illinois.

In addition, we have enclosed revised manual pages for Section III – Physicians & Surgeons for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons Program, and therefore are being included in this submission.

Along with the Actuarial Memorandum, please find enclosed revised class plan pages, the required checklists, transmittal forms, 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.

Sincerely,

Melissa Coker

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

Enclosure(s)

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective +0.0% effective as of July 1, 2007

(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 Line 11 - Med Mal (MD) (Line of Insurance)	$15,478,434 (estimated)	0.0 %

DIVISION OF INSURANCE STATE OF ILLINOIS RECEIVED JUN 01 2007 SPRINGFIELD, ILLINOIS

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): The Medical Protective Company hereby submits for your review and consideration our classification filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date of July 1, 2007 for this filing. The accompanying Actuarial Memorandum provides detailed support for the changes, which will result in an overall premium change of 0.0% in the state of Illinois.

In addition, we have enclosed revised manual pages for Section III – Physicians & Surgeons for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons Program, and therefore are being included in this submission.

*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

Trent C. Heinemeyer, SVP & General Counsel
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, __, Jim D. Kunce, 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 — Date: 5/30/2007

Signature, Title and Designation of Authorized Actuary — Date: 5/30/2007

Insurance Company FEIN 35-0506406 Filing Number 06-IL-105

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

PHYSICIANS AND SURGEONS

ACTUARIAL MEMORANDUM

The Medical Protective Company (MedPro) has undertaken a countrywide review of its pricing for Plastic Surgery. As a result of this review, MedPro proposes to introduce a new classification for specialists in Cosmetic Surgery in the state of Illinois. With this proposal, the new classification will have rates equal to the current rates for Plastic Surgery – NOC. Experience for the new classification will be evaluated as it matures, and subsequent adjustments will be made to pricing as they are warranted. Due to the nature of this change, there is no premium impact associated with the proposed change. The Company respectfully requests an effective date of July 1, 2007.

The Occurrence and Standard Claims-Made manual pages have been revised incorporating the proposed changes and are attached to this filing.

IDENTIFICATION

I, James D. Kunce, Actuary, am an officer of The Medical Protective Company (the Company), a Fellow of the Casualty Actuarial Society, and a Member of the American Academy of Actuaries meeting its qualification standards. I was appointed by the Board of Directors of The Medical Protective Company on August 2, 2005 to render this opinion.

SCOPE

I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 2006. My review was limited to the items listed in Exhibit A and did not include an analysis of any income statement or other balance sheet items. The items listed in Exhibit A reflect the Loss Disclosure Reserve Items (3 thru 8) in Exhibit B.

In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by Garret Davenport, Controller of The Medical Protective Company. I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P - Part 1 - Summary of the Company's current Annual Statement. Included in the reconciliation were paid losses, incurred losses, paid defense and cost containment expenses, incurred defense and cost containment expenses and earned premium. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations, as I considered necessary.

OPINION

In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of Indiana.

B. Are computed in accordance with accepted actuarial standards and principles.

C. Make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its contracts and agreements.

Thus, I am making a Determination of Reasonable Provision with respect to the amounts carried in Exhibit A.

RELEVANT COMMENTS

It should be noted that reserve calculations deal with the inherent economic and financial uncertainty of future contingent events. Other than as specifically noted, my projections make no provision for the extraordinary future emergence of new classes of losses or types of losses not sufficiently represented in the Company's historical database or which are not yet reported. While I believe the reserves represent a reasonable provision based on the appropriate application of actuarial techniques to the available data, there can be no guarantee that the actual future payments will not differ, perhaps significantly, from the amounts carried on the balance sheet. No warranty is expressed or implied that this will not occur.

MAJOR RISK FACTORS

The Company has written a variety of coverages whose major risk factors materially impact the variability of the Company's reserves. I have identified the major risk factors as: suits against the company by its insureds or other institutes, other mass torts mainly related to drugs prescribed by our insureds to the general public (eg. Vioxx); and as the company writes medical malpractice insurance new and ever changing medical malpractice legislative issues pose a risk.

The potential impact of these risk factors is described in more detail in the following paragraphs and in the report supporting this Opinion. The absence of other risk factors from this listing does not imply that additional risk factors will not be identified in the future as having been a significant influence on the Company's reserves.

The following paragraphs describe issues associated with each of the three major risk factors identified above:

Suits against the company:

I have assumed that interpretations of coverage implicit in the Company's historical data regarding excess of policy limits and extra contractual obligations will not materially change. I believe that this is a reasonable assumption. However, there is a risk that in the future, there may be social and/or judicial changes that result in an expansion in coverage greater than the Company has experienced in the past, which would have a material impact on reserve projections.

Increases in the number and types of other mass tort lawsuits:

The majority of both indemnity and legal expense liabilities for mass torts arising from medical products have been sustained by the manufacturers of the medical products associated with that particular mass tort. The company believes these past trends pertaining to very limited professional liability indemnity and legal expense expenditures associated with mass tort actions will continue. However a shift in greater allocation of liability toward the healthcare providers is possible.

Medical Malpractice legislative issues:

I have assumed that interpretations of coverage triggers with respect to occurrence dates implicit in the Company's historical data will not materially change. I believe this is a reasonable assumption. However, tort reform modifications have been enacted and continue to be discussed. Such actions could result in shifts in original treatment dates cited by the plaintiffs that vary from the historical patterns.

I believe that the risk factors above, coupled with the variability inherent in any reserve estimate, could result in material adverse deviation from the carried net reserve amounts. In making this determination, I have considered a material adverse deviation to be one in which the actual net outstanding losses and loss adjustment expenses exceed the subtotals in Exhibit A, by an amount greater than 20% of the Company's statutory surplus shown on the Liabilities, Surplus and Other Funds page of the Annual Statement (i.e., a reserve deviation greater than $129 million). My selection of the materiality standard (20% of statutory surplus) was based on the fact that this

opinion is prepared for the regulatory review of The Medical Protective Company. Other measures of materiality might be used for reserves being evaluated in a different context.

DISCLOSURE ITEMS

Included in the reserves are credits for a loss portfolio transfer reinsurance agreement. The agreement became effective on August 8, 1984, and amended on December 27, 1990. Both dates precede the requirements pertaining to loss portfolio transfer reinsurance referenced from "Statements of Statutory Accounting Principles, No. 62". The Indiana Department of Insurance approved this contract at both its inception and amendment dates for treatment as reinsurance and has therefore been treated as prospective reinsurance in the Annual Statement.

In addition the company entered into a loss portfolio agreement with National Indemnity Company and Columbia Insurance Company effective December 31, 2005. This agreement calls for Medical Protective to cede 50% of its net reserves equally to National Indemnity and Columbia Insurance. Consistent with "Statements of Statutory Accounting Principles, No. 62" paragraph 30 statement d, which states that accounting principles for retro reinsurance shall not apply to "...intercompany reinsurance agreements, and any amendments thereto, among companies 100% owned by a common or ultimate controlling person provided there is no gain in surplus as a result of the transaction", this agreement is not considered retro reinsurance.

Based on discussions with company management and its description of the company's ceded reinsurance, I am not aware of any reinsurance contract that either has been or should have been accounted for as retroactive reinsurance or financial reinsurance.

I have reviewed the Company's exposure to asbestos and environmental claims. In my opinion, there is only a remote chance of material liability, since reported claims are zero and the company writes primarily medical liability coverage.

During the course of my analysis, I reviewed the Company's exposure to terrorist attack losses. No claims have been presented to date. In my opinion, the risk of significant liabilities as of December 31, 2006 arising from terrorist attack losses is remote, given the nature of the coverages provided by the Company and prevailing coverage interpretations.

The Company does not discount loss or loss adjustment expense reserve liabilities.

The Company participates in one mandatory pool (Massachusetts Medical Malpractice Reinsurance Plan) in which premiums and liabilities are assumed in direct proportion to the Company's percentage of direct written premium. Total reserve exposure with respect to pools is considered immaterial (approx $4.90M).

The company's Schedule P, Part 2 summary indicates a reserve release of $18,819,000 during the past year. The loss activity as shown in Schedule P, Part 2 caused no exceptional values for the NAIC IRIS Tests 10 (One-Year Reserve Development to Surplus), 11 (Two-Year Reserve Development to Surplus) and 12 (Estimated Current Reserve Deficiency to Surplus).

The Company writes no policies or contracts related to single or fixed premium policies with coverage periods of thirteen months or greater that are non-cancelable and not subject to premium increase (excluding financial guarantee contracts, mortgage guaranty policies, and surety contracts).

Over 99% of the Company's ceded loss reserves is with either affiliated companies, companies rated A or better by A.M. Best Company, residual market pools or fully collateralized. Less than 1% is with various other companies either rated below A or not rated by A.M. Best Company. Past uncollectibility levels and current amounts in dispute have been reviewed and found to be immaterial relative to surplus. Therefore, reinsurance collectibility does not appear to be an issue.

The Company does not provide for anticipated salvage and subrogation

There has been no change in the actuarial assumptions, procedures, or methods that is likely to have a material effect of the statement loss and loss expense reserves.

This statement of opinion is solely for the use of, and only to be relied upon by, the Company and the various state insurance departments with which it files its Annual Statement.

An Actuarial Report and any underlying actuarial workpapers supporting the findings expressed in this Statement of Actuarial Opinion will be retained for a period of seven years in the administrative offices of The Medical Protective Company and available for regulatory examination.

James D. Kunce, F.C.A.S., M.A.A.A.
The Medical Protective Company
5814 Reed Road, Fort Wayne, IN 46835
260-486-0869
February 26, 2007

EXHIBIT A: SCOPE

Loss Reserves:	Amount
A. Reserve for Unpaid Losses (Liabilities, Surplus, and Other Funds Page 3, Line 1):	$513,568,832
B. Reserve for Unpaid Loss Adjustment Expenses (Liabilities, Surplus, and Other Funds Page 3, Line 3):	$267,663,342
Subtotal: A + B	$781,232,174
C. Reserve for Unpaid Losses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 13 and 15):	$1,353,753,000
D. Reserve for Unpaid Loss Adjustment Expenses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 17, 19 and 21):	$660,376,000
Subtotal: C + D	$2,014,129,000
E. The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$0
F. Other Loss Reserve items on which the Appointed Actuary is Expressing an Opinion (list separately)	$0

Premium Reserves:	Amount
G. Reserve for Direct and Assumed Unearned Premiums for Long Duration Contracts	$0
H. Reserve for Net Unearned Premiums for Long Duration Contracts	$0
I. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately)	$0

EXHIBIT B: DISCLOSURES

1. Materiality Standard expressed in $US	$129,00,000
2. Statutory Surplus	$645,884,989
3. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P	$0
4. Discount included as a reduction to loss reserves and loss expense reserves as reported in Schedule P	
4 (a) Nontabular discount	$0
4 (b) Tabular discount	$0
5. The net reserves for losses and expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	$4,903,000
6. The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	
6 (a) Asbestos, as disclosed in the Notes to Financial Statements	$0
6 (b) Environmental, as disclosed in the Notes to Financial Statements	$0
7. The total claims made extended loss and expense reserve (Schedule P Interrogatories).	
7 (a) amount reported as loss reserves	$0
7 (b) amount reported as unearned premium reserves	$30,039,142
8. Other items on which the Appointed Actuary is providing Relevant Comment (list separately)	$0

Contact Person:
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217-524-6497
Gayle.Neuman@illinois.gov

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
_X__MEDICAL MALPRACTICE	**11.0000**	***This checklist is for rate/rule
_X_Claims Made	11.10000	filings only.
_X__Occurrence	11.2000	See separate form checklist.

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_X_Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	Certificate No. 546900-51
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including all rates.	Not Applicable

		b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	The Company's Statistical Agent is ISO. This filing does not modify the existing base rate for Physicians & Surgeons, and thus there is no rate effect as a result.
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty	July 1, 2007

	929	Compliance Section, except as otherwise provided in Section 155.18.	
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	N/A
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Enclosed
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the	Refer to enclosed Cover letter for relevant information. This is a revision to the Physicians & Surgeons class plan, and replaces the current version with an edition date of 1/1/07. Actuarial Certification is enclosed.

		superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	N/A – no rate effect to current insureds.
PAYMENT PLANS			
Quarterly premium payment installment	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability	Current Rules and procedures comply

plan required as prescribed by the Director.		insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	with requirements
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Current Rules and procedures comply with requirements.
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the	Current Rules and procedures comply with requirements

		section that applies.	
CLAIMS MADE REQUIREMENTS			

Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2)
	
	Company Bulletin 88-50
		When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals:
		
		• Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).***
		
		• Cost of the extended reporting period, which must be priced as a factor of one of the following:***
		
		  o the last 12 months' premium.
		  o the premium in effect at policy issuance.
		  o the expiring annual premium.
		
		• List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium.
		
		• Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated.
		
		• Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request.
		
		• Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.***
		
		• Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first.
		
		***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must:
		
		• Offer free 5-year extended reporting period (tail coverage) or
		• Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate
			Current rules and procedures comply with requirements.

		expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	N/A
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Rate applicable to currently filed rates.
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Current Rules and procedures comply with requirements.
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and	

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	N/A
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	Enclosed
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	The Companys statistical agent is ISO.
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any	215 ILCS 5/155.18 50 IL Adm. Code	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The	Enclosed.

rate filing, as well as any rule filing that affects the ultimate premium.	929	explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	N/A
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	N/A – Existing rates are not being changed
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	N/A
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	N/A
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	N/A
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	N/A
Loss Adjustment Expenses			

Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	N/A
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	N/A
Other Actuarial Information Required			

Insurers must include the information described in this section.	215 ILCS 5/155.18
	
	50 IL Adm. Code 929
		Insurers shall also include the following information:
		
		• All actuarial support/justification for all rates being changed, including but not limited to changes in:
		  ○ Base rates;
		  ○ Territory definitions;
		  ○ Territory factor changes;
		  ○ Classification factor changes;
		  ○ Classification definition changes;
		  ○ Changes to schedule credits/debits, etc.
		
		• Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed.
			N/A

		• Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	N/A

STRIKE THRU VERSION

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED

JUL 0 1 2007

SPRINGFIELD, ILLINOIS

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUL 01 2007
SPRINGFIELD, ILLINOIS

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

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CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

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SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

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SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.

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CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

PHYSICIANS & SURGEONS

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 IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

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SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

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SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

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SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

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SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.

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SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

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SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

B. Manual Rates

1. Territory Definitions

Area 1	Cook, Jackson, Madison, St. Clair, and Will Counties
Area 2	Lake, and Vermillion Counties
Area 3	Kane, McHenry, and Winnebago Counties.
Area 4	Dupage, Kankakee, and Macon, Counties
Area 5	Bureau, Champaign, Coles, Dekalb, Effingham, Lasalle, Ogle, and Randolph Counties
Area 6	Grundy and Sangamon Counties
Area 7	Peoria County
Area 8	Remainder of State

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 01 2007
SPRINGFIELD, ILLINOIS

RECEIVED
FEB 20 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

February 16, 2007

John Gatlin, Director of 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: 07-IL-100 -R
ILLINOIS PHYSICIANS & SURGEONS - Occurrence Program
Introduce Convertible / Nose Rating Plan
Introduce E 840 – Convertible Claims Made Endorsement

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Introduce PEP-0201-00 (07/2006) – Convertible Claims Made Endorsement
Revised Section III – Physicians & Surgeons State Rate Pages

PROPOSED EFFECTIVE DATE: March 1, 2007

Dear Mr. Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule and form filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Package programs. We request **March 1, 2007,** as the effective date for this submission.

This filing will enable our company to offer "convertible claims made" coverage to Illinois physicians and physician groups, which will allow insureds to convert their current claims made coverage back to occurrence. Specifically, an individual insured who requests this option and purchases an occurrence policy from us will receive E-840, which will cover any claims filed after the termination of the insured's claims made coverage that are based upon services rendered between the retroactive date on the expiring claims made policy and the termination of that policy. The effect will be to "tail out" the insured's prior claims made coverage and convert it to occurrence coverage. (Physicians insured through a group policy will receive the same coverage through PEP-0201-00.)

Revised manual pages reflecting the aforementioned modifications are enclosed along with the filing form, 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.

Sincerely,

Melissa Coker

Melissa Coker, Paralegal
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835
Phone: 260-486-0838
Fax: 260-486-0733
melissa.coker@medpro.com

FORMS REMOVED FROM FILING.

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, Jim D. Kunce, 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 — Date: 2/15/07

Signature, Title and Designation of Authorized Actuary — Date: 2/15/07

Insurance Company FEIN 35-0506406 Filing Number 07-IL-100

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

PHYSICIANS AND SURGEONS

EXPLANATORY MEMORANDUM

The Medical Protective Company (MPCo) wishes to introduce a new product enhancement for Physicians & Surgeons in the State of Illinois. The following represents an explanatory of this product and the Company requests an effective date of March 1, 2007.

CONVERTIBLE / NOSE RATING PLAN

The Convertible / Nose Rating plan provides a rating option for claims made insureds who prefer occurrence coverage but find tail premium difficult to pay in a single lump sum. This product allows an insured to migrate to Occurrence coverage immediately and pay such tail premium at a reduced rate over an installment period. The tail premium is reduced to offset the insureds higher premium that would be due under the occurrence program versus claims made, as the insured will pay the applicable premium under this plan in addition to their standard occurrence premium. Corresponding installment options as required by 215 ILCS 5/155.18 will continue to be available to the insureds occurrence premium and no changes are being proposed to such options. As this is an initial product offering, there is no rate impact associated with this filing.

Exhibit A – Rating Examples

Exhibit A provides examples of how this product will be rated and billed/collected.

E840 (07/06) – Convertible Claims Made Endorsement – This endorsement is added to individual policies to clarify the terms and conditions for such coverage. This endorsement is optional, and has a rate impact.

PEP-0201-00 – Convertible Claims Made Endorsement – Professional Liability Coverage – This endorsement is added to Comprehensive Liability for Healthcare Provider policies to clarify the terms and conditions for such coverage. This endorsement is optional, and has a rate impact.

MANUAL RULE PAGES

The Occurrence manual pages have been revised incorporating the proposed changes and are attached to this filing.

The Medical Protective Company
Exhibit A

Convertible Claims Made Rating Example #1

Policyholder Info:	Limit: 1m/3m Policy Type: Occurrence ISO/Speciality 84020 - General Practice "Retro" Date 2004 Years with Med Pro: New Business Insured					
Rating Info:	Years before Exp of Nose (Covg Period)	2				
	CCM Rating Factor	1.19				
Formula:	(Mature CM Premium)	X	CCM Rating Factor	=	CCM Premium	
	11831	X	1.19	=	$	14,079
Premium Due:	Occurrence Premium	$	12,136			
	CCM Coverage:	$	4,693	(1/3 due - 2/3 due over next two policy terms)		
		$	16,829			

Convertible Claims Made Rating Example #2

Policyholder Info:	Limit: 1m/3m Policy Type: Occurrence ISO/Speciality 84020 - General Practice "Retro" Date 2000 Years with Med Pro: New Business Insured					
Rating Info:	Years before Exp of Nose (Covg Period)	4 or more				
	CCM Rating Factor	1.55				
Formula:	(Mature CM Premium)	X	CCM Rating Factor	=	CCM Premium	
	11831	X	1.55	=	$	18,338
Premium Due:	Occurrence Premium	$	12,136			
	CCM Coverage:	$	6,113	(1/3 due - 2/3 due over next two policy terms)		
		$	18,249			

Statement of Actuarial Opinion

IDENTIFICATION

I, James D. Kunce, Actuary, am an officer of The Medical Protective Company (the Company), a Fellow of the Casualty Actuarial Society, and a Member of the American Academy of Actuaries meeting its qualification standards. I was appointed by the Board of Directors of The Medical Protective Company on August 2, 2005 to render this opinion.

SCOPE

I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 2005. My review was limited to the items listed in Exhibit A and did not include an analysis of any income statement or other balance sheet items. The items listed in Exhibit A reflect the Loss Disclosure Reserve Items (3 thru 8) in Exhibit B.

In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by Garret Davenport, Controller of The Medical Protective Company. I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P - Part 1 - Summary of the Company's current Annual Statement. Included in the reconciliation were paid losses, incurred losses, paid defense and cost containment expenses, incurred defense and cost containment expenses and earned premium. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations, as I considered necessary.

OPINION

In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of Indiana.

B. Are computed in accordance with accepted actuarial standards and principles.

C. Make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its contracts and agreements.

Thus I am making a Determination of Reasonable Provision with respect to the amounts carried in Exhibit A.

RELEVANT COMMENTS

It should be noted that reserve calculations deal with the inherent economic and financial uncertainty of future contingent events. Other than as specifically noted, my projections make no provision for the extraordinary future emergence of new classes of losses or types of losses not sufficiently represented in the Company's historical database or which are not yet reported. While I believe the reserves represent a reasonable provision based on the appropriate application of actuarial techniques to the available data, there can be no guarantee that the

actual future payments will not differ, perhaps significantly, from the amounts carried on the balance sheet. No warranty is expressed or implied that this will not occur.

MAJOR RISK FACTORS

The Company has written a variety of coverages whose major risk factors materially impact the variability of the Company's reserves. I have identified the major risk factors as: suits against the company by its insureds or other institutes, other mass torts mainly related to drugs prescribed by our insureds to the general public (eg. Vioxx); and as the company writes medical malpractice insurance new and ever changing medical malpractice legislative issues pose a risk.

The potential impact of these risk factors is described in more detail in the following paragraphs and in the report supporting this Opinion. The absence of other risk factors from this listing does not imply that additional risk factors will not be identified in the future as having been a significant influence on the Company's reserves.

The following paragraphs describe issues associated with each of the three major risk factors identified above:

Suits against the company:

I have assumed that interpretations of coverage implicit in the Company's historical data regarding excess of policy limits and extra contractual obligations will not materially change. I believe that this is a reasonable assumption. However, there is a risk that in the future, there may be social and/or judicial changes that result in an expansion in coverage greater than the Company has experienced in the past, which would have a material impact on reserve projections.

Increases in the number and types of other mass tort lawsuits:

The majority of both indemnity and legal expense liabilities for mass torts arising from medical products have been sustained by the manufacturers of the medical products associated with that particular mass tort. The company believes these past trends pertaining to very limited professional liability indemnity and legal expense expenditures associated with mass tort actions will continue. However a shift in greater allocation of liability toward the healthcare providers is possible.

Medical Malpractice legislative issues:

I have assumed that interpretations of coverage triggers with respect to occurrence dates implicit in the Company's historical data will not materially change. I believe this is a reasonable assumption. However, tort reform modifications have been enacted and continue to be discussed. Such actions could result in shifts in original treatment dates cited by the plaintiffs that vary from the historical patterns.

I believe that the risk factors above, coupled with the variability inherent in any reserve estimate, could result in material adverse deviation from the carried net reserve amounts. In making this determination, I have considered a material adverse deviation to be one in which the actual net outstanding losses and loss adjustment expenses exceed the subtotals in Exhibit A, by an amount greater than 10% of the Company's statutory surplus shown on the Liabilities, Surplus and Other Funds page of the Annual Statement (i.e., a reserve deviation greater than $57 million). My selection of the materiality standard (10% of statutory surplus) was based on the fact that this

opinion is prepared for the regulatory review of The Medical Protective Company. Other measures of materiality might be used for reserves being evaluated in a different context.

DISCLOSURE ITEMS

Included in the reserves are credits for a loss portfolio transfer reinsurance agreement. The agreement became effective on August 8, 1984, and amended on December 27, 1990. Both dates precede the requirements pertaining to loss portfolio transfer reinsurance referenced from "Statements of Statutory Accounting Principles, No. 62". The Indiana Department of Insurance approved this contract at both its inception and amendment dates for treatment as reinsurance and has therefore been treated as prospective reinsurance in the Annual Statement.

In addition the company entered into a loss portfolio agreement with National Indemnity Company and Columbia Insurance Company effective December 31, 2005. This agreement calls for Medical Protective to ceded 50% of its net reserves equally to National Indemnity and Columbia Insurance. Consistent with "Statements of Statutory Accounting Principles, No. 62" paragraph 30 statement d, which states that accounting principles for retro reinsurance shall not apply to "...intercompany reinsurance agreements, and any amendments thereto, among companies 100% owned by a common or ultimate controlling person provided there is no gain in surplus as a result of the transaction", this agreement is not considered retro reinsurance.

Based on discussions with company management and its description of the company's ceded reinsurance, I am not aware of any reinsurance contract that either has been or should have been accounted for as retroactive reinsurance or financial reinsurance.

I have reviewed the Company's exposure to asbestos and environmental claims. In my opinion, there is only a remote chance of material liability, since reported claims are zero and the company writes primarily medical liability coverage.

During the course of my analysis, I reviewed the Company's exposure to terrorist attack losses. No claims have been presented to date. In my opinion, the risk of significant liabilities as of December 31, 2005 arising from terrorist attack losses is remote, given the nature of the coverages provided by the Company and prevailing coverage interpretations.

The Company does not discount loss or loss adjustment expense reserve liabilities.

The Company participates in one mandatory pool (Massachusetts Medical Malpractice Reinsurance Plan) in which premiums and liabilities are assumed in direct proportion to the Company's percentage of direct written premium. Total reserve exposure with respect to pools is considered immaterial (approx $3.76M).

The company's Schedule P, Part 2 summary indicates a reserve release of $407,778,000 during the past year. However, this number is the result of the 50% loss portfolio transfer (LPT) the company entered into on December 31, 2005. The loss activity as shown in Schedule P, Part 2 caused no exceptional values for the NAIC IRIS Tests 10 (One-Year Reserve Development to Surplus), 11 (Two-Year Reserve Development to Surplus) and 12 (Estimated Current Reserve Deficiency to Surplus). Prior to the LPT, the actual reserve adjustment for the year equated to strengthening net reserves for prior accident years by $96,776,000. Reserve activity prior to the LPT would have caused the company to fail NAIC IRIS Test 11 (Two-Year Reserve Development to Surplus). Nearly $79 million of the strengthening was for the company's medical malpractice business in accident years 2001 and 2002.

The Company writes no policies or contracts related to single or fixed premium policies with coverage periods of thirteen months or greater that are non-cancelable and not subject to

premium increase (excluding financial guarantee contracts, mortgage guaranty policies, and surety contracts).

Over 99% of the Company's ceded loss reserves is with either affiliated companies, companies rated A or better by A.M. Best Company, residual market pools or fully collateralized. Less than 1% is with various other companies either rated below A or not rated by A.M. Best Company. Past uncollectibility levels and current amounts in dispute have been reviewed and found to be immaterial relative to surplus. Therefore, reinsurance collectibility does not appear to be an issue.

The Company does not provide for anticipated salvage and subrogation

There has been no change in the actuarial assumptions, procedures, or methods that is likely to have a material effect of the statement loss and loss expense reserves.

This statement of opinion is solely for the use of, and only to be relied upon by, the Company and the various state insurance departments with which it files its Annual Statement.

An Actuarial Report and any underlying actuarial workpapers supporting the findings expressed in this Statement of Actuarial Opinion will be retained for a period of seven years in the administrative offices of The Medical Protective Company and available for regulatory examination.

James D. Kunce, F.C.A.S., M.A.A.A.
The Medical Protective Company
5814 Reed Road, Fort Wayne, IN 46835
260-486-0869
February 24, 2006

EXHIBIT A: SCOPE

Loss Reserves:	Amount
A. Reserve for Unpaid Losses (Liabilities, Surplus, and Other Funds Page 3, Line 1):	$483,111,441
B. Reserve for Unpaid Loss Adjustment Expenses (Liabilities, Surplus, and Other Funds Page 3, Line 3):	$214,470,385
Subtotal: A + B	$697,581,826
C. Reserve for Unpaid Losses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 13 and 15):	$1,306,354,000
D. Reserve for Unpaid Loss Adjustment Expenses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 17, 19 and 21):	$546,689,000
Subtotal: C + D	$1,853,043,000
E. The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$0
F. Other Loss Reserve items on which the Appointed Actuary is Expressing an Opinion (list separately)	$0

Premium Reserves:	Amount
G. Reserve for Direct and Assumed Unearned Premiums for Long Duration Contracts	$0
H. Reserve for Net Unearned Premiums for Long Duration Contracts	$0
I. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately)	$0

EXHIBIT B: DISCLOSURES

1.	Materiality Standard expressed in $US	$57,000,000
2.	Statutory Surplus	$571,330,518
3.	Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P	$0
4.	Discount included as a reduction to loss reserves and loss expense reserves as reported in Schedule P	
	4 (a) Nontabular discount	$0
	4 (b) Tabular discount	$0
5.	The net reserves for losses and expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	$3,755,000
6.	The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	
	6 (a) Asbestos, as disclosed in the Notes to Financial Statements	$0
	6 (b) Environmental, as disclosed in the Notes to Financial Statements	$0
7.	The total claims made extended loss and expense reserve (Schedule P Interrogatories).	
	7 (a) amount reported as loss reserves	$0
	7 (b) amount reported as unearned premium reserves	$11,515,056
8.	Other items on which the Appointed Actuary is providing Relevant Comment (list separately)	$0

THE MEDICAL PROTECTIVE COMPANY

SUPPLEMENTAL EXHIBIT A

ILLINOIS

PHYSICIANS & SURGEONS

CONVERTIBLE REPORTING ENDORSEMENT FACTOR

CM Step	Current Standard Factor	Proposed Convertible Factor	Difference
1	0.90	0.75	-16.7%
2	1.50	1.19	-20.7%
3	1.70	1.40	-17.6%
4	1.82	1.55	-14.8%
5	1.82	1.55	-14.8%

Filing	LLAE Ratio
Standard	76.7%
Convertible	92.5%
Difference	-17.0%

THE MEDICAL PROTECTIVE COMPANY

SUPPLEMENTAL EXHIBIT B

ILLINOIS

PHYSICIANS & SURGEONS

CALCULATION OF UNDERWRITING PROFIT PROVISION
REFLECTING INVESTMENT INCOME

Investment Income Rate	3.68%
Investment Income Tax Rate	14.10%
Underwriting Tax Rate	35.00%
UEPR/Surplus Ratio	2.21
LLAE Reserve/Surplus Ratio	2.10
Variable Expense Ratio	9.62%
Fixed Expense Ratio	8.65%
LLAE Ratio	76.73%
Combined Ratio	95.00%
Underwriting Profit Provision	**5.00%**
Total Return on Surplus	11.82%

Time	Premium Collection Pattern
0.00	100.0%
0.25	0.0%
0.50	0.0%
0.75	0.0%
1.00	0.0%

Time	LLAE Payment Pattern
0.00	0.0%
0.25	0.6%
1.25	13.5%
2.25	33.1%
3.25	25.7%
4.25	14.1%
5.25	5.9%
6.25	3.6%
7.25	1.8%
8.25	0.8%
9.25	0.4%
10.25	0.1%
11.25	0.2%
12.25	0.1%
13.25	0.0%
14.25	0.0%
15.25	0.0%

Time	(1) Collected Premium	(2) Earned Premium	(3) UEPR	(4) Change in UEPR	(5) Written Expenses	(6) Earned Expenses	(7) Incurred LLAE	(8) Paid LLAE	(9) LLAE Reserve	(10) Change in LLAE Reserve	(11) Tax Code Reserve Discount Factors	(12) Discounted LLAE Reserve	(13) Change in Discounted LLAE Reserve	(14) Tax Code UW Profit/Loss	(15) Tax on Tax Code UW Profit/Loss
0.00	$ 100.00	$ -	$ 100.00	$ 100.00	$ 9.62	$ -	$ -	$ -	$ -	$ -	0.9223	$ -	$ -	$ 10.38	$ 3.63
0.25	$ -	$ 25.00	$ 75.00	$ (25.00)	$ -	$ 2.16	$ 19.18	$ 0.50	$ 18.68	$ 18.68	0.9223	$ 17.23	$ 17.23	$ 0.11	$ 0.04
0.50	$ -	$ 25.00	$ 50.00	$ (25.00)	$ -	$ 2.16	$ 19.18	$ -	$ 37.87	$ 19.18	0.9223	$ 34.92	$ 17.69	$ 0.15	$ 0.05
0.75	$ -	$ 25.00	$ 25.00	$ (25.00)	$ -	$ 2.16	$ 19.18	$ -	$ 57.05	$ 19.18	0.9223	$ 52.62	$ 17.69	$ 0.15	$ 0.05
1.00	$ -	$ 25.00	$ -	$ (25.00)	$ -	$ 2.16	$ 19.18	$ -	$ 76.23	$ 19.18	0.9223	$ 70.31	$ 17.69	$ 0.15	$ 0.05
1.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10.34	$ 65.89	$ (10.34)	0.9321	$ 61.41	$ (8.89)	$ (1.45)	$ (0.51)
2.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25.40	$ 40.49	$ (25.40)	0.9291	$ 37.62	$ (23.80)	$ (1.61)	$ (0.56)
3.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19.74	$ 20.75	$ (19.74)	0.8884	$ 18.44	$ (19.18)	$ (0.55)	$ (0.19)
4.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10.82	$ 9.94	$ (10.82)	0.8906	$ 8.85	$ (9.59)	$ (1.23)	$ (0.43)
5.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4.51	$ 5.43	$ (4.51)	0.9288	$ 5.04	$ (3.81)	$ (0.70)	$ (0.25)
6.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2.78	$ 2.65	$ (2.78)	0.9423	$ 2.49	$ (2.55)	$ (0.23)	$ (0.08)
7.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.38	$ 1.27	$ (1.38)	0.9621	$ 1.22	$ (1.28)	$ (0.10)	$ (0.04)
8.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.64	$ 0.63	$ (0.64)	0.9698	$ 0.61	$ (0.61)	$ (0.03)	$ (0.01)
9.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.33	$ 0.30	$ (0.33)	0.9684	$ 0.29	$ (0.32)	$ (0.01)	$ (0.00)
10.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.06	$ 0.24	$ (0.06)	0.9668	$ 0.23	$ (0.06)	$ (0.00)	$ (0.00)
11.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.19	$ 0.06	$ (0.19)	0.9668	$ 0.05	$ (0.18)	$ (0.01)	$ (0.00)
12.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.06	$ -	$ (0.06)	0.9668	$ -	$ (0.05)	$ (0.00)	$ (0.00)
13.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
14.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
15.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
Totals	$ 100.00	$ 100.00		$ -	$ 9.62	$ 8.65	$ 76.73	$ 76.73		$ -			$ (0.00)	$ 5.00	$ 1.75

Time	(16) Total Reserves	(17) From Reserves: Investment Income	(18) From Reserves: Investment Income Net of Tax	(19) Required Surplus	(20) Change in Required Surplus	(21) From Required Surplus: Investment Income	(22) From Required Surplus: Investment Income Net of Tax	(23) Cash Flow	(24) 11.82% Discount Factors	(25) Discounted Cash Flow
0.00	$ 100.00	$ -	$ -	$ 45.24	$ 45.24	$ -	$ -	$ (58.49)	1.0000	$ (58.49)
0.25	$ 93.68	$ 0.91	$ 0.78	$ 42.83	$ (2.41)	$ 0.41	$ 0.35	$ 7.16	0.9725	$ 6.96
0.50	$ 87.87	$ 0.85	$ 0.73	$ 40.65	$ (2.18)	$ 0.39	$ 0.33	$ 6.84	0.9457	$ 6.47
0.75	$ 82.05	$ 0.80	$ 0.68	$ 38.48	$ (2.18)	$ 0.37	$ 0.32	$ 6.78	0.9196	$ 6.24
1.00	$ 76.23	$ 0.74	$ 0.64	$ 36.30	$ (2.18)	$ 0.35	$ 0.30	$ 6.72	0.8943	$ 6.01
1.25	$ 65.89	$ 0.69	$ 0.59	$ 31.38	$ (4.92)	$ 0.33	$ 0.28	$ 6.31	0.8696	$ 5.48
2.25	$ 40.49	$ 2.42	$ 2.08	$ 19.28	$ (12.10)	$ 1.15	$ 0.99	$ 15.73	0.7777	$ 12.23
3.25	$ 20.75	$ 1.49	$ 1.28	$ 9.88	$ (9.40)	$ 0.71	$ 0.61	$ 11.48	0.6955	$ 7.98
4.25	$ 9.94	$ 0.76	$ 0.66	$ 4.73	$ (5.15)	$ 0.36	$ 0.31	$ 6.55	0.6219	$ 4.07
5.25	$ 5.43	$ 0.37	$ 0.31	$ 2.59	$ (2.15)	$ 0.17	$ 0.15	$ 2.85	0.5562	$ 1.59
6.25	$ 2.65	$ 0.20	$ 0.17	$ 1.26	$ (1.33)	$ 0.10	$ 0.08	$ 1.66	0.4974	$ 0.83
7.25	$ 1.27	$ 0.10	$ 0.08	$ 0.60	$ (0.66)	$ 0.05	$ 0.04	$ 0.82	0.4448	$ 0.36
8.25	$ 0.63	$ 0.05	$ 0.04	$ 0.30	$ (0.30)	$ 0.02	$ 0.02	$ 0.37	0.3978	$ 0.15
9.25	$ 0.30	$ 0.02	$ 0.02	$ 0.14	$ (0.16)	$ 0.01	$ 0.01	$ 0.19	0.3557	$ 0.07
10.25	$ 0.24	$ 0.01	$ 0.01	$ 0.11	$ (0.03)	$ 0.01	$ 0.00	$ 0.04	0.3181	$ 0.01
11.25	$ 0.06	$ 0.01	$ 0.01	$ 0.03	$ (0.09)	$ 0.00	$ 0.00	$ 0.10	0.2845	$ 0.03
12.25	$ -	$ 0.00	$ 0.00	$ -	$ (0.03)	$ 0.00	$ 0.00	$ 0.03	0.2544	$ 0.01
13.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.2275	$ -
14.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.2035	$ -
15.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.1819	$ -
Totals		$ 9.41	$ 8.09		$ (0.00)	$ 4.43	$ 3.80	$ 15.14		$ 0.00

THE MEDICAL PROTECTIVE COMPANY

SUPPLEMENTAL EXHIBIT C

ILLINOIS

PHYSICIANS & SURGEONS

CALCULATION OF UNDERWRITING PROFIT PROVISION
REFLECTING INVESTMENT INCOME

Investment Income Rate	3.68%
Investment Income Tax Rate	14.10%
Underwriting Tax Rate	35.00%
UEPR/Surplus Ratio	1.87
LLAE Reserve/Surplus Ratio	2.10
Variable Expense Ratio	9.62%
Fixed Expense Ratio	10.42%
LLAE Ratio	92.46%
Combined Ratio	112.50%
Underwriting Profit Provision	**-12.50%**
Total Return on Surplus	3.34%

Time	Premium Collection Pattern
0.00	100.0%
0.25	0.0%
0.50	0.0%
0.75	0.0%
1.00	0.0%

Time	LLAE Payment Pattern
0.00	0.0%
0.25	0.6%
1.25	13.5%
2.25	33.1%
3.25	25.7%
4.25	14.1%
5.25	5.9%
6.25	3.6%
7.25	1.8%
8.25	0.8%
9.25	0.4%
10.25	0.1%
11.25	0.2%
12.25	0.1%
13.25	0.0%
14.25	0.0%
15.25	0.0%

Time	(1) Collected Premium	(2) Earned Premium	(3) UEPR	(4) Change in UEPR	(5) Written Expenses	(6) Earned Expenses	(7) Incurred LLAE	(8) Paid LLAE	(9) LLAE Reserve	(10) Change in LLAE Reserve	(11) Tax Code Reserve Discount Factors	(12) Discounted LLAE Reserve	(13) Change in Discounted LLAE Reserve	(14) Tax Code UW Profit/Loss	(15) Tax on Tax Code UW Profit/Loss
0.00	$ 100.00	$ -	$ 100.00	$ 100.00	$ 9.62	$ -	$ -	$ -	$ -	$ -	0.9223	$ -	$ -	$ 10.38	$ 3.63
0.25	$ -	$ 25.00	$ 75.00	$ (25.00)	$ -	$ 2.61	$ 23.11	$ 0.60	$ 22.51	$ 22.51	0.9223	$ 20.77	$ 20.77	$ (3.97)	$ (1.39)
0.50	$ -	$ 25.00	$ 50.00	$ (25.00)	$ -	$ 2.61	$ 23.11	$ -	$ 45.63	$ 23.11	0.9223	$ 42.08	$ 21.32	$ (3.92)	$ (1.37)
0.75	$ -	$ 25.00	$ 25.00	$ (25.00)	$ -	$ 2.61	$ 23.11	$ -	$ 68.74	$ 23.11	0.9223	$ 63.40	$ 21.32	$ (3.92)	$ (1.37)
1.00	$ -	$ 25.00	$ -	$ (25.00)	$ -	$ 2.61	$ 23.11	$ -	$ 91.86	$ 23.11	0.9223	$ 84.72	$ 21.32	$ (3.92)	$ (1.37)
1.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12.46	$ 79.40	$ (12.46)	0.9321	$ 74.00	$ (10.72)	$ (1.74)	$ (0.61)
2.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 30.61	$ 48.79	$ (30.61)	0.9291	$ 45.33	$ (28.67)	$ (1.93)	$ (0.68)
3.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23.78	$ 25.01	$ (23.78)	0.8884	$ 22.21	$ (23.11)	$ (0.67)	$ (0.23)
4.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13.03	$ 11.97	$ (13.03)	0.8936	$ 10.66	$ (11.55)	$ (1.48)	$ (0.52)
5.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5.43	$ 6.54	$ (5.43)	0.9288	$ 6.08	$ (4.59)	$ (0.84)	$ (0.30)
6.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3.35	$ 3.19	$ (3.35)	0.9423	$ 3.01	$ (3.07)	$ (0.28)	$ (0.10)
7.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.66	$ 1.53	$ (1.66)	0.9621	$ 1.47	$ (1.54)	$ (0.13)	$ (0.04)
8.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.77	$ 0.75	$ (0.77)	0.9698	$ 0.73	$ (0.74)	$ (0.03)	$ (0.01)
9.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.39	$ 0.36	$ (0.39)	0.9684	$ 0.35	$ (0.38)	$ (0.01)	$ (0.00)
10.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.07	$ 0.29	$ (0.07)	0.9668	$ 0.28	$ (0.07)	$ (0.00)	$ (0.00)
11.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.22	$ 0.07	$ (0.22)	0.9668	$ 0.06	$ (0.22)	$ (0.01)	$ (0.00)
12.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.07	$ -	$ (0.07)	0.9668	$ -	$ (0.06)	$ (0.00)	$ (0.00)
13.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
14.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
15.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
Totals	$ 100.00	$ 100.00		$ -	$ 9.62	$ 10.42	$ 92.46	$ 92.46		$ -			$ (0.00)	$ (12.50)	$ (4.38)

Time	(16) Total Reserves	(17) From Reserves: Investment Income	(18) From Reserves: Investment Income Net of Tax	(19) Required Surplus	(20) Change in Required Surplus	(21) From Required Surplus: Investment Income	(22) From Required Surplus: Investment Income Net of Tax	(23) Cash Flow	(24) 3.34% Discount Factors	(25) Discounted Cash Flow
0.00	$ 100.00	$ -	$ -	$ 53.57	$ 53.57	$ -	$ -	$ (66.83)	1.0000	$ (66.83)
0.25	$ 97.51	$ 0.91	$ 0.78	$ 50.90	$ (2.67)	$ 0.49	$ 0.42	$ 4.54	0.9918	$ 4.50
0.50	$ 95.63	$ 0.88	$ 0.76	$ 48.51	$ (2.39)	$ 0.46	$ 0.40	$ 4.20	0.9837	$ 4.13
0.75	$ 93.74	$ 0.87	$ 0.74	$ 46.13	$ (2.39)	$ 0.44	$ 0.38	$ 4.16	0.9756	$ 4.06
1.00	$ 91.86	$ 0.85	$ 0.73	$ 43.74	$ (2.39)	$ 0.42	$ 0.36	$ 4.13	0.9677	$ 4.00
1.25	$ 79.40	$ 0.83	$ 0.72	$ 37.81	$ (5.93)	$ 0.40	$ 0.34	$ 7.60	0.9597	$ 7.29
2.25	$ 48.79	$ 2.92	$ 2.51	$ 23.23	$ (14.57)	$ 1.39	$ 1.19	$ 18.95	0.9287	$ 17.60
3.25	$ 25.01	$ 1.79	$ 1.54	$ 11.91	$ (11.33)	$ 0.85	$ 0.73	$ 13.83	0.8987	$ 12.43
4.25	$ 11.97	$ 0.92	$ 0.79	$ 5.70	$ (6.21)	$ 0.44	$ 0.38	$ 7.89	0.8696	$ 6.86
5.25	$ 6.54	$ 0.44	$ 0.38	$ 3.12	$ (2.59)	$ 0.21	$ 0.18	$ 3.44	0.8415	$ 2.89
6.25	$ 3.19	$ 0.24	$ 0.21	$ 1.52	$ (1.60)	$ 0.11	$ 0.10	$ 2.00	0.8143	$ 1.63
7.25	$ 1.53	$ 0.12	$ 0.10	$ 0.73	$ (0.79)	$ 0.06	$ 0.05	$ 0.99	0.7879	$ 0.78
8.25	$ 0.75	$ 0.06	$ 0.05	$ 0.36	$ (0.37)	$ 0.03	$ 0.02	$ 0.45	0.7625	$ 0.34
9.25	$ 0.36	$ 0.03	$ 0.02	$ 0.17	$ (0.19)	$ 0.01	$ 0.01	$ 0.23	0.7378	$ 0.17
10.25	$ 0.29	$ 0.01	$ 0.01	$ 0.14	$ (0.03)	$ 0.01	$ 0.01	$ 0.05	0.7139	$ 0.04
11.25	$ 0.07	$ 0.01	$ 0.01	$ 0.03	$ (0.11)	$ 0.01	$ 0.00	$ 0.12	0.6909	$ 0.08
12.25	$ -	$ 0.00	$ 0.00	$ -	$ (0.03)	$ 0.00	$ 0.00	$ 0.04	0.6685	$ 0.02
13.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.6469	$ -
14.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.6260	$ -
15.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.6057	$ -
Totals		$ 10.88	$ 9.34		$ (0.00)	$ 5.31	$ 4.57	$ 5.78		$ (0.00)

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, March 15, 2007 7:24 AM
To: Neuman, Gayle
Subject: FW: Rule Filing #07-IL-100-R
Attachments: 03 14 07 Response.pdf

Dear Ms. Neuman,

Thank you for your email of March 14th, please find our response below and pages attached.

1) As identified on the Filing Checklist, the Company utilizes the statistical agent ISO for data reporting purposes.

2) Please find attached the necessary pages. We apologize for the oversight and error.
Please let me know if you should have any additional questions or need any further information.

Sincerely,
Melissa Coker

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, March 14, 2007 10:55 AM
To: Coker, Melissa
Subject: Rule Filing #07-IL-100-R

Ms. Coker,

We are in receipt of filing #07-IL-100 submitted on February 16, 2007. In the future, rate/rule should be submitted in a filing separate from any forms. Therefore, we changed the filing number to what is referenced in the "subject" line.

Please address the following issues:

1. 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?

2. Medical Protective has a continuous problem with submitting changes on pages that are not updated. Pages SR-IL-III-42 and 43 that were submitted with this filing were previously changed. These pages should be SR-IL-III-68 and 69. Additionally, the text of such pages are not updated. Please submitt the appropriate changes with the updated text.

We request receipt of your response by March 23, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3

Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

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

AVAILABLE

17. **Convertible Coverage Rating Plan**

An insured may be eligible for Convertible / Nose coverage. The rating for such coverage is based upon the insureds standard mature claims made rate times the factor identified in the table below.

Number of years before expiration date of Nose coverage	Factor
0	0.750
1	1.190
2	1.400
3	1.550
4 or more	1.550

The applicable premium under this plan shall be in addition to the insureds standard occurrence premium and shall be paid to the company over an installment period.

The above rating is subject to applicable part-time and schedule rating modifications.

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

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

AVAILABLE

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

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.

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

Credit
5%

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

Max AvailableCredit
50%

Contact Person:
Gayle Neuman
217-524-6497
Gayle.Neuman@illinois.gov

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
_X__MEDICAL MALPRACTICE	11.0000	***This checklist is for rate/rule filings only. See separate form checklist.
___Claims Made	11.10000	
_X__Occurrence	11.2000	

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_X_Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	Certificate No. 546900-51
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including all rates.	Not Applicable

		b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	The Company's Statistical Agent is ISO. This filing does not modify the existing base rate for Physicians & Surgeons, and thus there is no rate effect as a result.
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty	March 1, 2007

	929	Compliance Section, except as otherwise provided in Section 155.18.	
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	N/A
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Enclosed
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the	Refer to enclosed Cover letter for relevant information. This is a new product filing, and does not supersede an existing filing. Actuarial Certification is enclosed.

		superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	N/A – no rate effect to current insureds.
PAYMENT PLANS			
Quarterly premium payment installment	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability	Current Rules and procedures comply

plan required as prescribed by the Director.		insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	with requirements
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Current Rules and procedures comply with requirements.
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the	Current Rules and procedures comply with requirements

		section that applies.	
CLAIMS MADE REQUIREMENTS			

Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2)
	
	Company Bulletin 88-50
		When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals:
		
		• Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).***
		
		• Cost of the extended reporting period, which must be priced as a factor of one of the following:***
		
		  o the last 12 months' premium.
		  o the premium in effect at policy issuance.
		  o the expiring annual premium.
		
		• List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium.
		
		• Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated.
		
		• Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request.
		
		• Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.***
		
		• Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first.
		
		***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must:
		
		• Offer free 5-year extended reporting period (tail coverage) or
		• Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate
			Current rules and procedures comply with requirements.

		expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	N/A
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Rate applicable to currently filed rates.
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Current Rules and procedures comply with requirements.
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	N/A
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and	

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	N/A
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	Enclosed
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	The Companys statistical agent is ISO.
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any	215 ILCS 5/155.18 50 IL Adm. Code	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The	Enclosed.

rate filing, as well as any rule filing that affects the ultimate premium.	929	explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	N/A
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	N/A – Existing rates are not being changed
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	N/A
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	N/A
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	N/A
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	N/A
Loss Adjustment Expenses			

Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	N/A
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	N/A
Other Actuarial Information Required			

Insurers must include the information described in this section.	215 ILCS 5/155.18
	
	50 IL Adm. Code 929
		Insurers shall also include the following information:
		
		• All actuarial support/justification for all rates being changed, including but not limited to changes in:
		  ○ Base rates;
		  ○ Territory definitions;
		  ○ Territory factor changes;
		  ○ Classification factor changes;
		  ○ Classification definition changes;
		  ○ Changes to schedule credits/debits, etc.
		
		• Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed.
			N/A

		• Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	N/A

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

September 12, 2006

RECEIVED
SEP 12 2006
IDFPR (LPC)
DIVISION OF INSURANCE
SPRINGFIELD

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
COMPANY FILE NO: 06-IL-99
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS, DENTISTS and ALLIEDS
Occurrence and Standard Claims Made Programs
Various Rule Revision (rule grid attached)

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revised General Manual Pages and State Rate Pages

PROPOSED EFFECTIVE DATE: 01/01/07

Dear Mr. Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to our Illinois Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Package programs. We request an effective date of January 1, 2007 for this filing.

The accompanying rule filing grid provides detailed title, description, if the rule is revised or new and the degree and program explaining the various rule changes. The overall rate impact of this filing is +0.0%. In addition, we have enclosed revised general manual pages and state rate pages for the Company's Comprehensive Liability Coverage for Health Care Providers. These pages included for this program mirror those used for the Company's individual Physicians & Surgeons, Dentists and Allied Health Care Provider Programs, and therefore are being included in this submission.

Revised manual pages reflecting the aforementioned modifications are enclosed along with 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.

Sincerely,

Melissa Coker

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

Enclosure(s)

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 0% - rule revision with no rate impact

(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 Line 11 - Med Mal (DDS)	$1,623,962	0%
Line of Insurance (MD)	$12,828,450	

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): The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to our Illinois Physicians & Surgeons, Dentists, Allieds and Comprehensive Liability Package programs. We request an effective date of January 1, 2007 for this filing.

The accompanying rule filing grid provides detailed title, description, if the rule is revised or new and the degree and program explaining the various rule changes. The overall rate impact of this filing is +0.0%. In addition, we have enclosed revised general manual pages and state rate pages for the Company's Comprehensive Liability Coverage for Health Care Providers. These pages included for this program mirror those used for the Company's individual Physicians & Surgeons, Dentists and Allied Health Care Provider Programs, and therefore are being included in this submission.

Revised manual pages reflecting the aforementioned modifications are enclosed along with 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

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
SEP 12 2006
SPRINGFIELD, ILLINOIS

The Medical Protective Company
Name of Company

Phillip J. Troyer, Associate General Counsel
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, __, Jim D. Kunce, 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 — Date: 10/5/06

Signature, Title and Designation of Authorized Actuary — Date: 10/5/06

Insurance Company FEIN 35-0506406 Filing Number 06-IL-99

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

The Medical Protective Company
Countrywide Rule Revision Filing
ILLINOIS

Title	New or Revised	Description	Indv Stand Alone Program						Comprehensive Program - General Manual					Comprehensive Program - State Rate Pages				
			MD		DDS		ANCP											
			Occ	Sum	Occ	Sum	Occ	Sum	Sect I	Sect II	Sect III	Sect IV	Sect V	Sect I	Sect II	Sect III	Sect IV	Sect V
Accelerated Extension Contract Rating	Revised	Revised to clarify the application of the rule. This change has no rate impact.		X		X		X	X	X	X	X	X					
Aggregate Credit Rule	Revised	Revised to incl 50% on State Rate Page, in leiu of "available" This change has no rate impact.														X	X	X
Allied FTE Rating Rule	Revised	Revised credits to reflect FTE Allied Exposures rather than MD Exposures. This change has no rate impact as we currently write zero Allieds as FTE's.					X	X					X					X
Claim Free Credit Rule	Revised	Revised - to include Part Time Years in calculation. This change does not have a significant rate impact.	X	X	X	X					X	X						
Convertible CM Rating Rule	Revised	Revised to include New to Company Credit in the calc, where available.										X						
Extension Contract Rating Rule	Revised	Revised to include Deductible credits in calculation of Extension Contract Rating. This revision has no significant rate impact.		X		X		X	X									
Group Rating Rule	Revised	Revised to clarify the application of the rule and the rating of the extension contract for Large Groups								X	X		X		X	X		X
Large Group Rating Rule	Revised	Revised to clarify the calculation of the Extension Contract Rating formula. This revision has no rate impact.								X	X		X					
Leave of Absence / FMLA Issues	Revised	Revise Leave of Absence Credit Rule provide a credit for FMLA issues, and revises the credit to 100%. This revision has no significant rate impact.	X	X	X	X	X	X			X	X	X			X		X
Locum Tenens Group Rating	Revised - Change in Title only	Revised to change title from Locum Tenens Group Rating to Temporary Staffing Agency Rating. This revision has no rate impact.								X	X		X		X	X		X
Partnership / corporation Rating	Revised	Revised to provide a separate charge for Corporation coverage for Oral Surgeons of 1%. This revision has no significant rate impact.															X	
Renewal Rate Rule	New - placemat, revised - modular	This rule is being introduced to hold the insureds rate constant for a subsequent renewal period when certain conditions are met. This rule has no significant rate impact.	X	X	X	X	X	X	X							X	X	
Risk Management Credit Rule	Revised	Revised to incl an additional 2.5% credit for electronic medical records. This revision has no significant rate impact.	X	X	X	X	X	X			X	X	X			X	X	X
Schedule Rating Plan	Revised	Revised langauge within each criteria to allow for a debit or credit to be applied for better or worse than average conditions. There are no other revisions to this rule and the changes have no rate impact.	X	X	X	X	X	X		X	X	X	X			X	X	X
Deductible Credits	Revised	Revised credits to reflect additional expenses not originally contemplated in Medical Protectives initial filing of deductible credits. This revision has no significant rate impact.	X	X			X	X							X	X	X	X
New to Company Credit	New	This rule is being introduced to provide a credit for new insureds of Medical Protective. This credit has no significant rate impact.										X					X	
New to Practice Credit	Revised	Revise credit structure to 60/40/20. This revision has no significant rate impact.															X	

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Friday, December 22, 2006 11:26 AM
To: Neuman, Gayle
Subject: FW: Rule Filing #06-IL-99 - additional questions
Attachments: Response2.pdf

Please find it attached.

Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, December 22, 2006 11:29 AM
To: Coker, Melissa
Subject: RE: Rule Filing #06-IL-99 - additional questions

Melissa,

One last change - on SR-IL-V-9, the paragraph "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**." The words "policy term" were not included.

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, December 22, 2006 9:14 AM
To: Coker, Melissa
Subject: RE: Rule Filing #06-IL-99

Melissa,

Thanks for your prompt attention. I have a few more issues to address:

1. We need you to provide the final print of SR-IL-II-3 (I mistakenly indicated page 2 in my previous e-mail).

2. Issue 5 of my previous e-mail was not addressed. Page SR-IL-V-8 did not include the "quarterly installment option" that was previously filed on 9/14/06.

We request receipt of your response by December 29, 2006.

Happy Holidays to You!

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]

Sent: Friday, December 22, 2006 6:51 AM
To: Neuman, Gayle
Subject: FW: Rule Filing #06-IL-99
Importance: High

Ms. Neuman,

Please find attached the revised pages that will respond to your correspondence of December 5th. We have included a complete copy of the Section IV state rate pages (your item 3) as adding the additional text caused the page numbering to change.

Please let me know if you should need anything additional.
Melissa

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Friday, December 22, 2006 9:30 AM
To: Neuman, Gayle
Subject: FW: Rule Filing #06-IL-99 - additional questions
Attachments: 12 22 06 Response.pdf

Here's the additional information, item #2 was inadvertently not scanned with the response earlier today, the attachment should cover the items in your last email. Let me know if you need anything additional.

Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, December 22, 2006 9:14 AM
To: Coker, Melissa
Subject: RE: Rule Filing #06-IL-99

Melissa,

Thanks for your prompt attention. I have a few more issues to address:

1. We need you to provide the final print of SR-IL-II-3 (I mistakenly indicated page 2 in my previous e-mail).

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We request receipt of your response by December 29, 2006.

Happy Holidays to You!

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Friday, December 22, 2006 6:51 AM
To: Neuman, Gayle
Subject: FW: Rule Filing #06-IL-99
Importance: High

Ms. Neuman,

Please find attached the revised pages that will respond to your correspondence of December 5th. We have included a complete copy of the Section IV state rate pages (your item 3) as adding the additional text caused the page numbering to change.

Please let me know if you should need anything additional.
Melissa

19. **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.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Friday, December 22, 2006 7:36 AM
To: Neuman, Gayle
Subject: RE: Rule Filing #06-IL-99
Attachments: response 122206.pdf

I am so sorry!, please find them attached below.

Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, December 22, 2006 8:29 AM
To: Coker, Melissa
Subject: RE: Rule Filing #06-IL-99

There were no pages attached.

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Friday, December 22, 2006 6:51 AM
To: Neuman, Gayle
Subject: FW: Rule Filing #06-IL-99
Importance: High

Ms. Neuman,

Please find attached the revised pages that will respond to your correspondence of December 5th. We have included a complete copy of the Section IV state rate pages (your item 3) as adding the additional text caused the page numbering to change.

Please let me know if you should need anything additional.
Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, December 18, 2006 4:23 PM
To: Nielsen, Kimberly
Subject: FW: Rule Filing #06-IL-99

Kim,

I got your voice mail message. A response by the end of the week is fine. Thank you for your response.

From: Neuman, Gayle
Sent: Monday, December 18, 2006 1:23 PM
To: 'Coker, Melissa'
Subject: FW: Rule Filing #06-IL-99

No response to the attached e-mail has been received. Do you wish to withdraw this filing?

From: Neuman, Gayle
Sent: Tuesday, December 05, 2006 1:49 PM
To: 'Coker, Melissa'
Subject: Rule Filing #06-IL-99

Ms. Coker,

Please address the following issues/questions:

1. Page SR-IL-II-2 indicate the dentists' scheduled rating maximum is +/-30%. Other pages indicate it is +/-50%.

2. We need you to provide the final print of SR-IL-II-2.

3. Page SR-IL-IV-15 has two paragraphs missing after the second chart under premium credits.

4. Since other changes are required, there were two typographical errors on both AEC-CWs ("extended" and
"insured" are misspelled).

5. Page SR-IL-V-8 did not include the "quarterly installment option" that was filed on 9/14/06.

Upon completed review of these filings, filing #06-IL-99 will be inserted in the manual before filing #06-IL-101.

We request your response by no later than December 12, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENED 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 FIVE YEARS.

3) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSRUED HAD LIMITED PRIOR ACTS EXPOSURE.

4) AT THE TIME THE INSURED PERMANENTLY RETIRES, HE OR SHE HAS ATTAINED THE AGE OF 55 AND IS ASSOCIATED WITH THE GROUP INSURED BY THE COMPANY.

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

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

ACCELERATED EXTENSION CONTRACT RULE

THE COMPANY MAY AGREE TO WAIVE THE STANDARD REQUIREMENTS FOR QUALIFYING FOR A FREE EXTENED 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 MEDICINE IN LESS THAN FIVE YEARS.

3) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSRUED HAD LIMITED PRIOR ACTS EXPOSURE.

4) AT THE TIME THE INSURED PERMANENTLY RETIRES, HE OR SHE HAS ATTAINED THE AGE OF 55 AND IS ASSOCIATED WITH THE GROUP INSURED BY THE COMPANY.

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

3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.750	1.150	1.200
5 or more	1.820	1.750	1.200	1.250

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

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$25
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 35%
Allied Health Care Providers	+/- 50%

+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

2. Deductible Credits
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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.

3. Self-Insured Retention Credits

NOT AVAILABLE

4. Group, Large Group & Temporary Staffing Agency Rating – Corporations
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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

Dentists	$100

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

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

NOT AVAILABLE

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	$25

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

AVAILABLE

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

Years New to Practice	Credit
1st	60%
2nd	40%
3rd	20%

5. **New to Company Credit**

Program	Credit
Standard Claims Made	25%
Occurrence	25%

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 - 50% / + 50%		

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

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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%

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: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

16. **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.

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

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

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.

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

AVAILABLE

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

Credit
5%

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

Max AvailableCredit
50%

25. 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.

XVII. Extended Reporting Period Coverage

C. 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 Expiring standard mature claims made rate, subject to expiring part time, Non-Discretionary Debit and schedule rating modifications.

Neuman, Gayle

From: Neuman, Gayle
Sent: Monday, December 18, 2006 3:23 PM
To: 'Nielsen, Kimberly'
Subject: FW: Rule Filing #06-IL-99

Kim,

I got your voice mail message. A response by the end of the week is fine. Thank you for your response.

From: Neuman, Gayle
Sent: Monday, December 18, 2006 1:23 PM
To: 'Coker, Melissa'
Subject: FW: Rule Filing #06-IL-99

No response to the attached e-mail has been received. Do you wish to withdraw this filing?

From: Neuman, Gayle
Sent: Tuesday, December 05, 2006 1:49 PM
To: 'Coker, Melissa'
Subject: Rule Filing #06-IL-99

Ms. Coker,

Please address the following issues/questions:

1. Page SR-IL-II-2 indicate the dentists' scheduled rating maximum is +/-30%. Other pages indicate it is +/-50%.

2. We need you to provide the final print of SR-IL-II-2.

3. Page SR-IL-IV-15 has two paragraphs missing after the second chart under premium credits.

4. Since other changes are required, there were two typographical errors on both AEC-CWs ("extended" and "insured" are misspelled).

5. Page SR-IL-V-8 did not include the "quarterly installment option" that was filed on 9/14/06.

Upon completed review of these filings, filing #06-IL-99 will be inserted in the manual before filing #06-IL-101.

We request your response by no later than December 12, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

MEDICAL PROTECTIVE
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October 17, 2006

Ms. Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

Re: The Medical Protective Company NAIC#11843
Company Filing Number: 06-IL-98
Dentists Professional Liability Filing 01/01/2007

Dear Ms. Anderson:

Thank you for your attention to our filing. The following responds to the items raised concerning the above captioned Medical Protective Company (MPCo) filing.

1. We need to see actuarial justification exhibits for all rate changes...please provide me with all relevant items by September 28, 2006.

MPCo has analyzed its class relativities and increased limits factor on a countrywide basis and filed these changes countrywide. We are not modifying Illinois overall base rates, but are only changing a couple of small classes and our Increased Limits Factors (ILF). Since MPCo does not write a sufficient volume by class or limit in any single state, countywide data was used for the analysis. The analysis underlying the class & ILF analysis is provided in attached Supplemental Exhibits A and Supplemental Exhibits B, respectively.

Class
The following class changes are proposed in the filing (Exhibit A-I & A-II):

Change	Specialty	Current Relativity	Proposed Relativity
A	Implants/Host Dentists	1B – 1.25	1A – 1.00
B	Oral Pathologist	2A – 3	1B – 1.25

Each of the above classes represents a small portion of MPCo's dental professional liability book of business. Over 93% of MPCo insureds are Class 1A General Dentists, and thus, MPCo has limited data available for actuarially determining the rate for other classes. As such, MPCo's underwriting department has completed an analysis of each of the exposures from a risk perspective and has proposed the above modifications to the

class plan based on our underwriting judgment of the current risks in these specialties and is consistent with how the industry also treats these specialties..

ILF

Supplemental Exhibits B-I and B-II provide the actuarial support for the increased limits factor modifications for dentists and oral surgeons, respectively. The exhibits employ the Lognormal Distribution to calculate the Limited Expected Values [Column (2)] associated with the various limits of liability offered. The resulting Limited Expected Values are summed with Allocated Loss Adjustment Expenses [Column (3)], Unallocated Loss Adjustment Expenses [Column (4)] to produce the Limited Loss and Loss Adjustment Expenses associated with individual limits [Column (5)]. Expenses are loaded into the pure premiums to arrive at the indicated factors.

2. Schedule Rating Plan

When Med Pro files this new manual page, please provide me with a corrected copy for each filing that Med Pro has outstanding with Illinois along with a note indicating which filing number it belongs with. My reason for asking is to assure that all of my files are complete for any future reference.

The following represents the filings in which schedule rating justification has been requested. We wish to amend these filings accordingly.

Program	Filing Number	Revisions Submitted	Pages
Physicians & Surgeons	06-IL-101	10-12-06	SRP-IL & SR-IL-III-65 (01/01/07)
Dentists	06-IL-99	10-17-06	SRP-IL & SR-IL-IV-14 (11/01/07)
Allied Healthcare Providers	06-IL-99	10-17-06	SRP-IL & SR-IL-V-6 (11/01/07)
Hospitals	M-HPL-IL-05-00983-1-R	8-16-06 (withdrawn)	Filing Withdrawn

We trust the above has been responsive to the department's questions. Thank you for your continued attention to our filing.

Sincerely,

Kimberly A. Nielsen
Product Manager & Department Ops Leader
260-486-0801
encl:

Neuman, Gayle

From: Anderson, Julie
Sent: Wednesday, October 18, 2006 9:21 AM
To: Neuman, Gayle
Subject: FW: Med Pro Rate filing #06-IL-98
Attachments: 10 17 06 Response.pdf

I'm sorry. I thought Kim had copied you on her response.

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

Please note that my e-mail address has changed to: Julie.A.Anderson2@illinois.gov

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From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 2:04 PM
To: Anderson, Julie
Cc: Coker, Melissa; Clark, Eric; Whitcraft, Joel
Subject: FW: Med Pro Rate filing #06-IL-98

Dear Julie -

Thank you for your patienceas we prepared our response to your questions. Please accept the following, and let me know if you have additional questions or need more information. Thank you.

From: Anderson, Julie [mailto:Julie.A.Anderson2@illinois.gov]
Sent: Thursday, September 14, 2006 9:40 AM
To: Coker, Melissa
Cc: Nielsen, Kimberly
Subject: Med Pro Rate filing #06-IL-98

Hi, Melissa,

Thank you for your e-mail indicating the correction to the rate effect to +2.1% for this filing. I have started my initial review of this filing and find that I can't complete my review without more information. We need to see actuarial justification exhibits for all rate changes. Please refer to the link below for a list of actuarial information needed in all medical malpractice rate filings and please provide me with all relevant items by **September 28, 2006.**

http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/MedicalMalpracticeLiabilityRates.htm

Also, I wanted to touch base on the schedule debits/ credit issue. Kim Nielsen has indicated to me that Med Pro intends to refile the page in your manual to reflect our concerns. I haven't seen this refile yet, but I expect it soon. What I wanted to bring up to you is that I have several Med Pro filings that I am reviewing and nearly all of them have the schedule debit/credit rule that Med Pro has indicated they will be correcting. So, I request this: when Med Pro files this new manual page, please provide me with a corrected copy for each filing that Med Pro has outstanding with Illinois along with a note indicating which filing number it belongs with. My reason for asking is to assure that all of my files are complete for any future reference.

Thank you very much and please give me a call if you have any questions. Have an awesome day!

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

Please note that my e-mail address has changed to: Julie.A.Anderson2@illinois.gov

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

1. <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.

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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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   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).

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6. NUMBER/TYPE OF PATIENT EXPOSURES:
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9. **Schedule Rating**
(Occurrence & Standard Claims Made Programs)

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Healthcare Standards, Quality & Claim Review.	Presence of (1) committees that meet on a routine basis to review dental 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 undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification - 50% / + 50%	

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

1. <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.

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SCHEDULE RATING PLAN

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 DENTISTRY.

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.

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.

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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.

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.

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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.

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, 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.

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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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OCT - 6 2006
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

October 5, 2006

Ms. Gayle Neuman
Property & Casualty Compliance
Division of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY NAIC (11843)
File No: 06-IL-99
Response to Questions dated 9/29/06

Dear Ms. Neuman:

In response to your e-mail dated September 29, 2006 regarding the above referenced filing, please accept this as our response. Please find enclosed the following:

- Completed and Signed Certification dated 10/5/06
- Complete Copy of Current Rate & Rule Manuals indicating changes from subsequent filings for the following programs:
  - Individual – Stand alone Program
  - Comprehensive Liability Coverage for Healthcare Providers

Additionally, during the preparation of the manuals, it was discovered that certain manual pages were incorrect upon submission. Therefore, please find enclosed revised manual pages that should be *replaced* within the original submission packet for your review. We have incorporated these revisions in the strike thru versions noted above.

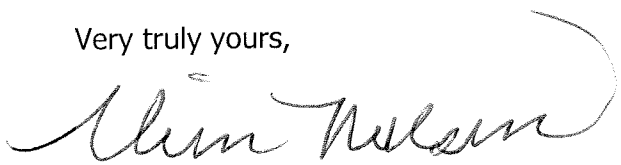
- **Add Leave of Absence Credit Rule** to filing packet for Dentists Occurrence & Standard Claims Made Programs. This was referenced in the summary grid which accompanied the filing, but was inadvertently omitted within the manual that was submitted for review.
  - **Add:** LAC-CW 06/01/06
  - **Remove and Replace:** SR-IL-IV-13.

- **Revise Quarterly Installment Option** to filing packet for Physicians & Surgeons & Dentists. This was included in a previous filing submission, but was inadvertently omitted within the manual that was submitted for review.
  - **Remove and Replace**: SR-IL-III-43
  - **Add**: SR-IL-IV-18.

- **Revise Extension Contract Rating** to filing packet for Dentists. This rule was revised at the DOI's request in a prior submission, but was inadvertently omitted within the manual that was submitted for review.
  - **Remove and Replace:** ERC-CW (06/01/06) & SR-IL-I-1 (01/01/07)

We appreciate your patience in reviewing these submissions which are changing recurrently. Feel free to contact me, at any time, at 800-348-4669. Thank you for your attention to our submission.

Very truly yours,



Kimberly A. Nielsen
Product Manager & Department Ops Leader
(260) 486-0801

Encl: Med Mal Certification
Leave of Absence Credit Rule (DDS)
SR-IL-IV-13
SR-IL-III-43
SR-IL-IV-18
Extension Contract Rating Rule
SR-IL-I-1
Individual Placemat Manual
Comprehensive Liability Coverage for Healthcare Providers Manual

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

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.

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

Credit
5%

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

Max AvailableCredit
50%

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

AVAILABLE

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

Years New to Practice	Credit
1st	60%
2nd	40%
3rd	20%

5. **New to Company Credit**

Program	Credit
Standard Claims Made	25%
Occurrence	25%

6. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

7. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	75%
Standard Claims Made	50%

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

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

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DENTISTS

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 DEBITS.

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.

Neuman, Gayle

From: Neuman, Gayle
Sent: Friday, September 29, 2006 8:47 AM
To: 'Nielsen, Kimberly'
Subject: RE: Physicians & Surgeons, Dentists, and Allieds - Rate/Rule Filing #06-IL-99 (CW RULE FILING)

Dear Kim,

Thank you for your response.

The certification provided was signed by Jim Kunce effective 9/28/07. We need a certification with a current effective date.

Provide a copy of the complete rate/rule manual, including any changes made with this filing. 50 Ill. Adm. Code 929.30 requires identification of all changes from superseding filings. We request a written statement indicating the only changes made to the filing were disclosed to this Division. This should also include instructions as to where specific information has been moved to and where it was previously provided.

Thank you for your prompt assistance. We request receipt of your response by October 6, 2006.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Thursday, September 28, 2006 4:12 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: FW: Physicians & Surgeons, Dentists, and Allieds - Rate/Rule Filing #06-IL-99 (CW RULE FILING)
Importance: High

Dear Gayle,

Please find attached a completed Illinois Certification for Medical Malpractice Rates.

The Medical Protective Company collects and reports statistically to ISO (Insurance Services Organization).

In 06-IL-94, we submitted Comprehensive Liability Coverage for Healthcare Provider manual pages, State Rate Page Section IV. Under this section, we added "New to Company Credit Rule" as item 24.

In 06-IL-99, we submitted various revised Comprehensive Liability Coverage for Healthcare Provider manual pages for all sections. Specifically to your question, in State Rate Page Section IV, we *moved* the rule "New to Company Credit Rule" from item 24 to item 5. This was done in an effort to flow more appropriately with the revisions being made in the General Manual, Section IV which applies on a countrywide basis.

As stated in my voice mail I left for you today, I will be happy to discuss this with you further if you have any questions. Please feel free to contact me directly, anytime, at 260-486-0801. Thank you.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, September 21, 2006 10:39 AM
To: Coker, Melissa
Subject: Physicians & Surgeons, Dentists, and Allieds - Rate/Rule Filing #06-IL-99

Ms. Coker,

We are in receipt of the above referenced filing submitted by your letter dated September 12, 2006.

At this time, we have not completed a thorough review of this filing. However, we do require that it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates and/or rate rules are based on sound actuarial principles and are not inconsistent with the company's experience. Please complete the attached certification form.

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?

Additionally, please review filing #06-IL-94 which is just one of the four Med Pro pending dental filings (three of them received within the past four months). There is language in the #06-IL-94 filing that is not provided in this new submission. Please explain how such information has changed.

Your response is due by October 4, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Thursday, September 28, 2006 4:12 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: FW: Physicians & Surgeons, Dentists, and Allieds - Rate/Rule Filing #06-IL-99 (CW RULE FILING)
Importance: High
Attachments: 06-IL-99 certification.pdf

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Your response is due by October 4, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

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, __, Jim D. Kunce, 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 — Date: 9/28/07

Signature, Title and Designation of Authorized Actuary — Date: 9/28/07

Insurance Company FEIN 35-0506406 Filing Number 06-IL-99

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

Statement of Actuarial Opinion

IDENTIFICATION

I, James D. Kunce, Actuary, am an officer of The Medical Protective Company (the Company), a Fellow of the Casualty Actuarial Society, and a Member of the American Academy of Actuaries meeting its qualification standards. I was appointed by the Board of Directors of The Medical Protective Company on August 2, 2005 to render this opinion.

SCOPE

I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 2005. My review was limited to the items listed in Exhibit A and did not include an analysis of any income statement or other balance sheet items. The items listed in Exhibit A reflect the Loss Disclosure Reserve Items (3 thru 8) in Exhibit B.

In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by Garret Davenport, Controller of The Medical Protective Company. I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P - Part 1 - Summary of the Company's current Annual Statement. Included in the reconciliation were paid losses, incurred losses, paid defense and cost containment expenses, incurred defense and cost containment expenses and earned premium. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations, as I considered necessary.

OPINION

In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of Indiana.

B. Are computed in accordance with accepted actuarial standards and principles.

C. Make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its contracts and agreements.

Thus I am making a Determination of Reasonable Provision with respect to the amounts carried in Exhibit A.

RELEVANT COMMENTS

It should be noted that reserve calculations deal with the inherent economic and financial uncertainty of future contingent events. Other than as specifically noted, my projections make no provision for the extraordinary future emergence of new classes of losses or types of losses not sufficiently represented in the Company's historical database or which are not yet reported. While I believe the reserves represent a reasonable provision based on the appropriate application of actuarial techniques to the available data, there can be no guarantee that the

actual future payments will not differ, perhaps significantly, from the amounts carried on the balance sheet. No warranty is expressed or implied that this will not occur.

MAJOR RISK FACTORS

The Company has written a variety of coverages whose major risk factors materially impact the variability of the Company's reserves. I have identified the major risk factors as: suits against the company by its insureds or other institutes, other mass torts mainly related to drugs prescribed by our insureds to the general public (eg. Vioxx); and as the company writes medical malpractice insurance new and ever changing medical malpractice legislative issues pose a risk.

The potential impact of these risk factors is described in more detail in the following paragraphs and in the report supporting this Opinion. The absence of other risk factors from this listing does not imply that additional risk factors will not be identified in the future as having been a significant influence on the Company's reserves.

The following paragraphs describe issues associated with each of the three major risk factors identified above:

Suits against the company:

I have assumed that interpretations of coverage implicit in the Company's historical data regarding excess of policy limits and extra contractual obligations will not materially change. I believe that this is a reasonable assumption. However, there is a risk that in the future, there may be social and/or judicial changes that result in an expansion in coverage greater than the Company has experienced in the past, which would have a material impact on reserve projections.

Increases in the number and types of other mass tort lawsuits:

The majority of both indemnity and legal expense liabilities for mass torts arising from medical products have been sustained by the manufacturers of the medical products associated with that particular mass tort. The company believes these past trends pertaining to very limited professional liability indemnity and legal expense expenditures associated with mass tort actions will continue. However a shift in greater allocation of liability toward the healthcare providers is possible.

Medical Malpractice legislative issues:

I have assumed that interpretations of coverage triggers with respect to occurrence dates implicit in the Company's historical data will not materially change. I believe this is a reasonable assumption. However, tort reform modifications have been enacted and continue to be discussed. Such actions could result in shifts in original treatment dates cited by the plaintiffs that vary from the historical patterns.

I believe that the risk factors above, coupled with the variability inherent in any reserve estimate, could result in material adverse deviation from the carried net reserve amounts. In making this determination, I have considered a material adverse deviation to be one in which the actual net outstanding losses and loss adjustment expenses exceed the subtotals in Exhibit A, by an amount greater than 10% of the Company's statutory surplus shown on the Liabilities, Surplus and Other Funds page of the Annual Statement (i.e., a reserve deviation greater than $57 million). My selection of the materiality standard (10% of statutory surplus) was based on the fact that this

opinion is prepared for the regulatory review of The Medical Protective Company. Other measures of materiality might be used for reserves being evaluated in a different context.

DISCLOSURE ITEMS

Included in the reserves are credits for a loss portfolio transfer reinsurance agreement. The agreement became effective on August 8, 1984, and amended on December 27, 1990. Both dates precede the requirements pertaining to loss portfolio transfer reinsurance referenced from "Statements of Statutory Accounting Principles, No. 62". The Indiana Department of Insurance approved this contract at both its inception and amendment dates for treatment as reinsurance and has therefore been treated as prospective reinsurance in the Annual Statement.

In addition the company entered into a loss portfolio agreement with National Indemnity Company and Columbia Insurance Company effective December 31, 2005. This agreement calls for Medical Protective to ceded 50% of its net reserves equally to National Indemnity and Columbia Insurance. Consistent with "Statements of Statutory Accounting Principles, No. 62" paragraph 30 statement d, which states that accounting principles for retro reinsurance shall not apply to "...intercompany reinsurance agreements, and any amendments thereto, among companies 100% owned by a common or ultimate controlling person provided there is no gain in surplus as a result of the transaction", this agreement is not considered retro reinsurance.

Based on discussions with company management and its description of the company's ceded reinsurance, I am not aware of any reinsurance contract that either has been or should have been accounted for as retroactive reinsurance or financial reinsurance.

I have reviewed the Company's exposure to asbestos and environmental claims. In my opinion, there is only a remote chance of material liability, since reported claims are zero and the company writes primarily medical liability coverage.

During the course of my analysis, I reviewed the Company's exposure to terrorist attack losses. No claims have been presented to date. In my opinion, the risk of significant liabilities as of December 31, 2005 arising from terrorist attack losses is remote, given the nature of the coverages provided by the Company and prevailing coverage interpretations.

The Company does not discount loss or loss adjustment expense reserve liabilities.

The Company participates in one mandatory pool (Massachusetts Medical Malpractice Reinsurance Plan) in which premiums and liabilities are assumed in direct proportion to the Company's percentage of direct written premium. Total reserve exposure with respect to pools is considered immaterial (approx $3.76M).

The company's Schedule P, Part 2 summary indicates a reserve release of $407,778,000 during the past year. However, this number is the result of the 50% loss portfolio transfer (LPT) the company entered into on December 31, 2005. The loss activity as shown in Schedule P, Part 2 caused no exceptional values for the NAIC IRIS Tests 10 (One-Year Reserve Development to Surplus), 11 (Two-Year Reserve Development to Surplus) and 12 (Estimated Current Reserve Deficiency to Surplus). Prior to the LPT, the actual reserve adjustment for the year equated to strengthening net reserves for prior accident years by $96,776,000. Reserve activity prior to the LPT would have caused the company to fail NAIC IRIS Test 11 (Two-Year Reserve Development to Surplus). Nearly $79 million of the strengthening was for the company's medical malpractice business in accident years 2001 and 2002.

The Company writes no policies or contracts related to single or fixed premium policies with coverage periods of thirteen months or greater that are non-cancelable and not subject to

premium increase (excluding financial guarantee contracts, mortgage guaranty policies, and surety contracts).

Over 99% of the Company's ceded loss reserves is with either affiliated companies, companies rated A or better by A.M. Best Company, residual market pools or fully collateralized. Less than 1% is with various other companies either rated below A or not rated by A.M. Best Company. Past uncollectibility levels and current amounts in dispute have been reviewed and found to be immaterial relative to surplus. Therefore, reinsurance collectibility does not appear to be an issue.

The Company does not provide for anticipated salvage and subrogation

There has been no change in the actuarial assumptions, procedures, or methods that is likely to have a material effect of the statement loss and loss expense reserves.

This statement of opinion is solely for the use of, and only to be relied upon by, the Company and the various state insurance departments with which it files its Annual Statement.

An Actuarial Report and any underlying actuarial workpapers supporting the findings expressed in this Statement of Actuarial Opinion will be retained for a period of seven years in the administrative offices of The Medical Protective Company and available for regulatory examination.

James D. Kunce, F.C.A.S., M.A.A.A.
The Medical Protective Company
5814 Reed Road, Fort Wayne, IN 46835
260-486-0869
February 24, 2006

EXHIBIT A: SCOPE

Loss Reserves:	Amount
A. Reserve for Unpaid Losses (Liabilities, Surplus, and Other Funds Page 3, Line 1):	$483,111,441
B. Reserve for Unpaid Loss Adjustment Expenses (Liabilities, Surplus, and Other Funds Page 3, Line 3):	$214,470,385
Subtotal: A + B	$697,581,826
C. Reserve for Unpaid Losses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 13 and 15):	$1,306,354,000
D. Reserve for Unpaid Loss Adjustment Expenses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 17, 19 and 21):	$546,689,000
Subtotal: C + D	$1,853,043,000
E. The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$0
F. Other Loss Reserve items on which the Appointed Actuary is Expressing an Opinion (list separately)	$0

Premium Reserves:	Amount
G. Reserve for Direct and Assumed Unearned Premiums for Long Duration Contracts	$0
H. Reserve for Net Unearned Premiums for Long Duration Contracts	$0
I. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately)	$0

EXHIBIT B: DISCLOSURES

1.	Materiality Standard expressed in $US	$57,000,000
2.	Statutory Surplus	$571,330,518
3.	Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P	$0
4.	Discount included as a reduction to loss reserves and loss expense reserves as reported in Schedule P	
	4 (a) Nontabular discount	$0
	4 (b) Tabular discount	$0
5.	The net reserves for losses and expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	$3,755,000
6.	The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	
	6 (a) Asbestos, as disclosed in the Notes to Financial Statements	$0
	6 (b) Environmental, as disclosed in the Notes to Financial Statements	$0
7.	The total claims made extended loss and expense reserve (Schedule P Interrogatories).	
	7 (a) amount reported as loss reserves	$0
	7 (b) amount reported as unearned premium reserves	$11,515,056
8.	Other items on which the Appointed Actuary is providing Relevant Comment (list separately)	$0

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT A-I

Speciality	(1) Medical Protective (Current)	(2) Medical Protective (Proposed)	(3) CNA	(4) Cincinnati
Implants	1B	1A	I	1
Host Dentist	1B	1A	I	1
Oral Pathologist	2A	1B	I	1

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT A-II

(1) Current Class	(2) Proposed Class	(3) Current Relativity	(4) Selected Relativity	(5) Rate Change Impact	(6) State % of Book	(7) Weighted Rate Effect
1B (Implants & Host Dentists)	1A	1.250	1.000	-20.0%	4.5%	-0.9%
2A	1B	3.000	1.250	-58.3%	0.0%	0.0%
Rate Effect Due To Classification Changes						-0.9%

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT B-I

(1) Limit	(2) Limited Expected Value	(3) ALE	(4) ULE	(5) LLAE (2)+(3)+(4)	(6) LLAE Excess Limit Factor	(7) Fixed Expense (5)xC	(8) Risk Index	(9) Total Cost Per Claim	(10) Indicated Excess Limit Factor	(11) Selected Excess Limit Factor	(12) Current Excess Limit Factor
100,000	30,795	33,796	1,735	66,326	0.823	26,500	0.27	111,070	0.87	**0.77**	0.667
200,000	37,356	33,796	1,735	72,887	0.904	26,500	0.44	118,920	0.93	**0.88**	0.760
500,000	42,985	33,796	1,735	78,515	0.974	26,500	0.74	125,655	0.98	**0.94**	0.873
1,000,000	45,061	33,796	1,735	80,591	1.000	26,500	1.00	128,139	1.00	**1.00**	1.000
2,000,000	45,946	33,796	1,735	81,477	1.011	26,500	1.22	131,840	1.10	**1.08**	1.133
3,000,000	46,165	33,796	1,735	81,696	1.014	26,500	1.31	133,133	1.20	**1.15**	1.207
4,000,000	46,249	33,796	1,735	81,780	1.015	26,500	1.32	133,440	1.30	**1.23**	1.260
5,000,000	46,289	33,796	1,735	81,820	1.015	26,500	1.32	133,490	1.40	**1.31**	1.293

NOTE: The Risk Index in Column (8) is based on a measurement of the risk associated with losses limited at the specified limit. Specifically, it is the ratio of the CV for losses limited at the specified limit to the CV for losses limited at $1M. [The CV for the losses from the lognormal distribution limited at the various limits was determined using asymptotic convergence.] The Lognormal Parameters for the distribution are mu = 9.75 and sigma = 1.41

THE MEDICAL PROTECTIVE COMPANY

Illinois

ORAL SURGEONS

SUPPLEMENTAL EXHIBIT B-II

(1) Limit	(2) Limited Expected Value	(3) ALE (2)xA	(4) ULE [(2)+(3)]xB	(5) LLAE (2)+(3)+(4)	(6) LLAE Excess Limit Factor	(7) Fixed Expense (5)xC	(8) Risk Index	(9) Total Cost Per Claim	(10) Indicated Excess Limit Factor	(11) Selected Excess Limit Factor	(12) Current Excess Limit Factor
100,000	48,522	74,548	3,827	126,897	0.714	5,048	0.20	157,877	0.72	**0.77**	0.667
200,000	66,480	74,548	3,827	144,855	0.815	5,048	0.35	179,364	0.82	**0.88**	0.760
500,000	87,877	74,548	3,827	166,252	0.935	5,048	0.66	204,966	0.94	**0.94**	0.873
1,000,000	99,398	74,548	3,827	177,773	1.000	5,048	1.00	218,751	1.00	**1.00**	1.000
2,000,000	106,369	74,548	3,827	184,744	1.039	5,048	1.41	235,817	1.15	**1.15**	1.180
3,000,000	108,728	74,548	3,827	187,103	1.052	5,048	1.66	244,443	1.30	**1.27**	1.260
4,000,000	109,837	74,548	3,827	188,212	1.059	5,048	1.83	249,871	1.45	**1.35**	1.320
5,000,000	110,453	74,548	3,827	188,828	1.062	5,048	1.95	253,577	1.60	**1.42**	1.367

NOTE: The Risk Index in Column (8) is based on a measurement of the risk associated with losses limited at the specified limit. Specifically, it is the ratio of the CV for losses limited at the specified limit to the CV for losses limited at $1M. [The CV for the losses from the lognormal distribution limited at the various limits was determined using asymptotic convergence.] The Lognormal Parameters for the distribution are mu = 10.53 and sigma = 1.48

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

RECEIVED
OCT 10 2006
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

October 9, 2006

John Gatlin, Director of 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: 06-IL-101
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Base rate decrease: -8.2%
Class Relativity Change: -11.7%
Territory relativity changes: -16.1%
OVERALL RATE DECREASE: -32.0%

Revise Claim Free Credit
Revise New to Practice Credit Rule
Revise Partnership Corporation Rating
Revise Claims Made Age Steps

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revise *State Rate Pages Section II – Corps, Partnerships and Associations*
Revise State Rate Pages Section III – Physicians & Surgeons

PROPOSED EFFECTIVE DATE: JANUARY 1, 2007

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration our rate and rule filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date of January 1, 2007 for this filing. The accompanying Actuarial Memorandum provides detailed support for the changes, which will result in an overall premium change of –32.0% in the state of Illinois.

In addition, we have enclosed revised manual pages for Sections II – Corps, Partnerships and Associations and Section III – Physicians & Surgeons for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons Program, and therefore are being included in this submission.

Along with the Actuarial Memorandum, please find enclosed revised rate pages, the required checklists, transmittal forms, 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.

Sincerely,

Melissa Coker

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

-32.0%

Enclosure(s)

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective -32.0% effective as of January 1, 2007

(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 Line 11 - Med Mal (MD) (Line of Insurance)	$15,478,434 (estimate of Direct Written Premium Only)	-32.0 %

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): The Medical Protective Company hereby submits for your review and consideration our rate and rule filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date of January 1, 2007 for this filing. The accompanying Actuarial Memorandum provides detailed support for the changes, which will result in an overall premium change of –32.0% in the state of Illinois.

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*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

Phillip J. Troyer, Associate General Counsel
Official – Title

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
OCT 10 2006
SPRINGFIELD, ILLINOIS

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, Jim D. Kunce, 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 — Date: 10/9/06

Signature, Title and Designation of Authorized Actuary — Date: 10/9/06

Insurance Company FEIN 35-0506406 Filing Number 06-IL-101

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Thursday, November 16, 2006 9:01 AM
To: Neuman, Gayle
Cc: Whitcraft, Joel; Coker, Melissa
Subject: RE: Med Pro Rate filing #06-IL-98 and #06-IL-101
Attachments: DOI Resp 11 16 07.pdf

Hi Gayle.

Yes, SR-IL-III-65 was revised to contain the changes to the SRP and was attached to our response to Julie Anderson on 10/12/06. I'm attaching just the specific page for your review/use as well.

As always, let me know if you have any questions!

Have a nice day!

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, November 16, 2006 8:58 AM
To: Nielsen, Kimberly
Cc: Whitcraft, Joel
Subject: Med Pro Rate filing #06-IL-98 and #06-IL-101

Kim,

I received the 8 pages you sent with the attached e-mail. I imagine there were suppose to be changes to the Illinois State Rate Pages (such as SR-IL-III-65) to coincide with the changes on the 8 pages. Please let me know ASAP.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Monday, October 30, 2006 11:51 AM
To: Neuman, Gayle
Cc: Coker, Melissa; Whitcraft, Joel
Subject: RE: Med Pro Rate filing #06-IL-98

Hello Gayle.

I'm not 100% sure which filing you are speaking to, so let me know if this isn't what you are looking for:

06-IL-98 is a filing specific to our Dental program only.

06-IL-101 is specific to Physicians & Surgeons, and therefore I'm attaching the SRP contained within that submission for your reference.

Also, feel free to call me if you want to discuss 260-486-0801.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, October 30, 2006 12:33 PM
To: Nielsen, Kimberly
Subject: FW: Med Pro Rate filing #06-IL-98

Ms. Nielsen,

I have received filing #06-IL-101 back from the routing process, therefore it will be filed. I was looking at your attachments to the e-mail below...but I don't find any pages marked for physician/surgeon. Is this correct? Your prompt attention is appreciated as this is spread out all over my desk right now.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 3:17 PM
To: Anderson, Julie
Cc: Neuman, Gayle; Coker, Melissa
Subject: RE: Med Pro Rate filing #06-IL-98

Hi Julie,

Thanks for your time today to discuss your e-mail below!

Per our discussion, since 05-IL-67 is superseded with 06-IL-101, the manual pages were amended to apply to 06-IL-101 as this is the most current filing we have made in IL for Physicians & Surgeons. Since the effective date of this filing is 1/1/07, and we are starting to process 1/1/07 business using this new SRP, we didn't amend manual pages for effective dates for business that has already been processed.

The same applies to 06-IL-94, in that it is superseded by 06-IL-99, which is also effective 1/1/07.

Let me know what you find out in your discussions there and if there is anything you'd like me to provide as a result of your discussions. Have a good evening!

Kim

-----Original Message-----
From: Anderson, Julie [mailto:Julie.A.Anderson2@illinois.gov]
Sent: Tuesday, October 17, 2006 3:23 PM
To: Nielsen, Kimberly
Cc: Neuman, Gayle
Subject: RE: Med Pro Rate filing #06-IL-98

Hi, Kim,

Thank you for your submission. With regard to the schedule rating plan, do you also wish to replace the schedule rating plan pages within rate filing numbers 05-IL-67 and 06-IL-94?

These filings do not make changes to the schedule rating plan rule, but the rule page in question was included when these filings were submitted.

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

Please note that my e-mail address has changed to: Julie.A.Anderson2@illinois...gov

This email message, including any attachments, is intended for the sole use of the addressee and it contains information that may be confidential, privileged and/or exempt from disclosure under applicable laws. Additionally, this email may contain information that is prohibited from disclosure by the Illinois Insurance Code 215 ILCS 5/101 et seq and any unauthorized disclosure may result in civil forfeitures or criminal penalties. This email is intended to be conveyed only to the designated recipient(s). If you are not an intended recipient of this message, please notify the sender by replying to this message, Julie.A.Anderson2@illinois.gov, and then delete it from your system. Use, dissemination, distribution, or reproduction of this message by unintended recipients is not authorized and may be unlawful.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 2:04 PM
To: Anderson, Julie
Cc: Coker, Melissa; Clark, Eric; Whitcraft, Joel
Subject: FW: Med Pro Rate filing #06-IL-98

Dear Julie -

Thank you for your patienceas we prepared our response to your questions. Please accept the following, and let me know if you have additional questions or need more information. Thank you.

From: Anderson, Julie [mailto:Julie.A.Anderson2@illinois.gov]
Sent: Thursday, September 14, 2006 9:40 AM
To: Coker, Melissa
Cc: Nielsen, Kimberly
Subject: Med Pro Rate filing #06-IL-98

Hi, Melissa,

Thank you for your e-mail indicating the correction to the rate effect to +2.1% for this filing. I have started my initial review of this filing and find that I can't complete my review without more information. We need to see actuarial justification exhibits for all rate changes. Please refer to the link below for a list of actuarial information needed in all medical malpractice rate filings and please provide me with all relevant items by **September 28, 2006.**

http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/MedicalMalpracticeLiabilityRates.htm

Also, I wanted to touch base on the schedule debits/ credit issue. Kim Nielsen has indicated to me that Med Pro intends to refile the page in your manual to reflect our concerns. I haven't seen this refile yet, but I expect it soon. What I wanted to bring up to you is that I have several Med Pro filings that I am reviewing and nearly all of them have the schedule debit/credit rule that Med Pro has indicated they will be correcting. So, I request this: when

Med Pro files this new manual page, please provide me with a corrected copy for each filing that Med Pro has outstanding with Illinois along with a note indicating which filing number it belongs with. My reason for asking is to assure that all of my files are complete for any future reference.

Thank you very much and please give me a call if you have any questions. Have an awesome day!

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Assistant Casualty Actuary
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Phone: 217-524-5421
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IL Dept of Financial and Professional Regulation
Division of Insurance
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Fax: 217-524-2271

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To: Anderson, Julie
Cc: Coker, Melissa; Clark, Eric; Whitcraft, Joel
Subject: FW: Med Pro Rate filing #06-IL-98

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Sent: Thursday, September 14, 2006 9:40 AM

To: Coker, Melissa
Cc: Nielsen, Kimberly
Subject: Med Pro Rate filing #06-IL-98

Hi, Melissa,

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http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/MedicalMalpracticeLiabilityRates.htm

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Thank you very much and please give me a call if you have any questions. Have an awesome day!

Julie Anderson
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Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Thursday, October 19, 2006 10:48 AM
To: Neuman, Gayle
Cc: Whitcraft, Joel; Spoerner, William
Subject: RE: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item
Attachments: 10 19 06 Resp.pdf

Hello Gayle.

I'm not sure what happened here - my excel file shows one thing, but the copy/paste into Word reflects something different.

Regardless, the pages attached should show you that everything matches and each speciality is assigned to a class.

Let me know if you need anything further.

Thanks.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, October 19, 2006 10:06 AM
To: Nielsen, Kimberly
Subject: RE: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item

Kim,

Thanks again for your prompt attention.

I have a few questions. Some codes did not get a class number – is there a reason for that? How would you then know what to charge them?

I found otorhinolaryngology is found in Class IB, IIB and IIIA. However, on pages 70 through 73, I can only find them referenced under Class IB, IC, and VIB. This is just one example I chose to use…I have no idea how the other classes are working. Please explain.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Wednesday, October 18, 2006 4:10 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item

Hi Gayle! Thanks for your note.

I've updated pages 70-73 to contain the rating class as well. Additionally, the "specialty code" is a designation we use for statistical purposes and references the specialty type (ie: Dermatology, Cardiology,

etc). We use the ISO code to further define the procedures the specialty performs (Major Surgery, Minor Surgery, No Surgery, etc). This is consist with ISO reporting requirements as well.

The differentiation between the "80's" and the "84's" is that the 84's represent doctors of osteopathy (DO), where as the "80's" represent doctors of medicine (MD). This is also consistent with ISO reporting requirements and thus we capture the data in this fashion.

Hope this all helps. Please let me know if you have any questions! Have a nice evening!

Kim

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Wednesday, October 18, 2006 4:10 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item
Attachments: 10 18 06 Response.pdf

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Hope this all helps. Please let me know if you have any questions! Have a nice evening!

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, October 18, 2006 9:51 AM
To: Nielsen, Kimberly
Subject: RE: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item

Kim,

Thank you for your prompt attention and response.

We request information on pages SR-IL-III-70 through SR-IL-III-73 be updated to indicate how each specialty in Medical Protective's classes IA through VIII match up with the ISO Code. Also on the chart, it references "specialty code" with numbers 10 through 40 and "D.O." code – we require further explanation of these designations.

Your prompt assistance is appreciated.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 3:35 PM
To: Neuman, Gayle
Cc: Spoerner, William; Coker, Melissa; Whitcraft, Joel
Subject: FW: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item
Importance: High

Hello Gayle.

Thank you for your note below. Please find attached amended State Rate Pages for Section III which

include an Speciality/ISO Description. Please let me know if you need anything further.

Have a nice evening!
Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, October 17, 2006 2:40 PM
To: Coker, Melissa
Subject: Medical Protective - Rate/Rule Filing #06-IL-101

Ms. Coker,

On page SR-IL-III-67 of the manual, the Non-Discretionary Debit Rating Plan (Tables A & B) references "any other ISO Code". Medical Protective is required to include a translation of the ISO codes or list the appropriate classes that apply.

We request receipt of your response by October 23, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

*****Classification Translation Table – Specialty Description to ISO Code**

	SPECIALTY	ISO CODE		
	CODE	M.D.	D.O.	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otorhinolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B
Rhinology	23	80247	84247	1B

Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Physician - N.O.C.	19	80268	84268	1B
SURGICAL SPECIALIST PERFORMING NO SURGERY, BUT STILL PRACTICING IN THAT SPECIALITY		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	
Dermatology	31	80282	84282	2C
Family/General Practice	19	80421	84421	1B
Geriatrics	32	80276	84276	2C
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2B
Endocrinology	32	80272	84272	2D
Gastroenterology	32	80274	84274	2A
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	2C
Nephrology	32	80287	84287	3A
Neurology	40	80288	84288	2B
Ophthalmology	16	80289	84289	3A
Otorhinolaryngology	23	80291	84291	1C
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B
Radiology - Diagnostic	37	80280	84280	2B
Radiology - Therapy	37	80425	84425	2D

Pain Management	19, 30, 40	80295	84295	2B
Hospitalist	32	80296	84296	2A
SURGICAL SPECIALIST PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS WHILE PRACTICING IN THAT SPECIALITY:		80294	84294	1D
PHYSICIANS AND SURGICAL SPECIALIST PERFORMING THE FOLLOWING PROCEDURES: (XX = Code for Speciality)				2B
Radiation Therapy	XX	80425	84425	
Radiopaque Dye Injection	XX	80449	84449	2B
Radiology - incld. Mammography	37	80472	84472	2D
Shock Therapy	XX	80431	84431	2D
				2B
PHYSICIANS PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY:				
Family/General Practice	19	80117	84117	
Geriatrics	19	80105	84105	3B
Gastroenterology	32	80104	84104	3B
Emergency Medicine (No Major Surg)	25	80102	84102	3A
Surgical Specialists:				4A
Ophthalmology	16	80114	84114	
Colon and Rectal	24	80115	84115	1D
Emergency Medicine (Incl. Major Surg)	25	80157	84157	3B
SURGICAL SPECIALIST PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS WHIL PRACTICING IN THAT SPECIALITY, BUT NOT PRIMARLEY ENGAGED IN MAJOR SURGERY:		80117	84117	4B
PHYSICIANS AND SURGICAL SPECIALIST PERFORMING THE FOLLOWING PROCEDURES: (XX = Code for Speciality)				3B
Acupuncture	XX	80437	84437	
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
				3A
Urology	17	80145	84145	
Fam./Gen. Practice - incl. deliveries	29	80273	84273	
Anesthesiology	30	80151	84151	3A
Abdominal	10	80166	84166	3A
General - N.O.C.	10	80143	84143	2A
Otorhinolaryngology	23	80159	84159	6B
Otology	23	80158	84158	6B

Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	3A
Head and Neck	13	80170	84170	3A
Obstetrics/Gynecology	15	80153	84153	4A
Obstetrics	15	80168	84168	4A
Gynecology	18	80167	84167	6B
Plastic - N.O.C.	20	80156	84156	6B
Cardiovascular	21	80150	84150	4A
Neurological	12	80152	84152	5A
Orthopedic (Excl. back)	13	80176	84176	5B
Orthopedic (Incl. back)	13	80154	84154	8
Thoracic	14	80144	84144	4A
Traumatic	10	80171	84171	6A
Vascular	22	80146	84146	5B

Neuman, Gayle

From: Anderson, Julie
Sent: Wednesday, October 18, 2006 9:21 AM
To: Neuman, Gayle
Subject: FW: Med Pro Rate filing #06-IL-98
Attachments: 10 17 06 Response.pdf

I'm sorry. I thought Kim had copied you on her response.

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

Please note that my e-mail address has changed to: Julie.A.Anderson2@illinois.gov

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From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 2:04 PM
To: Anderson, Julie
Cc: Coker, Melissa; Clark, Eric; Whitcraft, Joel
Subject: FW: Med Pro Rate filing #06-IL-98

Dear Julie -

Thank you for your patienceas we prepared our response to your questions. Please accept the following, and let me know if you have additional questions or need more information. Thank you.

From: Anderson, Julie [mailto:Julie.A.Anderson2@illinois.gov]
Sent: Thursday, September 14, 2006 9:40 AM
To: Coker, Melissa
Cc: Nielsen, Kimberly
Subject: Med Pro Rate filing #06-IL-98

Hi, Melissa,

Thank you for your e-mail indicating the correction to the rate effect to +2.1% for this filing. I have started my initial review of this filing and find that I can't complete my review without more information. We need to see actuarial justification exhibits for all rate changes. Please refer to the link below for a list of actuarial information needed in all medical malpractice rate filings and please provide me with all relevant items by **September 28, 2006.**

http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/MedicalMalpracticeLiabilityRates.htm

Also, I wanted to touch base on the schedule debits/ credit issue. Kim Nielsen has indicated to me that Med Pro intends to refile the page in your manual to reflect our concerns. I haven't seen this refile yet, but I expect it soon. What I wanted to bring up to you is that I have several Med Pro filings that I am reviewing and nearly all of them have the schedule debit/credit rule that Med Pro has indicated they will be correcting. So, I request this: when Med Pro files this new manual page, please provide me with a corrected copy for each filing that Med Pro has outstanding with Illinois along with a note indicating which filing number it belongs with. My reason for asking is to assure that all of my files are complete for any future reference.

Thank you very much and please give me a call if you have any questions. Have an awesome day!

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

Please note that my e-mail address has changed to: Julie.A.Anderson2@illinois.gov

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Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 3:35 PM
To: Neuman, Gayle
Cc: Spoerner, William; Coker, Melissa; Whitcraft, Joel
Subject: FW: Medical Protective - Rate/Rule Filing #06-IL-101 - additional item
Importance: High
Attachments: 10 17 06 Response.pdf

Hello Gayle.

Thank you for your note below. Please find attached amended State Rate Pages for Section III which include an Speciality/ISO Description. Please let me know if you need anything further.

Have a nice evening!
Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, October 17, 2006 2:40 PM
To: Coker, Melissa
Subject: Medical Protective - Rate/Rule Filing #06-IL-101

Ms. Coker,

On page SR-IL-III-67 of the manual, the Non-Discretionary Debit Rating Plan (Tables A & B) references "any other ISO Code". Medical Protective is required to include a translation of the ISO codes or list the appropriate classes that apply.

We request receipt of your response by October 23, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

***Classification Translation Table – Specialty Description to ISO Code

	SPECIALTY	ISO CODE	
	CODE	M.D.	D.O.
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Geriatrics	32	80243	84243
Nuclear Medicine	37	80262	84262
Nutrition	32	80248	84248
Occupational Medicine	19	80233	84233
Physiatry	19	80235	84235
Public Health	19	80236	84236
Gynecology	15	80244	84244
Internal Medicine	32	80257	84257
Diabetes	32	80237	84237
Endocrinology	32	80238	84238
Gastroenterology	32	80241	84241
Hematology / Oncology	32	80245	84245
Infectious Disease	32	80246	84246
Nephrology	32	80260	84260
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Otology	23	80264	84264
Larynogology	23	80258	84258
Rhinology	23	80247	84247

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Pediatrics	34	80267	84267
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Psychoanalysis	35	80250	84250
Psychosomatic	35	80251	84251
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Endocrinology	32	80272	84272
Gastroenterology	32	80274	84274
Hematology / Oncology	32	80278	84278
Infectious Disease	32	80279	84279
Intensive Care	32	80283	84283
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Neurology	40	80288	84288
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Otology	23	80290	84290
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Otology	23	80158	84158

Laryngology	23	80106	84106
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Plastic (No elected cosmetic)	23	80155	84155
Hand	13	80169	84169
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Obstetrics	15	80168	84168
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Orthopedic (Incl. back)	13	80154	84154
Thoracic	14	80144	84144
Traumatic	10	80171	84171
Vascular	22	80146	84146

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 3:17 PM
To: Anderson, Julie
Cc: Neuman, Gayle; Coker, Melissa
Subject: RE: Med Pro Rate filing #06-IL-98

Hi Julie,

Thanks for your time today to discuss your e-mail below!

Per our discussion, since 05-IL-67 is superseded with 06-IL-101, the manual pages were amended to apply to 06-IL-101 as this is the most current filing we have made in IL for Physicians & Surgeons. Since the effective date of this filing is 1/1/07, and we are starting to process 1/1/07 business using this new SRP, we didn't amend manual pages for effective dates for business that has already been processed.

The same applies to 06-IL-94, in that it is superseded by 06-IL-99, which is also effective 1/1/07.

Let me know what you find out in your discussions there and if there is anything you'd like me to provide as a result of your discussions. Have a good evening!

Kim

-----Original Message-----
From: Anderson, Julie [mailto:Julie.A.Anderson2@illinois.gov]
Sent: Tuesday, October 17, 2006 3:23 PM
To: Nielsen, Kimberly
Cc: Neuman, Gayle
Subject: RE: Med Pro Rate filing #06-IL-98

Hi, Kim,

Thank you for your submission. With regard to the schedule rating plan, do you also wish to replace the schedule rating plan pages within rate filing numbers 05-IL-67 and 06-IL-94? These filings do not make changes to the schedule rating plan rule, but the rule page in question was included when these filings were submitted.

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

Please note that my e-mail address has changed to: Julie.A.Anderson2@illinois.gov

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From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Tuesday, October 17, 2006 2:04 PM
To: Anderson, Julie
Cc: Coker, Melissa; Clark, Eric; Whitcraft, Joel
Subject: FW: Med Pro Rate filing #06-IL-98

Dear Julie -

Thank you for your patienceas we prepared our response to your questions. Please accept the following, and let me know if you have additional questions or need more information. Thank you.

From: Anderson, Julie [mailto:Julie.A.Anderson2@illinois.gov]
Sent: Thursday, September 14, 2006 9:40 AM
To: Coker, Melissa
Cc: Nielsen, Kimberly
Subject: Med Pro Rate filing #06-IL-98

Hi, Melissa,

Thank you for your e-mail indicating the correction to the rate effect to +2.1% for this filing. I have started my initial review of this filing and find that I can't complete my review without more information. We need to see actuarial justification exhibits for all rate changes. Please refer to the link below for a list of actuarial information needed in all medical malpractice rate filings and please provide me with all relevant items by **September 28, 2006.**

http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/MedicalMalpracticeLiabilityRates.htm

Also, I wanted to touch base on the schedule debits/ credit issue. Kim Nielsen has indicated to me that Med Pro intends to refile the page in your manual to reflect our concerns. I haven't seen this refile yet, but I expect it soon. What I wanted to bring up to you is that I have several Med Pro filings that I am reviewing and nearly all of them have the schedule debit/credit rule that Med Pro has indicated they will be correcting. So, I request this: when Med Pro files this new manual page, please provide me with a corrected copy for each filing that Med Pro has outstanding with Illinois along with a note indicating which filing number it belongs with. My reason for asking is to assure that all of my files are complete for any future reference.

Thank you very much and please give me a call if you have any questions. Have an awesome day!

Julie Anderson
Assistant Casualty Actuary
IL Dept of Financial and Professional Regulation
Division of Insurance
Phone: 217-524-5421
Fax: 217-524-2271

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reproduction of this message by unintended recipients is not authorized and may be unlawful.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Wednesday, October 11, 2006 9:48 AM
To: Neuman, Gayle
Subject: RE: Medical Protective - Filing #06-IL-101
Attachments: DOI Response 10 11 06.pdf

Ms. Neuman,

Please find our response below to your questions.

1. Please find enclosed revised Section II State Rate Pages (page 4) which includes the Quarterly Installment Option. Also included is an appropriate strike-thru version and revised "List of Manual Pages" grid for your file.

2. Please find enclosed a revised Claim Free Credit Rule amending the year span to 5 years but less than 8 years.

Please let me know if you have any additional questions.
Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, October 10, 2006 4:48 PM
To: Coker, Melissa
Subject: Medical Protective - Filing #06-IL-101

Ms. Coker,

Please address these issues on the above referenced filing. We request your immediate attention.

1. The filing does not include information about the quarterly premium installment payment plan under Section II – Corporations, Partnerships & Associations.
2. On the Illinois – Physicians and Surgeons – Occurrence Program – Claim Free Credit page, #2 incorrectly indicates the credit applies to insureds who are claim free for 5 years but less than 10 years (which should indicate 8 years).

Your cooperation is appreciated.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

The Medical Protective Company
Illinois Physicians & Surgeons
List of Manual Page Changes
Updated 10/11/06

Current Page	Description	New Page	Added	Withdrawn	Comments
RT-IL (01/01/04)	Rating Terrorities	RT-IL (01/01/07)			Occurrence & Standard Claims Made
PRC-IL (01/01/04)	Physician Rate Classes	PRC-IL (01/01/07)			Occurrence & Standard Claims Made
RTS-OCC (IL-04-2)	Occurrence Rates	RTS-OCC (IL-07-1)			Occurrence - 8 Areas
RTS-CM0 (IL-04-2)	Standard Claims Made Rates	RTS-CM0 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM1 (IL-04-2)	Standard Claims Made Rates	RTS-CM1 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM2 (IL-04-2)	Standard Claims Made Rates	RTS-CM2 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM3 (IL-04-2)	Standard Claims Made Rates	RTS-CM3 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM4 (IL-04-2)	Standard Claims Made Rates	RTS-CM4 (IL-07-1)			Standard Claims Made - 8 Areas
	Standard Claims Made Rates		RTS-CM5 (IL-07-1)		Standard Claims Made - 8 Areas
CMF-IL (IL-03-1)	Claims Made Age Factors	CMF-IL (IL-07-1)			Standard Claims Made
CFC-CW (06/01/06)	Claim Free Credit Rule	CFC-IL (01/01/07)			Occurrence & Standard Claims Made
NPC-CW (01/01/03)	New to Practice Credit Rule	NPC-IL-(01/01/07)			Occurrence & Standard Claims Made
PCC-IL (10/01/04)	Partnership Corporation Rating Rule	PCC-IL (01/01/07)			Occurrence & Standard Claims Made
SR-IL-II- (1-3) 11/01/06	Section II - Corporations	SR-IL-II (1-4) 01/01/07			
SR-IL-III- (1-4) 01/01/04	Section III - Physicians & Surgeons	SR-IL-III- (1-4) 01/01/07			
SR-IL-III-(5-36) 10/01/04	Section III - Physicians & Surgeons	SR-IL-III- (5-62) 01/01/07			
SR-IL-III-(37-43) 11/01/06	Section III - Physicians & Surgeons	SR-IL-III (63-69) 01/01/07			

5. 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.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE 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 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

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

4. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Wednesday, October 11, 2006 9:48 AM
To: Neuman, Gayle
Subject: RE: Medical Protective - Filing #06-IL-101
Attachments: DOI Response 10 11 06.pdf

Ms. Neuman,

Please find our response below to your questions.

1. Please find enclosed revised Section II State Rate Pages (page 4) which includes the Quarterly Installment Option. Also included is an appropriate strike-thru version and revised "List of Manual Pages" grid for your file.

2. Please find enclosed a revised Claim Free Credit Rule amending the year span to 5 years but less than 8 years.

Please let me know if you have any additional questions.
Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, October 10, 2006 4:48 PM
To: Coker, Melissa
Subject: Medical Protective - Filing #06-IL-101

Ms. Coker,

Please address these issues on the above referenced filing. We request your immediate attention.

1. The filing does not include information about the quarterly premium installment payment plan under Section II – Corporations, Partnerships & Associations.
2. On the Illinois – Physicians and Surgeons – Occurrence Program – Claim Free Credit page, #2 incorrectly indicates the credit applies to insureds who are claim free for 5 years but less than 10 years (which should indicate 8 years).

Your cooperation is appreciated.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

The Medical Protective Company
Illinois Physicians & Surgeons
List of Manual Page Changes
Updated 10/11/06

Current Page	Description	New Page	Added	Withdrawn	Comments
RT-IL (01/01/04)	Rating Terrorities	RT-IL (01/01/07)			Occurrence & Standard Claims Made
PRC-IL (01/01/04)	Physician Rate Classes	PRC-IL (01/01/07)			Occurrence & Standard Claims Made
RTS-OCC (IL-04-2)	Occurrence Rates	RTS-OCC (IL-07-1)			Occurrence - 8 Areas
RTS-CM0 (IL-04-2)	Standard Claims Made Rates	RTS-CM0 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM1 (IL-04-2)	Standard Claims Made Rates	RTS-CM1 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM2 (IL-04-2)	Standard Claims Made Rates	RTS-CM2 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM3 (IL-04-2)	Standard Claims Made Rates	RTS-CM3 (IL-07-1)			Standard Claims Made - 8 Areas
RTS-CM4 (IL-04-2)	Standard Claims Made Rates	RTS-CM4 (IL-07-1)			Standard Claims Made - 8 Areas
	Standard Claims Made Rates		RTS-CM5 (IL-07-1)		Standard Claims Made - 8 Areas
CMF-IL (IL-03-1)	Claims Made Age Factors	CMF-IL (IL-07-1)			Standard Claims Made
CFC-CW (06/01/06)	Claim Free Credit Rule	CFC-IL (01/01/07)			Occurrence & Standard Claims Made
NPC-CW (01/01/03)	New to Practice Credit Rule	NPC-IL-(01/01/07)			Occurrence & Standard Claims Made
PCC-IL (10/01/04)	Partnership Corporation Rating Rule	PCC-IL (01/01/07)			Occurrence & Standard Claims Made
SR-IL-II- (1-3) 11/01/06	Section II - Corporations	SR-IL-II (1-4) 01/01/07			
SR-IL-III- (1-4) 01/01/04	Section III - Physicians & Surgeons	SR-IL-III- (1-4) 01/01/07			
SR-IL-III-(5-36) 10/01/04	Section III - Physicians & Surgeons	SR-IL-III- (5-62) 01/01/07			
SR-IL-III-(37-43) 11/01/06	Section III - Physicians & Surgeons	SR-IL-III (63-69) 01/01/07			

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ILLINOIS CERTIFICATION
MANUAL PAGE CHANGES

The Medical Protective Company

Filing 06-IL-101

All changes made to the superseded filing have been disclosed within the complete strike thru copy of the Company's Physician & Surgeon manual, as well as within the attached matrix titled, "List of Manual Page Changes".

Certified by: Kimberly A Nielsen 10/9/06

Kimberly A. Nielsen – Product Manager (Date)

The Medical Protective Company
Illinois Physicians & Surgeons
List of Manual Page Changes

Current Page	Description	New Page	Added	Withdrawn	Comments
RT-IL (01/01/04)	Rating Terrorities	RT-IL (01/01/07)			Occurrence & Standard Claims Made
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SR-IL-III-(5-36) 10/01/04	Section III - Physicians & Surgeons	SR-IL-III- (5-62) 01/01/07			
SR-IL-III-(37-43) 11/01/06	Section III - Physicians & Surgeons	SR-IL-III (63-69) 01/01/07			

Contact Person:
Gayle Neuman
217-524-6497
Gayle.Neuman@illinois.gov

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
_x_ **MEDICAL MALPRACTICE**	**11.0000**	***This checklist is for rate/rule filings only. See separate form checklist.
_x_ Claims Made	11.10000	
_x_ Occurrence	11.2000	

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_x_ Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	Certificate Number: 546900-51
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including all rates.	**Not Applicable**

		b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	The Companys statistical agent is ISO.
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty	**01/01/07**

	929	Compliance Section, except as otherwise provided in Section 155.18.	
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	N/A
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	**Enclosed**
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the	Refer to enclosed cover letter, Illinois Certification of Manual Page Changes, List of Manual Page Changes and Complete strike-thru copies of rate/rule manual.

		superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	Enclosed
PAYMENT PLANS			
Quarterly premium payment installment	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability	

plan required as prescribed by the Director.		insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	Refer to Quarterly Installment Option Rule
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	Refer to Deductible Credit Rule.
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the	Refer to Risk Management Credit Rule

		section that applies.	
CLAIMS MADE REQUIREMENTS			

Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2)
	
	Company Bulletin 88-50
		When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals:
		
		• Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).***
		
		• Cost of the extended reporting period, which must be priced as a factor of one of the following:***
		
		  ○ the last 12 months' premium.
		  ○ the premium in effect at policy issuance.
		  ○ the expiring annual premium.
		
		• List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium.
		
		• Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated.
		
		• Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request.
		
		• Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.***
		
		• Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first.
		
		***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must:
		
		• Offer free 5-year extended reporting period (tail coverage) or
		• Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate	

		expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	N/A
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Refer to Minimum Premium Requirement Rule.
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	N/A
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Refer to Phys & Surg Class Plan
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	Not part of underwriting criteria
Unfair methods of	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and	

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	N/A
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	Refer to Rating Territory manual page
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	**Enclosed**
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	The Companys statistical agent is ISO.
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any	215 ILCS 5/155.18 50 IL Adm. Code	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The	**Enclosed**

rate filing, as well as any rule filing that affects the ultimate premium.	929	explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	**Actuarial Memorandum**
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	Refer to Exh XII & XIII
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	**Refer to Exhibits I-XI and Appendix. Current Level EP derived by extension of exposures.**
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	**Refer to: Exhibits VI-XI and Appendix.**
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	**Refer to: Exhibits 1-B**
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	**Refer to: Exhibit V**
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	**Current Level EP derived by extension of exposures.**
Loss Adjustment Expenses			

Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	**Refer to: Exhibits VI-XI,IV and Appendix.**
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	**Refer to: Exhibit II**
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	**Refer to: Exhibit III**
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	**Refer to: Exhibit III**
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	**Refer to: Exhibit 1-C**
Other Actuarial Information Required			

Insurers must include the information described in this section.	215 ILCS 5/155.18
	
	50 IL Adm. Code 929
		Insurers shall also include the following information:
		
		• All actuarial support/justification for all rates being changed, including but not limited to changes in:
		  ○ Base rates;
		  ○ Territory definitions;
		  ○ Territory factor changes;
		  ○ Classification factor changes;
		  ○ Classification definition changes;
		  ○ Changes to schedule credits/debits, etc.
		
		• Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed.
			Refer to: Memorandum Exhibits XII, XIII, XIV

		• Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

PHYSICIANS & SURGEONS PROGRAM

ACTUARIAL MEMORANDUM

The Medical Protective Company (MedPro) respectfully submits the attached exhibits supporting rate revisions to the Physicians & Surgeons Occurrence and Claims Made programs in the state of Illinois. The proposed revisions will result in an overall premium decrease of -32.0%. This will be accomplished through a base rate change of -8.2%, classification relativity changes with an estimated impact of -11.7% and territory relativity changes with an estimated impact of -16.1%. The combined premium effect of these changes is -32.0% {-0.320 = [(1.0 - 0.082) x (1.0 - 0.117) x (1.0 - 0.161)] - 1.0}. The proposed effective date for these revisions is January 1, 2007 for new and renewal business.

EXHIBIT I: DEVELOPMENT OF RATE LEVEL INDICATION

This exhibit presents the derivation of the Physicians & Surgeons statewide 200K/600K limits indicated rate change. The indicated rate change is based upon an analysis of a five-year experience period evaluated as of 06/30/2006; report years 2000 through 2004 for the Claims Made product.

In Exhibit I-B, loss and allocated loss adjustment expense (LALE) for the experience period are evaluated on a 200K/600K limits basis, developed to an ultimate closing value, and adjusted to the pure premium cost level expected to prevail during the period in which the proposed rates will be utilized. The resulting trended ultimate LALE are then loaded for unallocated loss adjustment expenses.

The trended ultimate loss and loss adjustment expense (LLAE) for each year is divided by the corresponding earned exposures in order to calculate the projected LLAE pure premium. These report year pure premiums are used to calculate the exposure-weighted average pure premium (Exhibit I-A, Line 1a). The claims made pure premium is adjusted for the Death, Disability & Retirement free tail provisions of the policy (Exhibit I-A, Line 1b).

The sum of the resulting LLAE pure premium (Exhibit I-A, Line 1c) and the base equivalent fixed expense (Exhibit I-A, Line 2) is divided by the variable expense factor (Exhibit I-A, Line 3) to calculate the experience indicated rate (Exhibit I-A, Line 4). The experience indicated rate is then compared to the current average rate adjusted for the average credit level (Exhibit I-A, Line 7) resulting in the experience indicated rate change of -31.7% for the Claims Made product (Exhibit I-A, Line 10).

The experience indicated rate change is weighted against the complement of credibility. This yields a credibility-weighted rate indication of -33.3% for the Claims Made product (Exhibit I-A, Line 13). The selected rate change of -32.0% is shown in Exhibit I-A, Line 14.

Exhibit I-C presents the development of the credibility factors used to weight the experience indicated rate changes with their respective complements of credibility. The calculations are based on the classical credibility model described in the Casualty Actuarial Society's text, "Foundations of Casualty Actuarial Science." The criterion for 100% credibility is 683 incurred claims, implying that the selected estimated value is within 7.5% of the true value with 95.0% certainty. Exhibit I-C illustrates the calculation indicating a credibility weight of 0.52 applicable to the experience indicated rate change for the Claims Made product in Exhibit I-A, Line 10.

Exhibit I-D documents the A Priori expected LALE ratio at the current rate level. This value is used as the a priori LALE ratio in the Bornhuetter Ferguson methods employed in Exhibit I-B(iii) and Exhibit I-B(iv).

Exhibit I-E documents the complement of credibility. These calculations are based on the filed rate structure of the ISMIE Mutual Insurance Company. The exhibit removes all expense and profit provisions employed by ISMIE, adjusts for trend due to the different average loss dates underlying the filings, adjusts for differences in filed class plans and recognizes Medical Protective's expense structure and profit provision. The indication is a 35.0% decrease. This is carried forward to Exhibit I-A, Line 12.

EXHIBIT II: FIXED EXPENSE AND VARIABLE EXPENSE FACTOR

The expense provisions for General and Acquisition Expenses are based upon data obtained directly from MedPro's Insurance Expense Exhibits and policy counts written over the past several years. These expenses are considered fixed and are a function of the type of program (e.g., physicians, dentists, or hospitals). Each year's fixed expense provision is calculated by taking the expense category for that year and dividing by the corresponding policy count. Trended total fixed expense per policy is $1,370 (Exhibit II, Line 3). The total fixed expense provision is divided by the average base equivalent factor to obtain the base equivalent fixed expense of $353 (Exhibit II, Line 5) for the Claims Made product.

For the Claims Made product, the variable expenses consist of two components: the 1.92% provision for Taxes, Licenses and Fees, and the 7.70% provision for Brokerage and Commissions. These variable expenses are summed with the Underwriting Profit Provision Reflecting Investment Income of 5.00% (Exhibit II, Line 8). The variable expense factor (Exhibit II, Line 10) is unity minus the sum of the variable expenses and underwriting profit provision ([1.0 - (1.92% + 7.70% + 5.00%)] = 0.854).

EXHIBIT III: UNDERWRITING PROFIT PROVISION REFLECTING INVESTMENT INCOME

Exhibit III presents the internal rate of return model used to calculate the underwriting profit provision reflecting investment income. The model uses as inputs the anticipated rate of return on invested assets, federal income tax rates on underwriting profit/loss and investment income, the expense provisions from MedPro's rate filing, expected premium collection and LLAE payout

patterns, and various leverage ratios. The model demonstrates that, for the Claims Made product, an underwriting profit provision of 5.0% corresponds to a target LLAE ratio of 76.7% and is consistent with a 11.8% rate of return on required surplus.

EXHIBIT IV: UNALLOCATED LOSS ADJUSTMENT EXPENSE FACTOR

The loading for unallocated loss adjustment expense is calculated in Exhibit IV. This calculation utilizes accident/report year data from MedPro's 2005 Annual Statement, Schedule P Part 1-F. Incurred unallocated loss expense for each year is compared to direct incurred loss & loss adjustment expense in order to calculate a loading factor to be applied to incurred loss & allocated loss expense. The selected provision for unallocated loss adjustment expense is incorporated directly into the rate level indications.

EXHIBIT V: TREND CALCULATIONS

The pure premium trend factors applied in the rate level indication are derived in Exhibit V. The Company's historical data in Illinois is insufficient to evaluate trends in pure premiums. As such, the projected pure premiums are derived from ISMIE Mutual Insurance Company's July 1, 2006 rate filing and fit utilizing an exponential least-squares technique for several combinations of years. Based upon the resulting trends, F-Statistics and R-squared values, an annual pure premium trend of 4.5% was selected to adjust historic pure premiums to the current cost level.

EXHIBIT VI: INCURRED LOSS & ALE DEVELOPMENT

Exhibit VI-A presents the countrywide 200K/600K limited case incurred loss and total ALE development patterns used to derive the corresponding incremental development factors. The resulting cumulative development factors (Exhibit VI-B) are used to project the 200K/600K limited case incurred loss and total ALE to ultimate settlement values in Exhibit I-B(iii).

EXHIBIT VII: PAID LOSS & ALE DEVELOPMENT

Exhibit VII-A presents the countrywide 200K/600K limited paid loss and total ALE development patterns used to derive the corresponding incremental development factors. The resulting cumulative development factors (Exhibit VII-B) are used to project the 200K/600K limited paid loss and total ALE to ultimate settlement values in Exhibit I-B(iv).

EXHIBIT VIII: INCURRED LOSS DEVELOPMENT

Exhibit VIII-A presents the countrywide 200K/600K limited case incurred loss development patterns used to derive the corresponding incremental development factors. The resulting cumulative development factors (Exhibit VIII-B) are used to project the 200K/600K limited case incurred losses to ultimate settlement values in Exhibit I-B(i).

EXHIBIT IX: INCURRED ALE DEVELOPMENT

Exhibit IX-A presents the countrywide total limits case incurred ALE development patterns used to derive the corresponding incremental development factors. The resulting cumulative development

factors (Exhibit IX-B) are used to project the total limits case incurred ALE to ultimate settlement values in Exhibit I-B(i).

EXHIBIT X: PAID LOSS DEVELOPMENT

Exhibit X-A presents the countrywide 200K/600K limited paid loss development patterns used to derive the corresponding incremental development factors. The resulting cumulative development factors (Exhibit X-B) are used to project the 200K/600K limited paid losses to ultimate settlement values in Exhibit I-B(ii).

EXHIBIT XI: PAID ALE DEVELOPMENT

Exhibit XI-A presents the countrywide total limits paid ALE development patterns used to derive the corresponding incremental development factors. The resulting cumulative development factors (Exhibit XI-B) are used to project the total limits paid ALE to ultimate settlement values in Exhibit I-B(ii).

EXHIBIT XII: TERRITORY CHANGES

Exhibit XII outlines the proposed changes to the current Territory structure and develops an overall premium effect of –16.1%. The proposed revisions to the Company's territory structure was based on an evaluation of the experience made available through the Illinois Division of Insurance's website pursuant to implementation of new subsection (C-5) to Section 1204 of the Illinois Insurance Code [215 ILCS 5/1204]. The Company focused its analysis on ISMIE Mutual Insurance Company's experience coded for both classification and geographic location. Utilizing a Generalized Linear Model to evaluate the interaction of classification data across and within counties/rating territories, the Company concluded that the current ISMIE territory structure reasonably represented differences in loss costs by geographic location. As such, the Company proposes to revise its territory structure and relativities so that it is identical to that of ISMIE.

EXHIBIT XIII: CLASSIFICATION CHANGES

The proposed revisions to MedPro's Physicians & Surgeons classification plan were determined by incorporating a number of considerations including: classification relativities derived from an ISO countrywide classification study, a review of the classification relativities of other carriers, an analysis of MedPro claim experience, the credibility of the classification indications, an evaluation of stability issues and underwriting judgment. The culmination of these considerations resulted in the proposed relativity changes outlined in Exhibit XII.

EXHIBIT XIV: CLAIMS-MADE STEP, LOSS FREE CREDIT AND NEW TO PRACTICE CREDIT

The Company also proposes to modify three additional components of the current rate structure, the claims-made step factors, the loss free credit structure and the new to practice credit structure. Exhibit XIV provides a comparison of the current and proposed factors.

The revisions to the claim-made rate structure reflect the consideration of the lag factors derived from ISMIE Mutual Insurance Company's experience in their July 1, 2006 rate filing. Specifically,

we propose to lower CMA 1 from 32.5% to 27.5%, increase CMA 2 from 45% to 47.5% and insert an additional step between CMA 4 and mature with a factor of 95%.

The Loss Free Credit table currently contains three tiers of credits based on the number of continuous years the insured has remained loss free. The Company proposes to introduce a fourth tier that will enhance the graduation of the credits. The current 10% credit associated with loss free years 8 and 9 will be increased to 15%. This revision will moderate the transition in credits over time while continuing to reward additional years in a loss free practice.

The New to Practice Credit currently provides for credits for the first two years after completing training. The Company proposes to expand the credit structure to a third year that will provide a 15% credit.

These modifications represent relatively small premium adjustments when the number of potentially affected insureds is considered, have some offsetting impact and ultimately have no material effect on the overall premium.

APPENDIX A-1: ILLINOIS INCURRED LOSS & ALE DEVELOPMENT

Appendix A-1 and A-2 present the statewide 200K/600K limited case incurred loss and total ALE development.

APPENDIX A-3: ILLINOIS PAID LOSS & ALE DEVELOPMENT

Appendix A-3 and A-4 present the statewide 200K/600K limited paid loss and total ALE development.

APPENDIX A-5/6: ILLINOIS INCURRED LOSS DEVELOPMENT

Appendix A-5 and A-6 present the statewide 200K/600K limited case incurred loss development.

APPENDIX A-7/8: ILLINOIS INCURRED ALE DEVELOPMENT

Appendix A-7 and A-8 present the statewide total limits case incurred ALE development.

APPENDIX A-9/10: ILLINOIS PAID LOSS DEVELOPMENT

Appendix A-9 and A-10 present the statewide 200K/600K limited paid loss development.

APPENDIX A-11/12: ILLINOIS PAID ALE DEVELOPMENT

Appendix A-11 and A-12 present the statewide total limits paid ALE development.

REVISED MANUAL RATES

Rate and Rule pages for the Occurrence and Claims Made programs have been revised to incorporate the proposed changes and are attached to this filing.

REVISED PARTNERSHIP OR CORPORATION COVERAGE RULE

The Company proposes to revise its Partnership or Corporation Rating Rule for the Occurrence and Claims Made programs. The premium caps have been revised in a manner commensurate with the rate revisions, and no other modifications have been made.

REVISED COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Also attached are revised manual pages for Sections II & III of the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons program, and therefore are being included in this submission for manual purposes only.

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

RATE LEVEL INDICATION
200/600 LIMITS

Proposed Rates Effective: 01/01/2007
Data Evaluated as of: 06/30/2006

	(1)	(2)	(3)	(4)
Report Year	**Base Equivalent Earned Exposures**	**Earned Premium at Curent Manual Rates**	**Ultimate LLAE at 01/01/2008 Cost Level**	**(3) / (1) Trended Accident Year LLAE Pure Premium**
2000	778	$5,817,443	$3,268,010	$4,199
2001	1,605	$11,992,790	$6,598,732	$4,112
2002	1,970	$14,720,067	$4,036,707	$2,050
2003	3,793	$28,333,899	$10,083,077	$2,658
2004	2,295	$17,144,600	$6,845,700	$2,982
TOTAL	10,441	$78,008,799	$30,832,225	$2,953

1a) Claims Made LLAE Pure Premium		$2,953
1b) Death, Disability and Retirement (DDR) Load		6.0%
1c) Claims Made LLAE Pure Premium with DDR Load	(1a) x [1.0 + (1b)]	$3,130
2) Base Equivalent Fixed Expense	Exhibit II	$353
3) Variable Expense Factor	Exhibit II	0.854
4) Calculated Rate	[(1c) + (2)] / (3)	$4,079
5) Earned Premium at Current Manual Rates		$78,008,799
6) Base Equivalent Exposures		10,441
7) Current Average Manual Rate	(5) / (6)	$7,471
8) Average Credit		20.0%
9) Current Average Rate Including Credits	(7) x [1.0 - (8)]	$5,975
10) Indicated Rate Change with Credit Offset	[(4) / (9)] - 1.0	-31.7%
11) Credibility Factor	Exhibit I - C	0.52
12) Complement of Credibility	Exhibit I - E(i)	-35.0%
13) Credibility Weighted Rate Change	(10) x (11) + (12) x [1.0 - (11)]	-33.3%
14) Selected Rate Change		-32.0%

NOTE: This exhibit is based upon statewide data.

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

RATE LEVEL INDICATION
200/600 LIMITS

Proposed Rates Effective: 01/01/2007
Data Evaluated as of: 06/30/2006

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Report Year	**Incurred LDF Ultimate LALE Exhibit I - B(i)**	**Paid LDF Ultimate LALE Exhibit I - B(ii)**	**Incurred BF Ultimate LALE Exhibit I - B(iii)**	**Paid BF Ultimate LALE Exhibit I - B(iv)**	**Selected Ultimate LALE**	**Trend Factor at 4.5%**	**Trended Ultimate LALE**	**Trended Ultimate LLAE**
2000	$2,699,089	$1,912,886	$2,679,312	$1,917,856	$2,298,584	1.391	$3,197,662	$3,268,010
2001	$5,438,091	$4,235,707	$5,404,387	$4,295,880	$4,850,133	1.331	$6,456,684	$6,598,732
2002	$3,631,471	$1,975,901	$3,642,613	$2,569,600	$3,100,535	1.274	$3,949,811	$4,036,707
2003	$8,537,448	$5,528,299	$8,556,914	$7,648,900	$8,093,174	1.219	$9,866,024	$10,083,077
2004	$3,325,672	$2,518,975	$3,952,537	$5,741,957	$5,741,957	1.167	$6,698,337	$6,845,700
TOTAL					$24,084,384		$30,168,518	$30,832,225

NOTES:
1) LALE pure premium trend @ 4.5% per Exhibit V
2) Pure premium trend factor assumes an effective date of 01/01/2007
3) (8) = (7) * (1.0 + ULE load of 2.2%)

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - B(i)

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

RATE LEVEL INDICATION
200/600 LIMITS

Ultimate Loss & ALE by Incurred Chain Ladder Method
Data Evaluated as of: 06/30/2006

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Report Year	**To Date Incurred Loss Appendix A-5**	**Loss Development Factor Exhibit VIII - B**	**Ultimate Loss**	**To Date Incurred ALE Appendix A-7**	**ALE Development Factor Exhibit IX - B**	**Ultimate ALE**	**Ultimate LALE**
2000	$1,400,000	0.981	$1,373,239	$1,275,538	1.039	$1,325,850	$2,699,089
2001	$3,083,000	0.981	$3,025,189	$2,263,545	1.066	$2,412,902	$5,438,091
2002	$1,949,000	0.965	$1,881,273	$1,550,808	1.129	$1,750,198	$3,631,471
2003	$4,362,000	0.954	$4,162,058	$3,418,123	1.280	$4,375,390	$8,537,448
2004	$866,884	1.049	$909,611	$1,456,338	1.659	$2,416,062	$3,325,672
TOTAL	$11,660,884			$9,964,352			

NOTES:
1) (3) = Maximum of (1) x (2) or Paid to Date Losses
2) (6) = Maxiumum of (4) x (5) or Paid to Date ALE
3) (7) = (3) + (6)

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - B(ii)

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

RATE LEVEL INDICATION
200/600 LIMITS

Ultimate Loss & ALE by Paid Chain Ladder Method
Data Evaluated as of: 06/30/2006

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Report Year	**To Date Paid Loss Appendix A-9**	**Loss Development Factor Exhibit X - B**	**Ultimate Loss**	**To Date Paid ALE Appendix A-11**	**ALE Development Factor Exhibit XI - B**	**Ultimate ALE**	**Ultimate LALE**
2000	$600,000	1.027	$616,374	$1,233,960	1.051	$1,296,512	$1,912,886
2001	$1,765,000	1.071	$1,890,228	$2,160,130	1.086	$2,345,478	$4,235,707
2002	$311,000	1.137	$353,756	$1,388,483	1.168	$1,622,145	$1,975,901
2003	$1,150,000	1.356	$1,559,433	$2,843,091	1.396	$3,968,866	$5,528,299
2004	$122,884	2.200	$270,289	$1,108,866	2.028	$2,248,686	$2,518,975
TOTAL	$3,948,884			$8,734,530			

NOTES:
1) (3) = (1) x (2)
2) (6) = (4) x (5)
3) (7) = (3) + (6)

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - B(iii)

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

RATE LEVEL INDICATION
200/600 LIMITS

Ultimate Loss & ALE by Incurred Bornhuetter-Ferguson Method
Data Evaluated as of: 06/30/2006

	(1)	(2)	(3)	(4)	(5)	(6)
Report Year	**Detrended Earned Premium at Current Average Rates**	**Expected LALE Ratio**	**To Date Incurred LALE Appendix A-1**	**LALE Development Factor Exhibit VI - B**	**LALE Outstanding**	**Ultimate LALE**
2000	$3,344,631	72.7%	$2,675,538	1.002	0.002	$2,679,312
2001	$7,205,308	72.7%	$5,346,545	1.011	0.011	$5,404,387
2002	$9,241,840	72.7%	$3,499,808	1.022	0.021	$3,642,613
2003	$18,589,652	72.7%	$7,780,123	1.061	0.057	$8,556,914
2004	$11,754,620	72.7%	$2,323,222	1.236	0.191	$3,952,537
TOTAL	$50,366,669		$21,625,236			$24,235,763

NOTES: (5) = 1.0 - [1.0 / (4)]
(6) = Maxiumum of (1) x (2) x (5) + (3) or Paid to Date LALE

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - B(iv)

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

RATE LEVEL INDICATION
200/600 LIMITS

Ultimate Loss & ALE by Paid Bornhuetter-Ferguson Method
Data Evaluated as of: 06/30/2006

	(1)	(2)	(3)	(4)	(5)	(6)
Report Year	**Detrended Earned Premium at Current Average Rates**	**Expected LALE Ratio**	**To Date Paid LALE Appendix A-3**	**LALE Development Factor Exhibit VII - B**	**LALE Outstanding**	**Ultimate LALE**
2000	$3,344,631	72.7%	$1,833,960	1.036	0.034	$1,917,856
2001	$7,205,308	72.7%	$3,925,130	1.076	0.071	$4,295,880
2002	$9,241,840	72.7%	$1,699,483	1.149	0.129	$2,569,600
2003	$18,589,652	72.7%	$3,993,091	1.371	0.270	$7,648,900
2004	$11,754,620	72.7%	$1,231,750	2.117	0.528	$5,741,957
TOTAL	$50,366,669		$12,683,414			$22,174,193

NOTES: (5) = 1.0 - [1.0 / (4)]
(6) = (1) x (2) x (5) + (3)

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - C

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Development of Credibility Factor
Data Evaluated as of: 06/30/2006

I. Establishment of Credibility Standard:

A. Error % = K = 7.5%

B. Probability = P = 95.0%

C. N = { (Z^2) / (K^2) } = (1.96^2) / (0.075^2) = 683

II. Calculated Credibility :

Based on the Number of Incurred Counts:

Net Number of Incurred Counts = C

100% Credibility is assigned to 683 Incurred Counts

$$\text{Credibility} = \sqrt{\frac{C}{683}}$$

Calculation:

C = 183

$$\text{Credibility} = \sqrt{\frac{183}{683}} = 0.52$$

Selected Credibility Factor = 0.52

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - D(i)

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

A PRIORI LALE RATIO & COMPLEMENT OF CREDIBILITY
200/600 LIMITS

1) LALE Pure Premium underlying Current Rates	Exhibit I - D(ii)	$3,920
2a) Pure Premium Trend	Exhibit V	4.5%
2b) Trend Factor from 10/01/04 to 01/01/07		1.104
3) Trended LALE Pure Premium	(1) x (2b)	$4,328
4) Current Base Equivalent Rate Including Credit	Exhibit I-A, Line 9	$5,952
5) A Priori Expected LALE Ratio at Current Rate Level	(3) / (11)	72.7%

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - D(ii)

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

CALCULATION OF PURE PREMIUM UNDERLYING CURRENT RATES
200/600 LIMITS

1) Indicated Base Equivalent Manual Rate from filing effective 10/01/04		$7,442
2) Average Credit underlying Current Rates		15.1%
3) Indicated Base Equivalent Rate Including Credit	(1) x [1.0 - (2)]	**$6,318**
4) Variable Expense Factor underlying Current Rates		0.737
5) Base Equivalent Fixed Expense underlying Current Rates		$409
6) LLAE Pure Premium underlying Current Rates	(3) x (4) - (5)	**$4,248**
7a) ULE Load underlying Current Rates		3.2%
7b) DDR Load underlying Current Rates		5.0%
8) LALE Pure Premium underlying Current Rates	(6) / {[1.0 + (7a)] x [1.0 + (7b)]}	**$3,920**

THE MEDICAL PROTECTIVE COMPANY

EXHIBIT I - E(i)

ILLINOIS

PHYSICIANS & SURGEONS
(CLAIMS MADE)

MPCO BASE RATE

I. LOSS COST COMPONENT		
A. Average 1M/3M Limit Claims Made LALE Pure Premium	Exhibit I - E(ii)	$28,248
B. MPCO Unallocated Loss Adjustment Expense Factor	Exhibit IV	1.023
C. DDR provision		1.06
D. MPCO 1M/3M Limit Average CM LLAE Pure Premium	**IA x IB x 1C=**	**$30,632**
II. FIXED EXPENSE COMPONENT		
A. General Expense		$1,027
B. Other Acquisition Expense		$343
C. Total Fixed Expense	**IIA + IIB =**	**$1,370**
III. VARIABLE EXPENSE COMPONENT		
A. MPCO Commissions		7.7%
B. MPCO Taxes, Licenses & Fees		1.9%
C. Other		0.0%
D. MPCO Investment Income Offset		5.0%
E. Total Variable Expenses	**IIIA + IIIB + IIIC + IIID**	**14.6%**
F. Variable Expense Factor	**1 - IIIE**	**0.854**
IV. INDICATED $1M/$3M CLAIMS MADE BASE RATE		
A. MPCO 1M/3M Claims Made Indicated Rate	(ID + IIC) / IIIF	**$37,482**
B. MPCO Average Credits		**20.0%**
C. MPCO Average Class Factor Including ILF Differential		2.170
D. MPCO Average Territory Factor (Relative to Territory 1)		0.782
E. Indicated 1M/3M Claims Made Base Rate	**IVA / (IVC x IVD) / (1.0 - IVB)**	**$27,616**
F. Current 1M/3M Claims Made Base Rate (Territory 1)		$42,517
G. Indicated Rate Change	**(IVE/ IVF) - 1.0**	**-35.0%**
H. Proposed Base Rate Change		-35.0%

THE MEDICAL PROTECTIVE COMPANY

Exhibit I - E(ii)

ILLINOIS

PHYSICIANS & SURGEONS

UNDISCOUNTED LLAE PURE PREMIUM

(1)	ISMIE LALE Pure Premium (Base Class)		**$22,249**
(2)	Average LALE Pure Premium	Line (1) * 1.248 =	**$27,766**
(3)	Trended Undiscounted Average LALE Pure Premium		**$28,248**

Note: 1) From Tillinghast ISMIE indication, App. E, Exh. A: 22,249 = 21,960/.989/.998
2) Average Class/Territory Relativiry of 1.248 from Tillinghast ISMIE Exh. C, Sheet 2

THE MEDICAL PROTECTIVE COMPANY

Exhibit II

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

Fixed Expenses and Variable Expense Factor

Fixed Expense Components:

1. Acquisition Expense		$ 326
2. General Expense		$ 1,044
3. Total Fixed Expense per Policy		$ 1,370
4. Average Base Equivalent Factor		3.884
5. Base Equivalent Fixed Expense		$ 353

Variable Expense Components:

6. Taxes, Licenses and Fees		1.92%
7. Brokerage & Commissions		7.70%
8. Underwriting Profit Provision Reflecting Investment Income	Exhibit III - A	5.00%
9. Total Variable Expenses (Excluding LAE, Aq. Exp., and Gen. Exp.)		14.62%
10. Variable Expense Factor (Unity minus Variable Expenses)		0.854

NOTE: The non-variable expenses are based on the average cost per policy, at a 7/1/2007 cost level.

THE MEDICAL PROTECTIVE COMPANY

Exhibit III - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

CALCULATION OF UNDERWRITING PROFIT PROVISION
REFLECTING INVESTMENT INCOME

Investment Income Rate	3.68%
Investment Income Tax Rate	14.10%
Underwriting Tax Rate	35.00%
UEPR/Surplus Ratio	2.21
LLAE Reserve/Surplus Ratio	2.10
Variable Expense Ratio	9.62%
Fixed Expense Ratio	8.65%
LLAE Ratio	76.73%
Combined Ratio	95.00%
Underwriting Profit Provision	**5.00%**
Total Return on Surplus	11.82%

Time	Premium Collection Pattern
0.00	100.0%
0.25	0.0%
0.50	0.0%
0.75	0.0%
1.00	0.0%

Time	LLAE Payment Pattern
0.00	0.0%
0.25	0.6%
1.25	13.5%
2.25	33.1%
3.25	25.7%
4.25	14.1%
5.25	5.9%
6.25	3.6%
7.25	1.8%
8.25	0.8%
9.25	0.4%
10.25	0.1%
11.25	0.2%
12.25	0.1%
13.25	0.0%
14.25	0.0%
15.25	0.0%

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
Time	Collected Premium	Earned Premium	UEPR	Change in UEPR	Written Expenses	Earned Expenses	Incurred LLAE	Paid LLAE	LLAE Reserve	Change in LLAE Reserve	Tax Code Reserve Discount Factors	Discounted LLAE Reserve	Change in Discounted LLAE Reserve	Tax Code UW Profit/Loss	Tax on Tax Code UW Profit/Loss
0.00	$ 100.00	$ -	$ 100.00	$ 100.00	$ 9.62	$ -	$ -	$ -	$ -	$ -	0.9223	$ -	$ -	$ 10.38	$ 3.63
0.25	$ -	$ 25.00	$ 75.00	$ (25.00)	$ -	$ 2.16	$ 19.18	$ 0.50	$ 18.68	$ 18.68	0.9223	$ 17.23	$ 17.23	$ 0.11	$ 0.04
0.50	$ -	$ 25.00	$ 50.00	$ (25.00)	$ -	$ 2.16	$ 19.18	$ -	$ 37.87	$ 19.18	0.9223	$ 34.92	$ 17.69	$ 0.15	$ 0.05
0.75	$ -	$ 25.00	$ 25.00	$ (25.00)	$ -	$ 2.16	$ 19.18	$ -	$ 57.05	$ 19.18	0.9223	$ 52.62	$ 17.69	$ 0.15	$ 0.05
1.00	$ -	$ 25.00	$ -	$ (25.00)	$ -	$ 2.16	$ 19.18	$ -	$ 76.23	$ 19.18	0.9223	$ 70.31	$ 17.69	$ 0.15	$ 0.05
1.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10.34	$ 65.89	$ (10.34)	0.9321	$ 61.41	$ (8.89)	$ (1.45)	$ (0.51)
2.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25.40	$ 40.49	$ (25.40)	0.9291	$ 37.62	$ (23.80)	$ (1.61)	$ (0.56)
3.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19.74	$ 20.75	$ (19.74)	0.8884	$ 18.44	$ (19.18)	$ (0.55)	$ (0.19)
4.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10.82	$ 9.94	$ (10.82)	0.8906	$ 8.85	$ (9.59)	$ (1.23)	$ (0.43)
5.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4.51	$ 5.43	$ (4.51)	0.9288	$ 5.04	$ (3.81)	$ (0.70)	$ (0.25)
6.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2.78	$ 2.65	$ (2.78)	0.9423	$ 2.49	$ (2.55)	$ (0.23)	$ (0.08)
7.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.38	$ 1.27	$ (1.38)	0.9621	$ 1.22	$ (1.28)	$ (0.10)	$ (0.04)
8.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.64	$ 0.63	$ (0.64)	0.9698	$ 0.61	$ (0.61)	$ (0.03)	$ (0.01)
9.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.33	$ 0.30	$ (0.33)	0.9684	$ 0.29	$ (0.32)	$ (0.01)	$ (0.00)
10.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.06	$ 0.24	$ (0.06)	0.9668	$ 0.23	$ (0.06)	$ (0.00)	$ (0.00)
11.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.19	$ 0.06	$ (0.19)	0.9668	$ 0.05	$ (0.18)	$ (0.01)	$ (0.00)
12.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.06	$ -	$ (0.06)	0.9668	$ -	$ (0.05)	$ (0.00)	$ (0.00)
13.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
14.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
15.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.9668	$ -	$ -	$ -	$ -
Totals	$ 100.00	$ 100.00		$ -	$ 9.62	$ 8.65	$ 76.73	$ 76.73		$ -			$ (0.00)	$ 5.00	$ 1.75

	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)
		From Reserves				From Required Surplus				
Time	Total Reserves	Investment Income	Investment Income Net of Tax	Required Surplus	Change in Required Surplus	Investment Income	Investment Income Net of Tax	Cash Flow	11.82% Discount Factors	Discounted Cash Flow
0.00	$ 100.00	$ -	$ -	$ 45.24	$ 45.24	$ -	$ -	$ (58.49)	1.0000	$ (58.49)
0.25	$ 93.68	$ 0.91	$ 0.78	$ 42.83	$ (2.41)	$ 0.41	$ 0.35	$ 7.16	0.9725	$ 6.96
0.50	$ 87.87	$ 0.85	$ 0.73	$ 40.65	$ (2.18)	$ 0.39	$ 0.33	$ 6.84	0.9457	$ 6.47
0.75	$ 82.05	$ 0.80	$ 0.68	$ 38.48	$ (2.18)	$ 0.37	$ 0.32	$ 6.78	0.9196	$ 6.24
1.00	$ 76.23	$ 0.74	$ 0.64	$ 36.30	$ (2.18)	$ 0.35	$ 0.30	$ 6.72	0.8943	$ 6.01
1.25	$ 65.89	$ 0.69	$ 0.59	$ 31.38	$ (4.92)	$ 0.33	$ 0.28	$ 6.31	0.8696	$ 5.48
2.25	$ 40.49	$ 2.42	$ 2.08	$ 19.28	$ (12.10)	$ 1.15	$ 0.99	$ 15.73	0.7777	$ 12.23
3.25	$ 20.75	$ 1.49	$ 1.28	$ 9.88	$ (9.40)	$ 0.71	$ 0.61	$ 11.48	0.6955	$ 7.98
4.25	$ 9.94	$ 0.76	$ 0.66	$ 4.73	$ (5.15)	$ 0.36	$ 0.31	$ 6.55	0.6219	$ 4.07
5.25	$ 5.43	$ 0.37	$ 0.31	$ 2.59	$ (2.15)	$ 0.17	$ 0.15	$ 2.85	0.5562	$ 1.59
6.25	$ 2.65	$ 0.20	$ 0.17	$ 1.26	$ (1.33)	$ 0.10	$ 0.08	$ 1.66	0.4974	$ 0.83
7.25	$ 1.27	$ 0.10	$ 0.08	$ 0.60	$ (0.66)	$ 0.05	$ 0.04	$ 0.82	0.4448	$ 0.36
8.25	$ 0.63	$ 0.05	$ 0.04	$ 0.30	$ (0.30)	$ 0.02	$ 0.02	$ 0.37	0.3978	$ 0.15
9.25	$ 0.30	$ 0.02	$ 0.02	$ 0.14	$ (0.16)	$ 0.01	$ 0.01	$ 0.19	0.3557	$ 0.07
10.25	$ 0.24	$ 0.01	$ 0.01	$ 0.11	$ (0.03)	$ 0.01	$ 0.00	$ 0.04	0.3181	$ 0.01
11.25	$ 0.06	$ 0.01	$ 0.01	$ 0.03	$ (0.09)	$ 0.00	$ 0.00	$ 0.10	0.2845	$ 0.03
12.25	$ -	$ 0.00	$ 0.00	$ -	$ (0.03)	$ 0.00	$ 0.00	$ 0.03	0.2544	$ 0.01
13.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.2275	$ -
14.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.2035	$ -
15.25	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.1819	$ -
Totals		$ 9.41	$ 8.09		$ (0.00)	$ 4.43	$ 3.80	$ 15.14		$ 0.00

THE MEDICAL PROTECTIVE COMPANY

Exhibit III - B

ILLINOIS

PHYSICIANS & SURGEONS

CALCULATION OF INVESTMENT INCOME RATE AND
EFFECTIVE FEDERAL INCOME TAX RATE ON INVESTMENT INCOME

The rate of return is the ratio of net investment income earned to mean cash and invested assets as determined from the Annual Statement.

Year	Prior Year Cash and Invested Assets	Current Year Cash and Invested Assets	Mean Cash and Invested Assets	Net Investment Income	Rate of Return
2003	$ 1,582,814,730	$ 1,934,006,083	**$ 1,758,410,407**	$ 62,878,046	3.58%
2004	**$ 1,934,006,083**	$ 1,958,098,806	**$ 1,946,052,445**	$ 70,520,509	3.62%
2005	**$ 1,958,098,806**	$ 2,101,581,058	**$ 2,029,839,932**	$ 74,605,991	3.68%
Selected					3.68%

The effective rate of Federal Income Tax was determined by applying current tax rates to the distribution of Annual Statement investment income.

Asset Type		Net Investment Income	FIT Rate
Bonds			
	Taxable	$ 18,579,293	35.00% (a)
	Nontaxable	$ 52,407,005	5.25% (b)
	Subtotal	**$ 70,986,298**	13.04%
Stocks			
	Affiliates	$ -	
	Nonaffiliates	$ -	
	Subtotal	**$ -**	14.18% (c)
Other			
	Mortgage loans	$ -	
	Real estate	$ 550,000	
	Cash and short-term investments	$ 5,259,948	
	All other	$ -	
	Subtotal	**$ 5,809,948**	35.00% (a)
Total Gross Investment Income		**$ 76,796,246**	14.70%
Total Investment Deductions		$ 2,190,255	35.00% (a)
Total Net Investment Income		**$ 74,605,991**	14.10%

Notes:

(a) Full corporate tax rate of 35%.

(b) 100% of the income on tax-exempt bonds is subject to proration. That is, 15% of that income is taxed at the full corporate tax rate of 35%. The applicable tax rate is (15%)(35%) = 5.25%.

(c) 30% of the dividend income on stock is subject to the full corporate tax rate of 35%. The remaining 70% of dividend income on stock is subject to proration. That is, 15% of that income is taxed at the full corporate tax rate of 35%. The applicable tax rate is [(30%)(35%) + (70%)(15%)(35%)] = 14.18%.

THE MEDICAL PROTECTIVE COMPANY

Exhibit IV

ILLINOIS

PHYSICIANS & SURGEONS

UNALLOCATED LOSS EXPENSE FACTOR

	(1)	(2)	(3)	(4)
Accident/ Report Year	**Total LLAE Incurred**	**Unallocated Loss Expense**		**ULE Factor**
		Paid	**Unpaid**	
2001	430,815	8,975	1,027	2.4%
2002	486,105	9,143	1,781	2.3%
2003	624,689	8,743	4,221	2.1%
2004	610,111	6,826	5,860	2.1%
2005	513,919	5,522	5,341	2.2%
5-Yr Avg	2,665,639	39,209	18,230	2.2%
3-Yr Avg	1,748,719	21,091	15,422	2.1%
			Selected:	**2.2%**

NOTES: 1) This exhibit is based upon companywide experience derived from the 2005 Annual Statement Schedule P - Part 1F.

2) (4) = [{(2) + (3)} / {(1) - (2) - (3)}]

THE MEDICAL PROTECTIVE COMPANY

Exhibit V

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made Only)

LALE PURE PREMIUM TREND

	ISMIE LALE Projections						Exponential Fits				
	(1)	(2)	(3)	(4)	(5)	(6)					
		Ultimate Loss & ALAE									
Report Year (X)	Mature Equiv Exposures	Freq x Sev Method	Paid Dev Method	Rept Dev Method	Selected Ultimate	Implied Pure Premium	'95-'03	'96-'03	'97-'03	'98-'03	'99-'03
1995	12,451.2	157,430	158,134	159,611	158,443	12,725	14,274				
1996	11,954.3	193,624	196,342	196,628	195,369	16,343	15,012	15,900			
1997	11,409.0	180,247	179,362	187,101	182,812	16,023	15,789	16,518	16,260		
1998	10,511.0	182,344	184,505	207,716	192,925	18,355	16,606	17,160	16,959	17,125	
1999	10,477.5	168,828	167,990	178,462	172,514	16,465	17,465	17,827	17,687	17,809	16,848
2000	10,877.5	194,306	180,758	208,036	197,088	18,119	18,368	18,520	18,447	18,519	17,888
2001	11,793.5	219,069	203,041	230,727	220,527	18,699	19,319	19,240	19,240	19,259	18,993
2002	13,474.0	301,913	276,699	299,132	295,758	21,950	20,318	19,988	20,066	20,027	20,166
2003	13,577.0	271,953	291,494	267,456	274,062	20,186	21,369	20,765	20,928	20,826	21,412
Trend:							5.2%	3.9%	4.3%	4.0%	6.2%
R-Squared:							77.4%	72.3%	69.2%	55.3%	75.6%
F-Statistic							23.97	15.67	11.21	4.94	9.29
Critical Value at 95%							5.59	5.99	6.61	7.71	10.13
							pass	pass	pass	fail	fail
Selected Pure Premium Trend											**4.5%**

Note:
1) ISMIE Mature Equivalent Exposures Exhibit I-Sheet 2 of Rate Filing Eff. July 1, 2006
2) ISMIE Ultimate Loss Projections Exhibit I-Sheet 2 of Rate Filing Eff. July 1, 2006
3) ISMIE Ultimate Loss Projections Exhibit I-Sheet 3 of Rate Filing Eff. July 1, 2006
4) ISMIE Ultimate Loss Projections Exhibit I-Sheet 4 of Rate Filing Eff. July 1, 2006
5) Weighted total of projection methods: 40% (2), (4) and 20% (3).
6) =(5)/(1)

THE MEDICAL PROTECTIVE COMPANY

Exhibit VI - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	350,487	8,193,892	13,295,499	15,076,550	14,897,058	15,742,338	15,232,707	15,065,489	15,006,852	15,262,493	15,202,517	15,260,740	15,260,740	15,260,740	15,260,740
1992	1,109,814	9,239,227	13,366,011	15,451,800	15,662,197	15,444,171	15,193,675	15,028,757	15,015,906	14,984,206	15,035,955	15,035,413	15,035,413	15,035,972	15,035,972
1993	1,356,041	13,688,443	23,414,155	22,889,238	22,983,881	22,845,956	22,891,698	22,959,287	23,206,330	23,189,436	23,152,071	23,193,123	23,208,881	23,155,315	
1994	1,195,389	22,088,257	33,552,193	36,340,956	38,005,067	37,997,231	38,374,611	38,600,076	38,406,010	38,294,676	38,428,956	38,351,812	38,370,533		
1995	1,814,941	30,632,779	48,196,378	55,912,849	58,422,309	58,050,694	58,725,938	58,220,521	58,329,769	58,480,467	58,424,450	58,183,551			
1996	3,735,604	37,412,556	58,513,409	62,515,106	63,958,792	65,274,627	66,134,827	67,088,487	67,439,725	67,570,172	67,526,034				
1997	5,473,471	41,902,427	69,571,546	77,018,166	78,858,401	78,919,508	80,750,328	80,733,767	81,313,420	81,139,557					
1998	3,189,275	41,166,922	75,820,109	87,298,722	92,099,927	95,050,628	96,113,672	95,782,105	95,806,297						
1999	1,908,346	40,146,361	75,885,350	89,298,756	95,993,064	96,941,979	97,753,310	97,765,283							
2000	2,827,499	40,387,740	80,626,905	103,743,882	108,979,707	108,343,222	109,350,444								
2001	4,084,216	51,561,629	112,840,691	139,057,110	142,935,444	146,252,510									
2002	6,485,673	81,705,106	154,603,614	176,512,706	183,510,930										
2003	11,059,006	103,880,044	168,573,367	192,184,003											
2004	6,790,379	48,165,211	87,519,477												
2005	4,962,679	33,310,211													
2006	4,245,810														

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit VI - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	23.379	1.623	1.134	0.988	1.057	0.968	0.989	0.996	1.017	0.996	1.004	1.000	1.000	1.000	
1992	8.325	1.447	1.156	1.014	0.986	0.984	0.989	0.999	0.998	1.003	1.000	1.000	1.000	1.000	
1993	10.094	1.711	0.978	1.004	0.994	1.002	1.003	1.011	0.999	0.998	1.002	1.001	0.998		
1994	18.478	1.519	1.083	1.046	1.000	1.010	1.006	0.995	0.997	1.004	0.998	1.000			
1995	16.878	1.573	1.160	1.045	0.994	1.012	0.991	1.002	1.003	0.999	0.996				
1996	10.015	1.564	1.068	1.023	1.021	1.013	1.014	1.005	1.002	0.999					
1997	7.656	1.660	1.107	1.024	1.001	1.023	1.000	1.007	0.998						
1998	12.908	1.842	1.151	1.055	1.032	1.011	0.997	1.000							
1999	21.037	1.890	1.177	1.075	1.010	1.008	1.000								
2000	14.284	1.996	1.287	1.050	0.994	1.009									
2001	12.625	2.188	1.232	1.028	1.023										
2002	12.598	1.892	1.142	1.040											
2003	9.393	1.623	1.140												
2004	7.093	1.817													
2005	6.712														
Projected Incremental Development Factor	8.125	1.757	1.165	1.038	1.010	1.010	0.999	1.004	1.001	1.000	0.998	1.000	1.000	1.000	1.000
Cumulative Development Factor	17.639	2.171	1.236	1.061	1.022	1.011	1.002	1.003	0.999	0.998	0.998	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit VII - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	17,555	2,640,992	6,795,261	10,029,667	13,456,023	14,346,334	14,793,230	14,843,565	14,887,857	14,944,281	14,998,688	15,260,740	15,260,740	15,260,740	15,260,740
1992	27,003	2,622,940	7,887,189	11,696,576	13,557,300	13,866,323	14,303,451	14,422,725	14,840,178	14,875,806	15,035,955	15,035,413	15,035,413	15,035,972	15,035,972
1993	44,507	4,246,717	14,553,206	19,370,575	19,968,839	21,485,508	22,099,083	22,671,293	22,733,768	22,992,029	23,001,641	23,134,388	23,154,435	23,155,315	
1994	164,027	6,321,617	18,754,004	26,639,191	31,964,505	34,853,629	36,548,689	37,926,066	38,120,171	38,209,139	38,263,524	38,314,436	38,349,528		
1995	306,067	9,027,522	30,058,294	44,063,044	50,162,290	54,072,899	56,981,575	57,681,431	57,816,137	57,849,865	57,884,195	57,989,888			
1996	621,194	8,995,239	31,399,274	49,152,585	57,096,106	61,485,844	63,582,167	66,463,524	66,867,874	67,364,963	67,402,063				
1997	622,410	12,451,142	39,994,949	61,385,141	71,233,317	74,441,529	77,543,930	79,499,972	80,340,497	80,688,328					
1998	358,216	12,282,692	38,853,775	70,512,053	80,424,246	89,271,595	93,134,902	94,186,760	94,979,027						
1999	239,226	14,154,946	43,691,954	71,099,659	85,867,697	90,372,261	94,166,477	96,095,041							
2000	222,963	12,266,286	48,249,904	78,563,892	96,121,248	102,744,669	106,108,884								
2001	334,510	18,461,376	68,340,601	104,935,073	127,151,862	136,875,969									
2002	586,703	22,837,850	83,440,087	140,208,360	162,989,106										
2003	1,627,949	32,012,722	102,614,987	147,804,956											
2004	536,805	18,621,085	59,606,561												
2005	767,504	13,291,998													
2006	371,807														

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit VII - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	150.441	2.573	1.476	1.342	1.066	1.031	1.003	1.003	1.004	1.004	1.017	1.000	1.000	1.000	
1992	97.135	3.007	1.483	1.159	1.023	1.032	1.008	1.029	1.002	1.011	1.000	1.000	1.000	1.000	
1993	95.417	3.427	1.331	1.031	1.076	1.029	1.026	1.003	1.011	1.000	1.006	1.001	1.000		
1994	38.540	2.967	1.420	1.200	1.090	1.049	1.038	1.005	1.002	1.001	1.001	1.001			
1995	29.495	3.330	1.466	1.138	1.078	1.054	1.012	1.002	1.001	1.001	1.002				
1996	14.481	3.491	1.565	1.162	1.077	1.034	1.045	1.006	1.007	1.001					
1997	20.005	3.212	1.535	1.160	1.045	1.042	1.025	1.011	1.004						
1998	34.289	3.163	1.815	1.141	1.110	1.043	1.011	1.008							
1999	59.170	3.087	1.627	1.208	1.052	1.042	1.020								
2000	55.015	3.934	1.628	1.223	1.069	1.033									
2001	55.189	3.702	1.535	1.212	1.076										
2002	38.926	3.654	1.680	1.162											
2003	19.664	3.205	1.440												
2004	34.689	3.201													
2005	17.318														
Projected Incremental Development Factor	21.801	3.344	1.545	1.193	1.067	1.039	1.019	1.008	1.004	1.001	1.002	1.001	1.000	1.000	1.000
Cumulative Development Factor	154.337	7.079	2.117	1.371	1.149	1.076	1.036	1.017	1.008	1.004	1.003	1.001	1.000	1.000	1.000

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit VIII - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	169,000	6,479,606	10,380,096	11,647,377	10,847,579	11,553,579	11,013,579	10,813,579	10,706,579	10,903,579	10,803,579	10,803,579	10,803,579	10,803,579	10,803,579
1992	903,686	7,219,907	10,207,655	11,431,384	11,337,464	11,025,663	10,563,163	10,337,163	10,237,163	10,187,163	10,242,163	10,242,163	10,242,163	10,242,163	10,242,163
1993	1,031,160	10,211,492	17,538,988	15,695,674	15,335,672	14,729,222	14,631,722	14,646,722	14,842,222	14,767,222	14,737,222	14,737,222	14,737,222	14,687,222	
1994	718,958	16,793,954	25,060,982	25,620,451	25,778,742	24,957,834	24,970,335	24,970,834	24,646,834	24,497,834	24,562,834	24,449,834	24,448,834		
1995	1,198,728	22,894,561	35,580,324	39,272,794	39,485,835	38,412,806	38,360,878	37,921,379	38,016,818	38,089,818	38,039,818	37,724,818			
1996	2,437,729	27,675,090	42,824,221	43,364,889	42,476,435	42,354,502	42,446,752	42,749,730	42,815,231	42,807,231	42,757,230				
1997	3,818,653	31,161,730	51,701,275	53,984,962	52,572,404	51,585,662	52,233,063	51,464,729	51,534,456	51,162,456					
1998	1,725,725	30,609,668	56,086,089	60,277,606	61,312,999	61,316,394	61,510,595	60,758,595	60,446,095						
1999	963,625	29,458,824	55,061,089	60,837,972	63,884,515	63,271,557	63,574,827	63,342,827							
2000	1,607,228	26,921,441	54,057,792	68,503,118	68,304,567	65,650,820	65,223,819								
2001	1,929,559	35,551,988	79,960,820	93,712,869	91,724,729	91,340,755									
2002	3,908,319	55,297,449	105,248,755	113,467,245	112,487,251										
2003	6,596,696	62,677,501	106,835,813	113,980,584											
2004	2,681,885	26,716,299	52,024,129												
2005	1,820,740	15,029,931													
2006	1,147,955														

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit VIII - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	38.341	1.602	1.122	0.931	1.065	0.953	0.982	0.990	1.018	0.991	1.000	1.000	1.000	1.000	
1992	7.989	1.414	1.120	0.992	0.972	0.958	0.979	0.990	0.995	1.005	1.000	1.000	1.000	1.000	
1993	9.903	1.718	0.895	0.977	0.960	0.993	1.001	1.013	0.995	0.998	1.000	1.000	0.997		
1994	23.359	1.492	1.022	1.006	0.968	1.001	1.000	0.987	0.994	1.003	0.995	1.000			
1995	19.099	1.554	1.104	1.005	0.973	0.999	0.989	1.003	1.002	0.999	0.992				
1996	11.353	1.547	1.013	0.980	0.997	1.002	1.007	1.002	1.000	0.999					
1997	8.160	1.659	1.044	0.974	0.981	1.013	0.985	1.001	0.993						
1998	17.737	1.832	1.075	1.017	1.000	1.003	0.988	0.995							
1999	30.571	1.869	1.105	1.050	0.990	1.005	0.996								
2000	16.750	2.008	1.267	0.997	0.961	0.993									
2001	18.425	2.249	1.172	0.979	0.996										
2002	14.149	1.903	1.078	0.991											
2003	9.501	1.705	1.067												
2004	9.962	1.947													
2005	8.255														
Projected Incremental Development Factor	9.408	1.825	1.100	0.989	0.984	1.000	0.990	0.999	0.998	1.000	0.994	1.000	1.000	1.000	1.000
Cumulative Development Factor	18.019	1.915	1.049	0.954	0.965	0.981	0.981	0.991	0.992	0.994	0.994	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit IX - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred ALE Development

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	181,487	1,714,286	2,915,403	3,429,173	4,049,479	4,188,759	4,219,128	4,251,910	4,300,273	4,358,914	4,398,938	4,457,161	4,457,161	4,457,161	4,457,161
1992	206,128	2,019,320	3,158,356	4,020,416	4,324,733	4,418,508	4,630,512	4,691,594	4,778,743	4,797,043	4,793,792	4,793,250	4,793,250	4,793,809	4,793,809
1993	324,881	3,476,951	5,875,167	7,193,564	7,648,209	8,116,734	8,259,976	8,312,565	8,364,108	8,422,214	8,414,849	8,455,901	8,471,659	8,468,093	
1994	476,431	5,294,303	8,491,211	10,720,505	12,226,325	13,039,397	13,404,276	13,629,242	13,759,176	13,796,842	13,866,122	13,901,978	13,921,699		
1995	616,213	7,738,218	12,616,054	16,640,055	18,936,474	19,637,888	20,365,060	20,299,142	20,312,951	20,390,649	20,384,632	20,458,733			
1996	1,297,875	9,737,466	15,689,188	19,150,217	21,482,357	22,920,125	23,688,075	24,338,757	24,624,494	24,762,941	24,768,804				
1997	1,654,818	10,740,697	17,870,271	23,033,204	26,285,997	27,333,846	28,517,265	29,269,038	29,778,964	29,977,101					
1998	1,463,550	10,557,254	19,734,020	27,021,116	30,786,928	33,734,234	34,603,077	35,023,510	35,360,202						
1999	944,721	10,687,537	20,824,261	28,460,784	32,108,549	33,670,422	34,178,483	34,422,456							
2000	1,220,271	13,466,299	26,569,113	35,240,764	40,675,140	42,692,402	44,126,625								
2001	2,154,657	16,009,641	32,879,871	45,344,241	51,210,715	54,911,755									
2002	2,577,354	26,407,657	49,354,859	63,045,461	71,023,679										
2003	4,462,310	41,202,543	61,737,554	78,203,419											
2004	4,108,494	21,448,912	35,495,348												
2005	3,141,939	18,280,280													
2006	3,097,855														

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit IX - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred ALE Development

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	9.446	1.701	1.176	1.181	1.034	1.007	1.008	1.011	1.014	1.009	1.013	1.000	1.000	1.000	
1992	9.796	1.564	1.273	1.076	1.022	1.048	1.013	1.019	1.004	0.999	1.000	1.000	1.000	1.000	
1993	10.702	1.690	1.224	1.063	1.061	1.018	1.006	1.006	1.007	0.999	1.005	1.002	1.000		
1994	11.112	1.604	1.263	1.140	1.067	1.028	1.017	1.010	1.003	1.005	1.003	1.001			
1995	12.558	1.630	1.319	1.138	1.037	1.037	0.997	1.001	1.004	1.000	1.004				
1996	7.503	1.611	1.221	1.122	1.067	1.034	1.027	1.012	1.006	1.000					
1997	6.491	1.664	1.289	1.141	1.040	1.043	1.026	1.017	1.007						
1998	7.213	1.869	1.369	1.139	1.096	1.026	1.012	1.010							
1999	11.313	1.948	1.367	1.128	1.049	1.015	1.007								
2000	11.035	1.973	1.326	1.154	1.050	1.034									
2001	7.430	2.054	1.379	1.129	1.072										
2002	10.246	1.869	1.277	1.127											
2003	9.233	1.498	1.267												
2004	5.221	1.655													
2005	5.818														
Projected Incremental Development Factor	6.910	1.646	1.296	1.134	1.059	1.026	1.015	1.013	1.006	1.001	1.004	1.001	1.000	1.000	1.000
Cumulative Development Factor	18.868	2.731	1.659	1.280	1.129	1.066	1.039	1.025	1.012	1.006	1.005	1.001	1.000	1.000	1.000

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit X - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	7,500	1,921,200	4,666,596	6,979,831	9,568,579	10,233,579	10,603,579	10,603,579	10,603,579	10,603,579	10,603,579	10,803,579	10,803,579	10,803,579	10,803,579
1992	6,460	1,876,678	5,547,928	8,173,382	9,468,463	9,567,663	9,752,163	9,787,163	10,087,163	10,087,163	10,242,163	10,242,163	10,242,163	10,242,163	10,242,163
1993	14,156	2,624,557	9,833,807	12,620,675	12,660,672	13,542,222	13,922,222	14,412,222	14,412,222	14,612,222	14,612,222	14,687,222	14,687,222	14,687,222	
1994	99,529	3,857,452	12,239,699	17,166,949	20,468,244	22,234,334	23,386,834	24,446,834	24,446,834	24,446,834	24,446,834	24,446,834	24,446,834		
1995	220,724	5,389,563	19,940,822	28,828,572	32,192,071	34,880,140	36,944,879	37,492,379	37,564,818	37,564,818	37,564,818	37,599,818			
1996	466,727	4,554,736	19,135,387	31,686,719	36,430,337	38,999,502	40,300,752	42,244,730	42,407,230	42,657,230	42,657,230				
1997	330,653	7,184,726	26,111,407	40,177,261	46,055,605	47,607,329	49,320,729	50,456,729	50,679,456	50,769,456					
1998	103,731	6,896,038	22,982,497	45,233,001	50,849,001	56,050,396	58,971,096	59,355,096	59,758,596						
1999	49,625	8,408,088	26,476,118	44,567,128	54,910,676	57,476,628	60,365,558	61,860,398							
2000	19,795	5,087,686	26,715,801	46,006,618	57,332,070	60,968,320	62,574,820								
2001	71,565	9,289,136	41,139,828	64,348,480	77,839,016	83,444,755									
2002	6,311	8,513,943	45,168,985	82,770,088	95,060,338										
2003	743,693	11,849,168	51,798,954	76,899,107											
2004	61,384	6,949,786	29,983,051												
2005	295,233	3,595,551													
2006	72,454														

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit X - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	256.160	2.429	1.496	1.371	1.069	1.036	1.000	1.000	1.000	1.000	1.019	1.000	1.000	1.000	
1992	290.507	2.956	1.473	1.158	1.010	1.019	1.004	1.031	1.000	1.015	1.000	1.000	1.000	1.000	
1993	185.402	3.747	1.283	1.003	1.070	1.028	1.035	1.000	1.014	1.000	1.005	1.000	1.000		
1994	38.757	3.173	1.403	1.192	1.086	1.052	1.045	1.000	1.000	1.000	1.000	1.000			
1995	24.418	3.700	1.446	1.117	1.084	1.059	1.015	1.002	1.000	1.000	1.001				
1996	9.759	4.201	1.656	1.150	1.071	1.033	1.048	1.004	1.006	1.000					
1997	21.729	3.634	1.539	1.146	1.034	1.036	1.023	1.004	1.002						
1998	66.480	3.333	1.968	1.124	1.102	1.052	1.007	1.007							
1999	169.433	3.149	1.683	1.232	1.047	1.050	1.025								
2000	257.019	5.251	1.722	1.246	1.063	1.026									
2001	129.800	4.429	1.564	1.210	1.072										
2002	1349.064	5.305	1.832	1.148											
2003	15.933	4.372	1.485												
2004	113.218	4.314													
2005	12.179														
Projected Incremental Development Factor	20.353	4.648	1.622	1.192	1.062	1.043	1.018	1.005	1.003	1.000	1.001	1.000	1.000	1.000	1.000
Cumulative Development Factor	208.079	10.224	2.200	1.356	1.137	1.071	1.027	1.009	1.004	1.001	1.001	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit XI - A

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid ALE Development

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	10,055	719,792	2,128,665	3,049,836	3,887,444	4,112,755	4,189,651	4,239,986	4,284,278	4,340,702	4,395,109	4,457,161	4,457,161	4,457,161	4,457,161
1992	20,543	746,262	2,339,261	3,523,194	4,088,837	4,298,660	4,551,288	4,635,562	4,753,015	4,788,643	4,793,792	4,793,250	4,793,250	4,793,809	4,793,809
1993	30,351	1,622,160	4,719,399	6,749,900	7,308,167	7,943,286	8,176,861	8,259,071	8,321,546	8,379,807	8,389,419	8,447,166	8,467,213	8,468,093	
1994	64,498	2,464,165	6,514,305	9,472,242	11,496,261	12,619,295	13,161,855	13,479,232	13,673,337	13,762,305	13,816,690	13,867,602	13,902,694		
1995	85,343	3,637,959	10,117,472	15,234,472	17,970,219	19,192,759	20,036,696	20,189,052	20,251,319	20,285,047	20,319,377	20,390,070			
1996	154,467	4,440,503	12,263,887	17,465,866	20,665,769	22,486,342	23,281,415	24,218,794	24,460,644	24,707,733	24,744,833				
1997	291,757	5,266,416	13,883,542	21,207,880	25,177,712	26,834,200	28,223,201	29,043,243	29,661,041	29,918,872					
1998	254,485	5,386,654	15,871,278	25,279,052	29,575,245	33,221,199	34,163,806	34,831,664	35,220,431						
1999	189,601	5,746,858	17,215,836	26,532,531	30,957,021	32,895,633	33,800,919	34,234,643							
2000	203,168	7,178,600	21,534,103	32,557,274	38,789,178	41,776,349	43,534,064								
2001	262,945	9,172,240	27,200,773	40,586,593	49,312,846	53,431,214									
2002	580,392	14,323,907	38,271,102	57,438,272	67,928,768										
2003	884,256	20,163,554	50,816,033	70,905,849											
2004	475,421	11,671,299	29,623,510												
2005	472,271	9,696,447													
2006	299,353														

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit XI - B

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid ALE Development

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	71.585	2.957	1.433	1.275	1.058	1.019	1.012	1.010	1.013	1.013	1.014	1.000	1.000	1.000	
1992	36.327	3.135	1.506	1.161	1.051	1.059	1.019	1.025	1.007	1.001	1.000	1.000	1.000	1.000	
1993	53.447	2.909	1.430	1.083	1.087	1.029	1.010	1.008	1.007	1.001	1.007	1.002	1.000		
1994	38.205	2.644	1.454	1.214	1.098	1.043	1.024	1.014	1.007	1.004	1.004	1.003			
1995	42.628	2.781	1.506	1.180	1.068	1.044	1.008	1.003	1.002	1.002	1.003				
1996	28.747	2.762	1.424	1.183	1.088	1.035	1.040	1.010	1.010	1.002					
1997	18.051	2.636	1.528	1.187	1.066	1.052	1.029	1.021	1.009						
1998	21.167	2.946	1.593	1.170	1.123	1.028	1.020	1.011							
1999	30.310	2.996	1.541	1.167	1.063	1.028	1.013								
2000	35.333	3.000	1.512	1.191	1.077	1.042									
2001	34.883	2.966	1.492	1.215	1.084										
2002	24.680	2.672	1.501	1.183											
2003	22.803	2.520	1.395												
2004	24.549	2.538													
2005	20.532														
Projected Incremental Development Factor	22.671	2.572	1.453	1.195	1.076	1.033	1.020	1.014	1.007	1.002	1.004	1.002	1.000	1.000	1.000
Cumulative Development Factor	118.235	5.215	2.028	1.396	1.168	1.086	1.051	1.030	1.016	1.008	1.006	1.002	1.000	1.000	1.000

NOTE: This exhibit is based on countrywide experience.

THE MEDICAL PROTECTIVE COMPANY

Exhibit XII

ILLINOIS

PHYSICIANS & SURGEONS

Territory Changes

County	Current Territory	Proposed Territory	Current Relativity	Proposed Relativity	Rate Effect
Cook	1	1	3.00	2.00	-33.3%
Jackson	2	1	1.90	2.00	5.3%
Madison	1	1	3.00	2.00	-33.3%
St. Clair	1	1	3.00	2.00	-33.3%
Will	1	1	3.00	2.00	-33.3%
Lake	2	2	1.90	1.80	-5.3%
Vermilion	2	2	1.90	1.80	-5.3%
Kane	2	3	1.90	1.70	-10.5%
McHenry	2	3	1.90	1.70	-10.5%
Winnebago	3	3	1.60	1.70	6.3%
Dupage	2	4	1.90	1.50	-21.1%
Kankakee	3	4	1.60	1.50	-6.3%
Macon	3	4	1.60	1.50	-6.3%
Bureau	4	5	1.00	1.40	40.0%
Champaign	3	5	1.00	1.40	40.0%
Coles	4	5	1.00	1.40	40.0%
DeKalb	4	5	1.00	1.40	40.0%
Effingham	5	5	1.00	1.40	40.0%
LaSalle	4	5	1.00	1.40	40.0%
Ogle	4	5	1.00	1.40	40.0%
Randolph	4	5	1.00	1.40	40.0%
Grundy	5	6	1.00	1.20	20.0%
Sangamon	3	6	1.60	1.20	-25.0%
Peoria	5	7	1.00	0.90	-10.0%
ROS	5	8	1.00	1.00	0.0%
				Total	**-16.1%**

THE MEDICAL PROTECTIVE COMPANY

Exhibit XIII

ILLINOIS

PHYSICIANS & SURGEONS

Classification Changes

Current Class	ISO Code	Description	Current Relativity to 1B	Proposed Class	Proposed Relativity to 1B	Relativity Change
		From 1A to 1B				
1A	234.00	Pharmacology	0.750	1B	1.000	33.3%
1A	268.00	Physicians - No Surg NOC	0.750	1B	1.000	33.3%
		From 1C to 1B				
1C	282.00	Dermatology - Minor Surg	1.175	1B	1.000	-14.9%
		From 1B to 1C				
1B	252.00	Rheumatology - No Surg	1.000	1C	1.175	17.5%
		From 2A to 1C				
2A	267.00	Pediatrics - No Surg	1.450	1C	1.175	-19.0%
		From 2A to 1D				
2A	114.00	Ophthalmology - Surg	1.450	1D	1.280	-11.7%
2A	257.00	Internal Medicine - No Surg	1.450	1D	1.280	-11.7%
		From 1C to 2A				
1C	102.26	Urgent Care - No Surg	1.175	2A	1.400	19.1%
1C	237.00	Diabetes - No Surg	1.175	2A	1.400	19.1%
		From 2B to 2A				
2B	245.00	Hematology - No Surg	1.650	2A	1.400	-15.2%
		From 2A to 2B				
2A	270.00	Rhinology - Minor Surg	1.450	2B	1.650	13.8%
2A	276.00	Geriatrics - Minor Surg	1.450	2B	1.650	13.8%
2A	277.00	Gynecology - Minor Surg	1.450	2B	1.650	13.8%
2A	285.00	Laryngology - Minor Surg	1.450	2B	1.650	13.8%
2A	290.00	Otology - Minor Surg	1.450	2B	1.650	13.8%
2A	291.00	Otorhinolaryngology - Minor Surg	1.450	2B	1.650	13.8%
		From 2C to 2B				
2C	241.00	Gastroenterology - No Surg	1.950	2B	1.650	-15.4%
2C	261.00	Neurology - No Surg	1.950	2B	1.650	-15.4%
2C	471.00	Neonatology	1.950	2B	1.650	-15.4%
		From 2D to 2C				
2D	274.00	Gastroenterology - Minor Surg	2.100	2C	1.950	-7.1%
2D	281.00	Cardiovascular Disease - Minor Surg	2.100	2C	1.950	-7.1%
		From 3A to 2C				
3A	278.00	Gastroenterology - Minor Surg	2.500	2C	1.950	-22.0%
3A	421.00	Family/General Practice - Minor Surg	2.500	2C	1.950	-22.0%
		From 2C to 2D				
2C	449.00	Radiopaque Dye Injection	1.950	2D	2.200	12.8%
		From 2C to 3A				
2C	288.00	Neurology - Minor Surg	1.950	3A	2.350	20.5%

THE MEDICAL PROTECTIVE COMPANY

Exhibit XIII

ILLINOIS

PHYSICIANS & SURGEONS

Classification Changes

Current Class	ISO Code	Description	Current Relativity to 1B	Proposed Class	Proposed Relativity to 1B	Relativity Change
		From 2D to 3A				
2D	283.00	Intensive Care Medicine	2.100	3A	2.350	11.9%
2D	422.00	Catheterization - NOC	2.100	3A	2.350	11.9%
		From 3B to 3A				
3B	106.00	Surgery - Laryngology	2.700	3A	2.350	-13.0%
3B	145.00	Surgery - Urological	2.700	3A	2.350	-13.0%
3B	158.00	Surgery - Otology	2.700	3A	2.350	-13.0%
3B	159.00	Surgery - Otorhinolaryngology	2.700	3A	2.350	-13.0%
3B	160.00	Surgery - Rhinology	2.700	3A	2.350	-13.0%
3B	273.00	Family Practice - Minor Surg	2.700	3A	2.350	-13.0%
3B	155.00	Surgery - Plastic (No Elected Cosmetic)	2.700	3A	2.350	-13.0%
		From 3A to 3B				
3A	105.00	Surgery - Geriatrics	2.500	3B	2.600	4.0%
		From 3B to 4A				
3B	102.00	Emergency Medicine - No Major Surg	2.700	4A	2.850	5.6%
		From 4B to 4A				
4B	167.00	Surgery - Gynecology	3.650	4A	2.850	-21.9%
4B	176.00	Orthopedic (Excl. Back)	3.650	4A	2.850	-21.9%
		From 5A to 4B				
5A	157.00	Emergency Medicine - Incld Major Surg	4.000	4B	3.100	-22.5%
		From 5B to 5A				
5B	156.00	Plastic Surgery	4.700	5A	3.500	-25.5%
		From 7 to 5B				
7	144.00	Surgery - Thoracic	5.900	5B	3.900	-33.9%
7	146.00	Surgery - Vascular	5.900	5B	3.900	-33.9%
7	150.00	Surgery - Cardiovascular Disease	5.900	5B	3.900	-33.9%
		From 5B to 6A				
5B	154.00	Orthopedic (Incld. Back)	4.700	6A	4.100	-12.8%
		From 5B to 6B				
5B	143.00	General Surgery	4.700	6B	4.600	-2.1%
		From 6 to 6B				
5B	166.00	Surgery - Abdominal	5.500	6B	4.600	-16.4%
		From 7 to 6B				
7	153.00	OB/GYN	5.900	6B	4.600	-22.0%
7	168.00	Surgery - Obstetrics	5.900	6B	4.600	-22.0%
				Overall Impact		**-11.7%**

THE MEDICAL PROTECTIVE COMPANY

Exhibit XIV

ILLINOIS

PHYSICIANS & SURGEONS

Claims-Made Step Factors

CMA	Current	Proposed	% Chg
1	32.5%	27.5%	-15.4%
2	45.0%	47.5%	5.6%
3	75.0%	75.0%	0.0%
4	90.0%	90.0%	0.0%
5	100.0%	95.0%	-5.0%
6	100.0%	100.0%	0.0%

Loss Free Credit

Years Loss Free	Current	Proposed	%Chg
3	5.0%	5.0%	0.0%
4	5.0%	5.0%	0.0%
5	10.0%	10.0%	0.0%
6	10.0%	10.0%	0.0%
7	10.0%	10.0%	0.0%
8	10.0%	15.0%	-5.6%
9	10.0%	15.0%	-5.6%
10	20.0%	20.0%	0.0%
11+	20.0%	20.0%	0.0%

New to Practice Credit

Years in Practice	Current	Proposed	%Chg
1	50.0%	50.0%	0.0%
2	30.0%	30.0%	0.0%
3	0.0%	15.0%	-15.0%

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 1

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1992	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1994	0	0	0	0	0	0	0	0	0	0	0	0	0		
1995	0	0	0	0	0	0	0	0	0	0	0	0			
1996	0	0	0	0	0	0	0	0	0	0	0				
1997	0	0	0	0	0	0	0	0	0	0					
1998	0	0	0	0	0	0	0	0	0						
1999	8,000	18,000	18,000	27,503	38,004	38,003	53,006	78,007							
2000	8,000	115,419	872,381	1,407,645	2,170,406	2,326,078	2,675,538								
2001	93,998	1,689,832	3,141,066	4,530,917	5,572,793	5,346,545									
2002	359,716	1,092,597	1,887,011	3,237,302	3,499,808										
2003	417,498	1,602,897	5,174,373	7,780,123											
2004	203,877	742,132	2,323,222												
2005	29,499	231,748													
2006	44,000														

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 2

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1992	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1993	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
1994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				
1996	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
1997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
1998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
1999	2.250	1.000	1.528	1.382	1.000	1.395	1.472								
2000	14.427	7.558	1.614	1.542	1.072	1.150									
2001	17.977	1.859	1.442	1.230	0.959										
2002	3.037	1.727	1.716	1.081											
2003	3.839	3.228	1.504												
2004	3.640	3.130													
2005	7.856														
Projected Incremental Development Factor	3.959	2.730	1.524	1.225	0.991	1.154	1.472	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Cumulative Development Factor	33.968	8.580	3.143	2.062	1.683	1.699	1.472	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 3

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1992	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1994	0	0	0	0	0	0	0	0	0	0	0	0	0		
1995	0	0	0	0	0	0	0	0	0	0	0	0			
1996	0	0	0	0	0	0	0	0	0	0	0				
1997	0	0	0	0	0	0	0	0	0	0					
1998	0	0	0	0	0	0	0	0	0						
1999	0	12,888	14,348	17,270	23,986	26,334	39,188	68,579							
2000	0	29,723	197,894	360,658	1,042,595	1,433,729	1,833,960								
2001	75	152,770	714,844	1,569,348	2,833,622	3,925,130									
2002	18,114	234,030	600,786	1,157,300	1,699,483										
2003	26,277	692,657	1,844,392	3,993,091											
2004	28,880	372,159	1,231,750												
2005	3,812	125,725													
2006	0														

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 4

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss & ALE Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1992	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1993	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
1994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				
1996	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
1997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
1998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
1999	n/a	1.113	1.204	1.389	1.098	1.488	1.750								
2000	n/a	6.658	1.822	2.891	1.375	1.279									
2001	2036.933	4.679	2.195	1.806	1.385										
2002	12.920	2.567	1.926	1.468											
2003	26.360	2.663	2.165												
2004	12.886	3.310													
2005	32.981														
Projected Incremental Development Factor	20.189	2.831	2.126	1.806	1.381	1.283	1.750	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Cumulative Development Factor	680.429	33.702	11.905	5.599	3.100	2.245	1.750	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 5

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1992	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1994	0	0	0	0	0	0	0	0	0	0	0	0	0		
1995	0	0	0	0	0	0	0	0	0	0	0	0			
1996	0	0	0	0	0	0	0	0	0	0	0				
1997	0	0	0	0	0	0	0	0	0	0					
1998	0	0	0	0	0	0	0	0	0						
1999	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000							
2000	3,000	48,002	605,001	947,001	1,387,000	1,230,001	1,400,000								
2001	47,998	1,343,999	2,261,000	2,975,001	3,556,999	3,083,000									
2002	247,001	649,001	1,017,999	1,996,000	1,949,000										
2003	198,002	289,002	3,008,002	4,362,000											
2004	59,884	110,884	866,884												
2005	10,000	30,000													
2006	12,000														

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 6

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1992	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1993	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
1994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				
1996	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
1997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
1998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
1999	1.000	1.000	1.000	1.000	1.000	1.000	1.000								
2000	16.001	12.604	1.565	1.465	0.887	1.138									
2001	28.001	1.682	1.316	1.196	0.867										
2002	2.628	1.569	1.961	0.976											
2003	1.460	10.408	1.450												
2004	1.852	7.818													
2005	3.000														
Projected Incremental Development Factor	1.605	4.665	1.484	1.165	0.872	1.138	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Cumulative Development Factor	12.849	8.007	1.717	1.156	0.993	1.138	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 7

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred ALE Development

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1992	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1994	0	0	0	0	0	0	0	0	0	0	0	0	0		
1995	0	0	0	0	0	0	0	0	0	0	0	0			
1996	0	0	0	0	0	0	0	0	0	0	0				
1997	0	0	0	0	0	0	0	0	0	0					
1998	0	0	0	0	0	0	0	0	0						
1999	5,000	15,000	15,000	24,503	35,004	35,003	50,006	75,007							
2000	5,000	67,417	267,380	460,644	783,406	1,096,077	1,275,538								
2001	46,000	345,833	880,066	1,555,916	2,015,794	2,263,545									
2002	112,715	443,596	869,012	1,241,302	1,550,808										
2003	219,496	1,313,895	2,166,371	3,418,123											
2004	143,993	631,248	1,456,338												
2005	19,499	201,748													
2006	32,000														

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 8

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Incurred ALE Development

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1992	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1993	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
1994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				
1996	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
1997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
1998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
1999	3.000	1.000	1.634	1.429	1.000	1.429	1.500								
2000	13.483	3.966	1.723	1.701	1.399	1.164									
2001	7.518	2.545	1.768	1.296	1.123										
2002	3.936	1.959	1.428	1.249											
2003	5.986	1.649	1.578												
2004	4.384	2.307													
2005	10.347														
Projected Incremental Development Factor	5.606	1.880	1.587	1.335	1.198	1.172	1.500	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Cumulative Development Factor	47.038	8.391	4.463	2.811	2.105	1.758	1.500	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 9

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1992	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1994	0	0	0	0	0	0	0	0	0	0	0	0	0		
1995	0	0	0	0	0	0	0	0	0	0	0	0			
1996	0	0	0	0	0	0	0	0	0	0	0				
1997	0	0	0	0	0	0	0	0	0	0					
1998	0	0	0	0	0	0	0	0	0						
1999	0	0	0	0	0	0	0	0							
2000	0	0	0	0	400,000	400,000	600,000								
2001	0	0	100,000	405,000	965,000	1,765,000									
2002	0	0	16,000	141,000	311,000										
2003	0	0	200,000	1,150,000											
2004	7,884	7,884	122,884												
2005	0	0													
2006	0														

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 10

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid Loss Development
200/600 LIMITS

As of 06/30/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1992	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1993	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
1994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				
1996	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
1997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
1998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
1999	n/a	n/a	n/a	n/a	n/a	n/a	n/a								
2000	n/a	n/a	n/a	n/a	1.000	1.500									
2001	n/a	n/a	4.050	2.383	1.829										
2002	n/a	n/a	8.813	2.206											
2003	n/a	n/a	5.750												
2004	1.000	15.587													
2005	n/a														
Projected Incremental Development Factor	1.000	42.984	5.367	3.070	1.586	1.500	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Cumulative Development Factor	1684.772	1684.772	39.196	7.303	2.379	1.500	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Appendix A - 11

ILLINOIS

PHYSICIANS & SURGEONS
(Claims Made only)

Paid ALE Development

As of 06/30/2006

Report Year	6	18	30	42	54	66	78	90	102	114	126	138	150	162	174
1991	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1992	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1994	0	0	0	0	0	0	0	0	0	0	0	0	0		
1995	0	0	0	0	0	0	0	0	0	0	0	0			
1996	0	0	0	0	0	0	0	0	0	0	0				
1997	0	0	0	0	0	0	0	0	0	0					
1998	0	0	0	0	0	0	0	0	0						
1999	0	12,888	14,348	17,270	23,986	26,334	39,188	68,579							
2000	0	29,723	197,894	360,658	642,595	1,033,729	1,233,960								
2001	75	152,770	614,844	1,164,348	1,868,622	2,160,130									
2002	18,114	234,030	584,786	1,016,300	1,388,483										
2003	26,277	692,657	1,644,392	2,843,091											
2004	20,996	364,275	1,108,866												
2005	3,812	125,725													
2006	0														

NOTE: This exhibit is based on statewide experience.

THE MEDIC TIVE COMPANY

A - 12

PHYSICIAN RGEONS
(Claims only)

Paid ALE ment

As of 06/00/2006

Report Year	06-18	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-Ult
1991	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1992	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
1993	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
1994	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				
1996	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
1997	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
1998	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
1999	n/a	1.113	1.204	1.389	1.098	1.488	1.750								
2000	n/a	6.658	1.822	1.782	1.609	1.194									
2001	2036.933	4.025	1.894	1.605	1.156										
2002	12.920	2.499	1.738	1.366											
2003	26.360	2.374	1.729												
2004	17.350	3.044													
2005	32.981														
Projected Incremental Development Factor	23.151	2.586	1.766	1.535	1.270	1.201	1.750	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Cumulative Development Factor	433.178	18.711	7.236	4.097	2.670	2.102	1.750	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

NOTE: This exhibit is based on statewide experience.

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT A-I

Speciality	(1) Medical Protective (Current)	(2) Medical Protective (Proposed)	(3) CNA	(4) Cincinnati
Implants	1B	1A	I	1
Host Dentist	1B	1A	I	1
Oral Pathologist	2A	1B	I	1

MEDICAL PROTECTIVE
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RECEIVED
AUG 1 8 2006
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

August 14, 2006

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 06-IL-94 99
COMPANY FEIN NO: 35-0506406
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Revise Class Plan 0.0%
Class Relativity Changes –0.9%
Revise Increase Limit Factors +3.0%
Introduce Student Resident Rating Rule
Revise New to Practice Rating Rule
Revise Partnership Corporation Rating Rule
Revise Convertible Claims Made Rating Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revise Section IV- State Rate Pages, Dentists

PROPOSED EFFECTIVE DATE: January 1, 2007

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests **January 1, 2007**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium decease of –2.1%. In addition, we have enclosed revised manual pages for *Section IV – Dentists* for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

Please find enclosed the required filing forms, actuary certification 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

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

Enclosure(s)

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, August 17, 2006 3:21 PM
To: Neuman, Gayle
Subject: The Medical Protective Company, Company filing dated August 14, 2006 with Company File # 06-IL-94 DDS Filing Effective 01/01/07
Attachments: 06 IL 98.pdf

Ms. Neuman,

I just found an error on a filing that has been sent to your office via Fed Ex today. It does not cause any change to the filing itself, only the company filing number used on the filing. We had made a DDS filing earlier this year, with company filing # 06-IL-94 for an effective date of 08/01/06. The filing I sent to you has a cover letter date of 08/14/06 with the same company filing #, for an effective date of 01/01/07. It is a totally separate filing and is not intended to be a revised or modified filing to the one sent to you earlier this year. I apologize for the error, the correct company filing # should be 06-IL-98.

I am attaching the two pages of the filing that reference the company file # for your records.

<<06 IL 98.pdf>>

If you have any questions or need anything additional, please let me know.

Sincerely,
Melissa Coker

Melissa Coker, Compliance Specialist
Legal Compliance Dept.
Medical Protective

The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835
Phone: 260-486-0838
Fax: 260-486-0733
Email: melissa.coker@medpro.com
web: www.medicalprotective.com

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DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
AUG 17 2006
SPRINGFIELD, ILLINOIS

August 14, 2006

John Gatlin, Director of 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: 06-IL- 98
COMPANY FEIN NO: 35-0506406
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Revise Class Plan 0.0%
Class Relativity Changes –0.9%
Revise Increase Limit Factors +3.0%
Introduce Student Resident Rating Rule
Revise New to Practice Rating Rule
Revise Partnership Corporation Rating Rule
Revise Convertible Claims Made Rating Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revise Section IV- State Rate Pages, Dentists

PROPOSED EFFECTIVE DATE: January 1, 2007

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests **January 1, 2007**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium decease of –2.1%. In addition, we have enclosed revised manual pages for *Section IV – Dentists* for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

Please find enclosed the required filing forms, actuary certification 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

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

Enclosure(s)

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, August 31, 2006 7:35 AM
To: Neuman, Gayle
Subject: FW: Illinois Dentists - Rate/Rule Filing #06-IL-98
Attachments: 06-IL-98.pdf; rev F540IL.rtf

Ms. Neuman,

We apologize for the oversight, the overall impact of the proposed changes is **+2.1%** rather than -2.1%. We have updated the RF3 form. In addition, please find a modified Partnership or Corporation Rating Rule for your review..

I apologize for not catching that one.

Please let me know if you have any additional questions.
Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, August 21, 2006 11:48 AM
To: Coker, Melissa
Subject: Illinois Dentists - Rate/Rule Filing #06-IL-98

Ms. Coker,

We are in receipt of the above referenced filing (in addition to the e-mail correcting the filing number) submitted by letter dated August 14, 2006.

The RF-3 Summary Sheet and the Actuarial Memorandum both indicate an overall rate change of -2.1%. In reviewing the rates pages and the summary provided, it appears the overall rate change is perhaps +2.1%. Please review and advise. If applicable, a revised RF-3 form would be required.

On the manual pages for "Partnership or Corporation Coverage", the wording of the first sentence seems incomplete. Additionally, the page for the Standard Claims Made Program does not indicate "pursuant to the following table".

We request receipt of your response by no later than August 31, 2006.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective -2.1% ; Proposed effective date 1/1/07

(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 Line 11 - Med Mal (DDS) (Line of Insurance)	$1,623,962	-2.1%

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):
The Medical Protective Company hereby submits for your review and consideration the enclosed rate and rule filing applicable to its Illinois Dentists programs. The company requests January 01, 2007, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium decrease of -2.1%. In addition, we have enclosed revised manual pages for Section IV – Dentists for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

*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

Phillip J. Troyer, Associate General Counsel
Official – Title

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
AUG 18 2006
SPRINGFIELD, ILLINOIS

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, Jim D. Kunce, a duly authorized actuary of N/A 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.

, SVP — 8/15/06

Signature and Title of Authorized Insurance Company Officer — Date

, SVP — 8/15/06

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35 -0506406 Filing Number 06-IL-98

Insurer's Address 5814 Reed Road

City For Wayne State IN Zip Code 46825

Contact Person's:
-Name and E-mail Melissa Coker Melissa.coker@medpro.com

-Direct Telephone and Fax Number 260-486-0838

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.

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I, Jim D. Kunce, a duly authorized actuary of N/A 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.

Jim D. Kunce, SVP — 8/15/06

Signature and Title of Authorized Insurance Company Officer — Date

Jim D. Kunce, SVP — 8/15/06

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 06-IL-94

Insurer's Address 5814 Reed Road

City For Wayne State IN Zip Code 46825

Contact Person's:
-Name and E-mail Melissa Coker Melissa.coker@medpro.com

-Direct Telephone and Fax Number 260-486-0838

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

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AUG 29 2006
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DIVISION OF INSURANCE
SPRINGFIELD

August 28, 2006

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

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 06-IL-98
COMPANY FEIN NO: 35-0506406
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Revise Class Plan 0.0%
Class Relativity Changes –0.9%
Revise Increase Limit Factors +3.0%
Introduce Student Resident Rating Rule
Revise New to Practice Rating Rule
Revise Partnership Corporation Rating Rule
Revise Convertible Claims Made Rating Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revise Section IV- State Rate Pages, Dentists

PROPOSED EFFECTIVE DATE: January 1, 2007

Dear Ms. Neuman:

We recently filed with your Department the above referenced filing, after review it has come to our attention we had a typographical error on the Occurrence Program New to Practice Credit Rule, NPC-CW; 01/01/07 edt. The percentages should have referenced 60/40/20, however in the page previously submitted the percentages referenced 60/40/10. Please find enclosed the corrected rule page for your file.

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

Sincerely,

Melissa Coker

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

Enclosure(s)

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

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 60% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 40% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 10% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR THIRD YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR DENTAL TRAINING PROGRAM.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS 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. 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	10%

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

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. 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	10%

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS PROGRAM

ACTUARIAL MEMORANDUM

The Medical Protective Company (MedPro) respectfully submits the attached exhibits supporting rating factor revisions to the Dentists Program in the state of Illinois. The proposed revisions will result in an overall premium impact of −2.1%. This will be accomplished through a base rate change of +0.0%, classification relativity changes of −0.9% and increased limit factor changes of +3.0%. The combined premium effect of these changes is −2.1% {−0.021 = [(1.0 − 0.009) x (1.0 + 0.030)] − 1.0}. The proposed effective date for the revisions is January 1, 2007 for new and renewal business.

EXHIBIT A: MODIFICATION SUMMARY

In this filing we are proposing to revise our currently filed Increased Limits Factors & Classification Factors. These factors are being filed countrywide. A comparison between current & proposed factors is provided in this exhibit along with the current exposures affected.

RULE REVISIONS

The following summarizes the rule revisions included with this submission.

Revise New to Practice Rating Rule

The Company wishes to revise the New to Practice Rating Rule credit structure for its Occurrence and Standard Claims Made Programs. The following outlines the proposed credit structure:

Year	Current	Proposed Credit
1st Year	50%	60%
2nd Year	30%	40%
3rd Year	15%	20%

There is not a substantive rate impact associated with this revision.

Introduce Student Resident Rating Rule

The Company wishes to introduce Student / Resident Rating Rule for its Occurrence and Standard Claims Made Program. This rule outlines the rate available to dental students and residents. There is not a substantive rate impact associated with the addition of this rule.

Revise Convertible Claims Made Rating Rule

The Company wishes to revise the Convertible Claims Made Rating Rule for the Standard Claims Made Program. The revision to this rule is to include the New to Company Credits to the Convertible CM rating. There are no other changes to this rule and there is no rate impact associated with this change.

Revise Partnership / Corporation Rating Rule

The Company wishes to revise the Partnership Corporation Rating Rule for its Occurrence and Standard Claims Made Programs. The revisions include revising the credit structure for oral surgeons corporation policies. There is not a substantive rate impact associated with this change.

REVISED COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Also enclosed, please find revised manual pages for Section IV for the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates 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.

THE MEDICAL PROTECTIVE COMPANY

EXHIBIT A

ILLINOIS

DENTISTS

MODIFICATION SUMMARY

Proposed Rates Effective: 01/01/2007

Table 1: Classification and Class Factors

Specialty	Current Class	Current Relativity	Proposed Class	Proposed Relativity	% of Exposure
Implants	1B	1.25	1A	1.00	3.2%
Host Dentist	1B	1.25	1A	1.00	0.3%
Oral Pathologist	2A	3.00	1B	1.25	0.0%

Table 2: Dentists' Increased Limit Factors

Limit	Current ILF	Indicated ILF	Proposed ILF	% of Exposure
100,000	0.67	0.87	0.77	8.9%
200,000	0.76	0.93	0.88	13.6%
500,000	0.87	0.98	0.94	5.9%
1,000,000	1.00	1.00	1.00	69.2%
2,000,000	1.13	1.10	1.08	1.7%
3,000,000	1.21	1.20	1.15	0.1%
4,000,000	1.26	1.30	1.23	0.0%
5,000,000	1.29	1.40	1.31	0.4%
			Total	99.9%

Table 3: Oral Surgeons' Increased Limit Factors

Limit	Current ILF	Indicated ILF	Proposed ILF	% of Exposure
100,000	0.67	0.72	0.77	0.0%
200,000	0.76	0.82	0.88	0.0%
500,000	0.87	0.94	0.94	0.0%
1,000,000	1.00	1.00	1.00	0.1%
2,000,000	1.18	1.15	1.15	0.0%
3,000,000	1.26	1.30	1.27	0.0%
4,000,000	1.32	1.45	1.35	0.0%
5,000,000	1.37	1.60	1.42	0.0%
			Total	0.1%

Note:
1) ILF's calculated above are normalized to 1M

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT A-I

Speciality	(1) Medical Protective (Current)	(2) Medical Protective (Proposed)	(3) CNA	(4) Cincinnati
Implants	1B	1A	I	1
Host Dentist	1B	1A	I	1
Oral Pathologist	2A	1B	I	1

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT A-II

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Current Class	Proposed Class	Current Relativity	Selected Relativity	Rate Change Impact	State % of Book	Weighted Rate Effect
1B (Implants & Host Dentists)	1A	1.250	1.000	-20.0%	4.5%	-0.9%
2A	1B	3.000	1.250	-58.3%	0.0%	0.0%
Rate Effect Due To Classification Changes						-0.9%

THE MEDICAL PROTECTIVE COMPANY

Illinois

DENTISTS

SUPPLEMENTAL EXHIBIT B-I

(1) Limit	(2) Limited Expected Value	(3) ALE	(4) ULE	(5) LLAE (2)+(3)+(4)	(6) LLAE Excess Limit Factor	(7) Fixed Expense (5)xC	(8) Risk Index	(9) Total Cost Per Claim	(10) Indicated Excess Limit Factor	(11) Selected Excess Limit Factor	(12) Current Excess Limit Factor
100,000	30,795	33,796	1,735	66,326	0.823	26,500	0.27	111,070	0.87	**0.77**	0.667
200,000	37,356	33,796	1,735	72,887	0.904	26,500	0.44	118,920	0.93	**0.88**	0.760
500,000	42,985	33,796	1,735	78,515	0.974	26,500	0.74	125,655	0.98	**0.94**	0.873
1,000,000	45,061	33,796	1,735	80,591	1.000	26,500	1.00	128,139	1.00	**1.00**	1.000
2,000,000	45,946	33,796	1,735	81,477	1.011	26,500	1.22	131,840	1.10	**1.08**	1.133
3,000,000	46,165	33,796	1,735	81,696	1.014	26,500	1.31	133,133	1.20	**1.15**	1.207
4,000,000	46,249	33,796	1,735	81,780	1.015	26,500	1.32	133,440	1.30	**1.23**	1.260
5,000,000	46,289	33,796	1,735	81,820	1.015	26,500	1.32	133,490	1.40	**1.31**	1.293

NOTE: The Risk Index in Column (8) is based on a measurement of the risk associated with losses limited at the specified limit. Specifically, it is the ratio of the CV for losses limited at the specified limit to the CV for losses limited at $1M. [The CV for the losses from the lognormal distribution limited at the various limits was determined using asymptotic convergence.] The Lognormal Parameters for the distribution are mu = 9.75 and sigma = 1.41

THE MEDICAL PROTECTIVE COMPANY

Illinois

ORAL SURGEONS

SUPPLEMENTAL EXHIBIT B-II

(1) Limit	(2) Limited Expected Value	(3) ALE (2)xA	(4) ULE [(2)+(3)]xB	(5) LLAE (2)+(3)+(4)	(6) LLAE Excess Limit Factor	(7) Fixed Expense (5)xC	(8) Risk Index	(9) Total Cost Per Claim	(10) Indicated Excess Limit Factor	(11) Selected Excess Limit Factor	(12) Current Excess Limit Factor
100,000	48,522	74,548	3,827	126,897	0.714	5,048	0.20	157,877	0.72	**0.77**	0.667
200,000	66,480	74,548	3,827	144,855	0.815	5,048	0.35	179,364	0.82	**0.88**	0.760
500,000	87,877	74,548	3,827	166,252	0.935	5,048	0.66	204,966	0.94	**0.94**	0.873
1,000,000	99,398	74,548	3,827	177,773	1.000	5,048	1.00	218,751	1.00	**1.00**	1.000
2,000,000	106,369	74,548	3,827	184,744	1.039	5,048	1.41	235,817	1.15	**1.15**	1.180
3,000,000	108,728	74,548	3,827	187,103	1.052	5,048	1.66	244,443	1.30	**1.27**	1.260
4,000,000	109,837	74,548	3,827	188,212	1.059	5,048	1.83	249,871	1.45	**1.35**	1.320
5,000,000	110,453	74,548	3,827	188,828	1.062	5,048	1.95	253,577	1.60	**1.42**	1.367

NOTE: The Risk Index in Column (8) is based on a measurement of the risk associated with losses limited at the specified limit. Specifically, it is the ratio of the CV for losses limited at the specified limit to the CV for losses limited at $1M. [The CV for the losses from the lognormal distribution limited at the various limits was determined using asymptotic convergence.] The Lognormal Parameters for the distribution are mu = 10.53 and sigma = 1.48

Statement of Actuarial Opinion

IDENTIFICATION

I, James D. Kunce, Actuary, am an officer of The Medical Protective Company (the Company), a Fellow of the Casualty Actuarial Society, and a Member of the American Academy of Actuaries meeting its qualification standards. I was appointed by the Board of Directors of The Medical Protective Company on August 2, 2005 to render this opinion.

SCOPE

I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 2005. My review was limited to the items listed in Exhibit A and did not include an analysis of any income statement or other balance sheet items. The items listed in Exhibit A reflect the Loss Disclosure Reserve Items (3 thru 8) in Exhibit B.

In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by Garret Davenport, Controller of The Medical Protective Company. I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P - Part 1 - Summary of the Company's current Annual Statement. Included in the reconciliation were paid losses, incurred losses, paid defense and cost containment expenses, incurred defense and cost containment expenses and earned premium. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations, as I considered necessary.

OPINION

In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of Indiana.

B. Are computed in accordance with accepted actuarial standards and principles.

C. Make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its contracts and agreements.

Thus I am making a Determination of Reasonable Provision with respect to the amounts carried in Exhibit A.

RELEVANT COMMENTS

It should be noted that reserve calculations deal with the inherent economic and financial uncertainty of future contingent events. Other than as specifically noted, my projections make no provision for the extraordinary future emergence of new classes of losses or types of losses not sufficiently represented in the Company's historical database or which are not yet reported. While I believe the reserves represent a reasonable provision based on the appropriate application of actuarial techniques to the available data, there can be no guarantee that the

actual future payments will not differ, perhaps significantly, from the amounts carried on the balance sheet. No warranty is expressed or implied that this will not occur.

MAJOR RISK FACTORS

The Company has written a variety of coverages whose major risk factors materially impact the variability of the Company's reserves. I have identified the major risk factors as: suits against the company by its insureds or other institutes, other mass torts mainly related to drugs prescribed by our insureds to the general public (eg. Vioxx); and as the company writes medical malpractice insurance new and ever changing medical malpractice legislative issues pose a risk.

The potential impact of these risk factors is described in more detail in the following paragraphs and in the report supporting this Opinion. The absence of other risk factors from this listing does not imply that additional risk factors will not be identified in the future as having been a significant influence on the Company's reserves.

The following paragraphs describe issues associated with each of the three major risk factors identified above:

Suits against the company:

I have assumed that interpretations of coverage implicit in the Company's historical data regarding excess of policy limits and extra contractual obligations will not materially change. I believe that this is a reasonable assumption. However, there is a risk that in the future, there may be social and/or judicial changes that result in an expansion in coverage greater than the Company has experienced in the past, which would have a material impact on reserve projections.

Increases in the number and types of other mass tort lawsuits:

The majority of both indemnity and legal expense liabilities for mass torts arising from medical products have been sustained by the manufacturers of the medical products associated with that particular mass tort. The company believes these past trends pertaining to very limited professional liability indemnity and legal expense expenditures associated with mass tort actions will continue. However a shift in greater allocation of liability toward the healthcare providers is possible.

Medical Malpractice legislative issues:

I have assumed that interpretations of coverage triggers with respect to occurrence dates implicit in the Company's historical data will not materially change. I believe this is a reasonable assumption. However, tort reform modifications have been enacted and continue to be discussed. Such actions could result in shifts in original treatment dates cited by the plaintiffs that vary from the historical patterns.

I believe that the risk factors above, coupled with the variability inherent in any reserve estimate, could result in material adverse deviation from the carried net reserve amounts. In making this determination, I have considered a material adverse deviation to be one in which the actual net outstanding losses and loss adjustment expenses exceed the subtotals in Exhibit A, by an amount greater than 10% of the Company's statutory surplus shown on the Liabilities, Surplus and Other Funds page of the Annual Statement (i.e., a reserve deviation greater than $57 million). My selection of the materiality standard (10% of statutory surplus) was based on the fact that this

opinion is prepared for the regulatory review of The Medical Protective Company. Other measures of materiality might be used for reserves being evaluated in a different context.

DISCLOSURE ITEMS

Included in the reserves are credits for a loss portfolio transfer reinsurance agreement. The agreement became effective on August 8, 1984, and amended on December 27, 1990. Both dates precede the requirements pertaining to loss portfolio transfer reinsurance referenced from "Statements of Statutory Accounting Principles, No. 62". The Indiana Department of Insurance approved this contract at both its inception and amendment dates for treatment as reinsurance and has therefore been treated as prospective reinsurance in the Annual Statement.

In addition the company entered into a loss portfolio agreement with National Indemnity Company and Columbia Insurance Company effective December 31, 2005. This agreement calls for Medical Protective to ceded 50% of its net reserves equally to National Indemnity and Columbia Insurance. Consistent with "Statements of Statutory Accounting Principles, No. 62" paragraph 30 statement d, which states that accounting principles for retro reinsurance shall not apply to "...intercompany reinsurance agreements, and any amendments thereto, among companies 100% owned by a common or ultimate controlling person provided there is no gain in surplus as a result of the transaction", this agreement is not considered retro reinsurance.

Based on discussions with company management and its description of the company's ceded reinsurance, I am not aware of any reinsurance contract that either has been or should have been accounted for as retroactive reinsurance or financial reinsurance.

I have reviewed the Company's exposure to asbestos and environmental claims. In my opinion, there is only a remote chance of material liability, since reported claims are zero and the company writes primarily medical liability coverage.

During the course of my analysis, I reviewed the Company's exposure to terrorist attack losses. No claims have been presented to date. In my opinion, the risk of significant liabilities as of December 31, 2005 arising from terrorist attack losses is remote, given the nature of the coverages provided by the Company and prevailing coverage interpretations.

The Company does not discount loss or loss adjustment expense reserve liabilities.

The Company participates in one mandatory pool (Massachusetts Medical Malpractice Reinsurance Plan) in which premiums and liabilities are assumed in direct proportion to the Company's percentage of direct written premium. Total reserve exposure with respect to pools is considered immaterial (approx $3.76M).

The company's Schedule P, Part 2 summary indicates a reserve release of $407,778,000 during the past year. However, this number is the result of the 50% loss portfolio transfer (LPT) the company entered into on December 31, 2005. The loss activity as shown in Schedule P, Part 2 caused no exceptional values for the NAIC IRIS Tests 10 (One-Year Reserve Development to Surplus), 11 (Two-Year Reserve Development to Surplus) and 12 (Estimated Current Reserve Deficiency to Surplus). Prior to the LPT, the actual reserve adjustment for the year equated to strengthening net reserves for prior accident years by $96,776,000. Reserve activity prior to the LPT would have caused the company to fail NAIC IRIS Test 11 (Two-Year Reserve Development to Surplus). Nearly $79 million of the strengthening was for the company's medical malpractice business in accident years 2001 and 2002.

The Company writes no policies or contracts related to single or fixed premium policies with coverage periods of thirteen months or greater that are non-cancelable and not subject to

premium increase (excluding financial guarantee contracts, mortgage guaranty policies, and surety contracts).

Over 99% of the Company's ceded loss reserves is with either affiliated companies, companies rated A or better by A.M. Best Company, residual market pools or fully collateralized. Less than 1% is with various other companies either rated below A or not rated by A.M. Best Company. Past uncollectibility levels and current amounts in dispute have been reviewed and found to be immaterial relative to surplus. Therefore, reinsurance collectibility does not appear to be an issue.

The Company does not provide for anticipated salvage and subrogation

There has been no change in the actuarial assumptions, procedures, or methods that is likely to have a material effect of the statement loss and loss expense reserves.

This statement of opinion is solely for the use of, and only to be relied upon by, the Company and the various state insurance departments with which it files its Annual Statement.

An Actuarial Report and any underlying actuarial workpapers supporting the findings expressed in this Statement of Actuarial Opinion will be retained for a period of seven years in the administrative offices of The Medical Protective Company and available for regulatory examination.

James D. Kunce, F.C.A.S., M.A.A.A.
The Medical Protective Company
5814 Reed Road, Fort Wayne, IN 46835
260-486-0869
February 24, 2006

EXHIBIT A: SCOPE

Loss Reserves:	Amount
A. Reserve for Unpaid Losses (Liabilities, Surplus, and Other Funds Page 3, Line 1):	$483,111,441
B. Reserve for Unpaid Loss Adjustment Expenses (Liabilities, Surplus, and Other Funds Page 3, Line 3):	$214,470,385
Subtotal: A + B	$697,581,826
C. Reserve for Unpaid Losses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 13 and 15):	$1,306,354,000
D. Reserve for Unpaid Loss Adjustment Expenses -- Direct and Assumed (Schedule P, Part 1, Totals from Columns 17, 19 and 21):	$546,689,000
Subtotal: C + D	$1,853,043,000
E. The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$0
F. Other Loss Reserve items on which the Appointed Actuary is Expressing an Opinion (list separately)	$0

Premium Reserves:	Amount
G. Reserve for Direct and Assumed Unearned Premiums for Long Duration Contracts	$0
H. Reserve for Net Unearned Premiums for Long Duration Contracts	$0
I. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately)	$0

EXHIBIT B: DISCLOSURES

1.	Materiality Standard expressed in $US	$57,000,000
2.	Statutory Surplus	$571,330,518
3.	Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P	$0
4.	Discount included as a reduction to loss reserves and loss expense reserves as reported in Schedule P	
	4 (a) Nontabular discount	$0
	4 (b) Tabular discount	$0
5.	The net reserves for losses and expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	$3,755,000
6.	The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines.	
	6 (a) Asbestos, as disclosed in the Notes to Financial Statements	$0
	6 (b) Environmental, as disclosed in the Notes to Financial Statements	$0
7.	The total claims made extended loss and expense reserve (Schedule P Interrogatories).	
	7 (a) amount reported as loss reserves	$0
	7 (b) amount reported as unearned premium reserves	$11,515,056
8.	Other items on which the Appointed Actuary is providing Relevant Comment (list separately)	$0

MEDICAL PROTECTIVE
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IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

May 25, 2006

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
SEP 1 4 2006
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 06-IL-91
COMPANY FEIN NO: 35-0506406
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Revise Excess Limit Factors
Revise Increase Limit Factors (Headings only)
Overall Rate Impact +0.0%

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revise Section III- State Rate Pages, Physicians & Surgeons

PROPOSED EFFECTIVE DATE: UPON APPROVAL

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration our Excess Limits Factors (ELFs) rate filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date commensurate with the approval of this filing.

The accompanying Actuarial Memorandum provides detailed support for the changes, which will result in an overall premium change of +0.0% in the state of Illinois.

In addition, we have enclosed revised manual pages for Sections III – Physicians & Surgeons for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons Program, and therefore are being included in this submission.

Along with the Actuarial Memorandum, please find enclosed revised rate pages, the required forms, 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

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

Enclosure(s)

Form (RF-3)

ILLIN S DEPARTMENT OF INSUR NCE

SUMMARY SHEET

9/14/06

Change in Company's premium or rate level produced by rate revision effective +0.0 % ; proposed eff. date Upon Approval

(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 Line 11 - Med Mal (MD) (Line of Insurance)	$24,887,648	+0.0%

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): The Medical Protective Company hereby submits for your review and consideration our Excess Limits Factors (ELFs) rate filing applicable to our Illinois Physicians & Surgeons and Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date commensurate with the approval of this filing.

The accompanying Actuarial Memorandum provides detailed support for the changes, which will result in an overall premium change of +0.0% in the state of Illinois.

In addition, we have enclosed revised manual pages for Sections III – Physicians & Surgeons for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physicians & Surgeons Program, and therefore are being included in this submission.

Along with the Actuarial Memorandum, please find enclosed revised rate pages, the required forms, 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.

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
MAY 26 2006
SPRINGFIELD, ILLINOIS

The Medical Protective Company
Name of Company

Phillip J. Troyer, Associate General Counsel
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, Jim D. Kunce, 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.

SVP — 05/25/06

Signature and Title of Authorized Insurance Company Officer — Date

SVP, FCAS, MAAA — 05/25/06

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 06-IL-91

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Friday, September 01, 2006 12:01 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-91
Attachments: 06-IL-91-2.pdf

Gayle -

Please find attached revised Physician & Allied Healthcare Provider Pages regarding 06-IL-91.

Please let me know if you need anything further.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, September 01, 2006 10:45 AM
To: Nielsen, Kimberly
Subject: Rate/Rule Filing #06-IL-91

The same changes apply to this filing as to the filing referenced below.

From: Neuman, Gayle
Sent: Friday, September 01, 2006 9:12 AM
To: 'Nielsen, Kimberly'
Subject: RE: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

I have been sorting through all the pages of attachments. One response includes multiple professions, and the next contained just dentists – this has made the view confusing.

In regard to the payment plan, the quarterly payment plan's maximum yearly installment fee would be $100.00. It appears with the nine-pay plan, the insured could be charged up to $225.00. We could allow the nine-pay plan if the company could show the terms are at least as or more favorable than our provisions.

Your prompt attention is appreciated.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Wednesday, August 30, 2006 3:40 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: FW: Rate/Rule Filing #06-IL-94
Importance: High

Ms. Neuman: -

1. We implemented this rate filing with a 8/1/06 effective date.
2. Please find attached the complete copies of the sections labeled "Illinois - State Rate Pages" for Dentists, only.
3. The pages were submitted in response to PA94-677 (SB 475). I will resend the MD & Allied pages to your attention via reference # 06-IL-91.

Please let me know if you have any additional questions.

Thank you.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, August 29, 2006 2:42 PM
To: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-94

Ms. Coker,

I have three unanswered questions.

1. Did you implement the rate change effective June 1, 2006?
2. You need to provide a copy of every page in the sections labeled "ILLINOIS - STATE RATE PAGES".
3. This is a dental filing. Please explain why physician/surgeon and allied health care providers are being submitted on this filing.

Your prompt attention is appreciated.

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Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Wednesday, August 30, 2006 4:33 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-91
Attachments: 06-IL-91.pdf

Dear Ms. Neuman -

I had asked Melissa Coker to forward all of the pages to you under DOI File No: 06-IL-94. I apologize for this confusion.

I have separated out the Physician & Allied Healthcare Provider pages for your reference. Additionally, I have included complete sets of the State Rate pages, as you had requested these as well under 06-IL-94, and I assume you will need them as well under this file no.

Please let me know if there is anything further you need from me or the Company regarding PA94-667(SB475) or the filing revisions contained in 06-IL-91. Thank you.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, August 30, 2006 11:30 AM
To: Nielsen, Kimberly
Subject: FW: Rate/Rule Filing #06-IL-91

Ms. Nielsen,

No response to the attached e-mail has been received. Your immediate attention is required. Your response is due by Thursday, August 31, 2006.

From: Neuman, Gayle
Sent: Wednesday, August 16, 2006 7:59 AM
To: 'Kimberly.Nielsen@medpro.com'
Subject: Rate/Rule Filing #06-IL-91

Ms. Nielsen,

As you know, the new Medical Professional Liability law in Illinois, PA94-677 (Senate Bill 475), requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

This email is to advise you of the requirements being prescribed by the Secretary and by the Director of the Division of Insurance regarding the quarterly premium payment installment plan you are required to offer to your insureds. In reviewing the filing referenced above, we note that your quarterly installment plan does

not meet and/or address some or all of the following prescribed requirements.

Please amend your rate/rule manual's quarterly installment plan provisions to comply with all of the following prescribed requirements and send me your updated manual pages no later than August 24, 2006.

Quarterly Premium Payment Installment Plan Prescribed Requirements

All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

i) An initial payment of no more than 40% of the estimated total premium due at policy inception;

ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

iii) No interest charges;

iv) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Additionally, please confirm Medical Protective is planning to implement the changes as of the date the review of the filing is complete.

Your immediate attention is requested.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Wednesday, August 30, 2006 10:30 AM
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Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Friday, June 30, 2006 3:25 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: FW: Physician/Surgeon - Rate/Rule Filing #06-IL-91- IL ELF Filing

Dear Ms. Neuman:

Thank you for your note below regarding the referenced filing. We hope to be able to respond to your questions/issues soon.

Kimberly Nielsen
Product Manager
260-486-0801

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Monday, June 12, 2006 3:48 PM
To: Coker, Melissa
Subject: Physician/Surgeon - Rate/Rule Filing #06-IL-91

Ms. Coker,

In regard to the above referenced filing submitted by your letter dated May 25, 2006, please address the following issues:

SB475 requires as of January 1, 2006 that insurers have on file and offer a quarterly premium installment payment plan. While a payment option is included, it does not indicate the payment will be offered in four quarterly installments (every three months). Additionally, you need to indicate the amount of the fee instead of just mentioning that there may or may not be one. In what situation would you not charge a fee?

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through our website at http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm.

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

Neuman, Gayle

From: Neuman, Gayle
Sent: Monday, June 12, 2006 2:48 PM
To: 'Coker, Melissa'
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THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

PHYSICIANS AND SURGEONS

ACTUARIAL MEMORANDUM

The Medical Protective Company (MPCo) has undertaken a countrywide review of its filed Excess Limits Factors (ELFs). The analysis was initiated as part of MPCo's regular actuarial review of experience and the regular review of excess limits with our reinsurer. The actuarial analysis of coverage layers in excess of $1 million is presented in the exhibits attached to this memorandum. The proposed revisions will result in an overall premium change of +0.0% in the state of Illinois. The Company requests an effective date commensurate with the approval of this filing.

EXHIBIT I: TOTAL RATE EFFECT

Exhibit I summarizes the premium impact of the proposed ELF changes by limit separately for Physicians and Surgeons, as well as on a combined basis. The overall rate impact is shown at the bottom rightmost column of the exhibit.

EXHIBIT II: CALCULATION OF PHYSICIANS & SURGEONS EXCESS LIMITS FACTORS

Exhibits II-A and II-B calculate the indicated MPCo ELFs for limits in excess of $1 million for Physicians and Surgeons, respectively. The exhibit employs the lognormal distribution to calculate the limited expected values [Column (2)] associated with the respective limits of liability shown.

The resulting limited expected values are summed with allocated loss adjustment expenses [Column (3)] and unallocated loss adjustment expenses [Column (4)] to produce the limited loss and loss adjustment expenses associated with respective limits [Column (5)].

Fixed expenses are loaded for Physicians and Surgeons separately [Exhibits II-A & II-B, Item C]. Fixed expenses are a flat dollar amount per policyholder associated with the general operating expenses of an insurance company. While the dollar amount of fixed expenses do not vary by policy, excess limits are calculated on a per-claim basis. To the degree that frequencies vary between classes of insureds (e.g., Physicians and Surgeons), the per-claim load must vary. That is, a flat dollar amount per policy translates into a higher flat dollar amount per claim for Physicians (lower frequency) and a lower flat dollar amount per claim for Surgeons (higher frequency). These fixed expense loads are calculated in Column (7).

Column (8) calculates a risk index based on the coefficient of variation (CV) for ground-up losses limited to the selected limit. The coefficient of variation for the limited expected losses is calculated for each of the respective limits utilizing the method of asymptotic convergence. For each limit, the risk index is the square of the ratio of the CV at that limit to the CV at the $1 million limit, providing a relative measure of risk. The index is then multiplied by the risk load at the $1 million limit to produce the appropriate risk load for the given limit.

The total cost per claim is calculated in Column (9), and is used to determine the indicated ELFs shown in Column (10). The selected ELFs are displayed in Column (11). These are compared to the current excess limit factors in Column (12) and the proposed rate change is displayed in Column (13).

REVISED MANUAL RATES

The Occurrence and Standard Claims-Made Excess Limits Factor pages have been revised incorporating the proposed changes and are attached to this filing.

THE MEDICAL PROTECTIVE COMPANY
Exhibit I

ILLINOIS
Rate Impact of Excess Limits Factor Changes

Limit	Physicians Premium Distribution	Physicians Rate Impact	Surgeons Premium Distribution	Surgeons Rate Impact	Combined Premium Distribution	Combined Rate Impact
Less than 1,000,000	2.9%	**0.0%**	86.2%	**0.0%**	76.1%	**0.0%**
1,000,000	93.4%	**0.0%**	13.6%	**0.0%**	23.2%	**0.0%**
2,000,000	3.7%	**-0.8%**	0.2%	**-1.5%**	0.7%	**-1.0%**
3,000,000	0.0%	**0.0%**	0.0%	**0.0%**	0.0%	**0.0%**
4,000,000	0.0%	**0.0%**	0.0%	**0.0%**	0.0%	**0.0%**
5,000,000	0.0%	**0.0%**	0.0%	**0.0%**	0.0%	**0.0%**
Totals / Averages	100.0%	**0.0%**	100.0%	**0.0%**	100.0%	**0.0%**

THE MEDICAL PROTECTIVE COMPANY
Exhibit II-A

ILLINOIS
Calculation of Physicians Excess Limits Factors

Severity Distribution			
Lognormal Parameters			
μ	12.53	Mean:	994,505
σ	1.60	Standard Deviation:	3,435,840

Expense Information	Percent	Limit
A) ALE to Loss:	35.0%	1,000,000
B) ULE to LALE:	2.2%	1,000,000
C) Fixed Expense to LLAE:	10.6%	1,000,000
D) Variable Expense:	7.8%	
E) Minimum Premium by Layer:	7.5%	
F) Base Limit for ILFs:		1,000,000

(1) Limit	(2) Limited Expected Value	(3) ALE (2)xA	(4) ULE [(2)+(3)]xB	(5) LLAE (2)+(3)+(4)	(6) LLAE Excess Limit Factor	(7) Fixed Expense (5)xC	(8) Risk Index	(9) Total Total Cost Per Claim	(10) Indicated Excess Limit Factor	(11) Selected Excess Limit Factor	(12) Current Excess Limit Factor	(13) Proposed Rate Change
1,000,000	422,544	147,890	12,550	582,984	1.000	62,000	1.00	739,581	1.00	1.00	1.000	0.0%
2,000,000	572,421	147,890	12,550	732,861	1.257	62,000	1.66	947,536	1.28	1.27	1.280	-0.8%
3,000,000	658,034	147,890	12,550	818,474	1.404	62,000	2.20	1,084,393	1.47	1.43	1.473	-2.9%
4,000,000	714,841	147,890	12,550	875,281	1.501	62,000	2.67	1,188,261	1.61	1.56	1.556	0.3%
5,000,000	755,700	147,890	12,550	916,140	1.571	62,000	3.08	1,273,213	1.72	1.67	1.615	3.4%

NOTE: The Risk Index in Column (8) is based on a measurement of the risk associated with losses limited at the specified limit. Specifically, it is the square of the ratio of the CV for losses limited at the specified limit to the CV for losses limited at $1M. [The CV for the losses from the lognormal distribution limited at the various limits was determined using asymptotic convergence.]

THE MEDICAL PROTECTIVE COMPANY
Exhibit II-B

ILLINOIS
Calculation of Surgeons Excess Limits Factors

Severity Distribution			
Lognormal Parameters			
μ	12.61	Mean:	1,011,353
σ	1.56	Standard Deviation:	3,261,493

Expense Information		
	Percent	Limit
A) ALE to Loss:	35.0%	1,000,000
B) ULE to LALE:	2.2%	1,000,000
C) Fixed Expense to LLAE:	3.7%	1,000,000
D) Variable Expense:	7.8%	
E) Minimum Premium by Layer:	7.5%	
F) Base Limit for ILFs:		1,000,000

(1) Limit	(2) Limited Expected Value	(3) ALE (2)xA	(4) ULE [(2)+(3)]xB	(5) LLAE (2)+(3)+(4)	(6) LLAE Excess Limit Factor	(7) Fixed Expense (5)xC	(8) Risk Index	(9) Total Cost Per Claim	(10) Indicated Excess Limit Factor	(11) Selected Excess Limit Factor	(12) Current Excess Limit Factor	(13) Proposed Rate Change
1,000,000	437,850	153,248	13,004	604,102	1.000	22,143	1.00	718,094	1.00	1.00	1.000	**0.0%**
2,000,000	593,557	153,248	13,004	759,808	1.258	22,143	1.68	933,061	1.30	1.30	1.320	**-1.5%**
3,000,000	681,740	153,248	13,004	847,992	1.404	22,143	2.23	1,073,630	1.50	1.48	1.502	**-1.5%**
4,000,000	739,785	153,248	13,004	906,037	1.500	22,143	2.71	1,179,744	1.64	1.62	1.592	**1.8%**
5,000,000	781,233	153,248	13,004	947,485	1.568	22,143	3.13	1,266,151	1.76	1.74	1.660	**4.8%**

NOTE: The Risk Index in Column (8) is based on a measurement of the risk associated with losses limited at the specified limit. Specifically, it is the square of the ratio of the CV for losses limited at the specified limit to the CV for losses limited at $1M. [The CV for the losses from the lognormal distribution limited at the various limits was determined using asymptotic convergence.]

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

RECEIVED
MAY 26 2006
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

May 25, 2006

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
AUG 01 2006
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 06-IL-94
COMPANY FEIN NO: 35-0506406
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Overall Rate Impact +0.0%
Classification Revisions
Revise Class 2B relativity
Move 80210/71 to 2B
Introduce New to Company Credit Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revise Section IV- State Rate Pages, Dentists

PROPOSED EFFECTIVE DATE: June 1, 2006

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests **June 01, 2006**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of +0.0 %. In addition, we have enclosed revised manual pages for *Section IV – Dentists* for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

Please find enclosed the required filing forms, actuary certification 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

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

Enclosure(s)

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective +0.0 % ; proposed eff. date 06/01/06

(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 Line 11 - Med Mal (DDS) (Line of Insurance)	$1,512,240	+0.0%

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): The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests June 01, 2006, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of +0.0 %. In addition, we have enclosed revised manual pages for Section IV – Dentists for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

Please find enclosed the required filing forms, actuary certification 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.

*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

Phillip J. Troyer, Associate General Counsel
Official – Title

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
MAY 26 2006
SPRINGFIELD, ILLINOIS

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, Jim D. Kunce, 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.

SVP — 05/25/06

Signature and Title of Authorized Insurance Company Officer — Date

SVP, FCAS, MAAA — 05/25/06

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 06-IL-94

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@medpro.com

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

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

ACTUARIAL MEMORANDUM

The Medical Protective Company (MPCo) proposes to revise its Professional Liability rates for Dentists in the state of Illinois under the Occurrence and Standard Claims Made programs. The overall effect of this revision is negligible and will be effective **June 1, 2006**. The rate revision includes the following: addition of the New to Company Credit, Classification Relativity and Speciality Assignment revisions.

REVISED CLASSIFICATION PLAN

Please refer to Exhibit 1-3, attached, for actuarial support of the classification revisions.

NEW TO COMPANY RATING RULE

The Company wishes to introduce the New to Company Rating rule for which will provide the insured with a 25% credit to insureds joining the Company for the first time, or those insureds which may have been insured with the company more than 3 years prior to their application. The addition of this rule has no substantive rate affect.

REVISED COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Also enclosed, please find revised manual State Rate pages for Section IV for the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission for manual consistency purposes.

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

Classification Revisions - Exhibit A

	(1) **Oral Surgeons** (Anesthesia in Hospital)	(2) **Oral Surgeons** (Anesthesia in Office)
Fireman's Fund	III	III
Pic Wisconsin	3	3
Medical Protective (Current)	2B	3
Medical Protective (Proposed)	2B	2B

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

Classification Revisions - Exhibit B

(1) Current Class	(2) Proposed Class	(3) Current Relativity	(4) Selected Relativity	(5) Rate Change Impact	(6) Percentage of Book	(7) Weighted Rate Effect
3 (Oral Surgeons)	**2B**	6.500	5.500	-15.4%	0.0%	0.0%
Rate Effect Due To Classification Changes						**0.0%**

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

Classification Revisions - Exhibit C

	Oral Surgeons Relativity
Current Medical Protective Rate Relativity	5.5/6.5
Fireman's Fund	6.00
Pic Wisconsin	6.00
ISO Multistate Analysis	5.00
Indicated OMSNIC Relativity	5.75
Selected Rate Relativity	**5.50**

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Thursday, September 07, 2006 2:57 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-94
Attachments: IL response 9 7 06.pdf

Gayle -

Apologies for the error. As you know, some days are better than others, and I guess on the 9/1 response I made an error. Please find attached the revised pages, which indicates the appropriate numerical order for the installment rule.

If you need anything further, or would like to discuss, please call me at 260-486-0801. Thank you, and have a nice afternoon.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, September 05, 2006 2:55 PM
To: Nielsen, Kimberly
Subject: RE: Rate/Rule Filing #06-IL-94

Kim,

The last edition had the quarterly installment option on page SR-IL-IV-17 and it was numbered as 25.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Friday, September 01, 2006 12:00 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-94

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Please find attached the revised installment pages for Dentists. Please let me know if you need anything further.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, September 01, 2006 10:44 AM
To: Nielsen, Kimberly
Subject: RE: Rate/Rule Filing #06-IL-94

Kimberly,

For this response, you can just simply attach the installment pages only. Thank you for your prompt attention.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Friday, September 01, 2006 9:30 AM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-94

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I will be more than happy to amend our manual pages to state that the total maximum installment fee any one insured will pay over the course of one policy term will not exceed $100. However, I'm not sure which pages, then, you want me to resubmit to you. Just the installment pages, only? The pages for the entire dental program (as requested in your e-mail of 8/29), or all amended manual pages for the installment issue as it relates to the revised SB (which was requested in your 8/16 e-mail regarding compliance with SB 475).

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Please let me know specifically what revised pages you would like.

Thanks.

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Your prompt attention is appreciated.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Wednesday, August 30, 2006 3:40 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: FW: Rate/Rule Filing #06-IL-94

Importance: High

Ms. Neuman: -

1. We implemented this rate filing with a 8/1/06 effective date.
2. Please find attached the complete copies of the sections labeled "Illinois - State Rate Pages" for Dentists, only.
3. The pages were submitted in response to PA94-677 (SB 475). I will resend the MD & Allied pages to your attention via reference # 06-IL-91.

Please let me know if you have any additional questions.

Thank you.

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Sent: Tuesday, August 29, 2006 2:42 PM
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Ms. Coker,

I have three unanswered questions.

1. Did you implement the rate change effective June 1, 2006?
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Subject: RE: Rate/Rule Filing #06-IL-94
Attachments: 06-IL-94-2.pdf

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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

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

CLASS I B

Any Dentist performing implants involving osseointegration or minor surgical procedures.*

General Dentists or Specialists other than Oral Surgeons or dental anesthesiologists allowing (hosting) unconscious sedation outside of a hospital, but only if the sedation is administered by an oral surgeon, dental or medical anesthesiologist or CRNA.

*Procedures do not include the administration of a general anesthetic intended to cause unconsciousness unless administered in a hospital.

CLASS II A

Specialists in Dental Anesthesiology or Oral Pathology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery or any dentist performing major surgical procedures not included in class III.

CLASS III

Any dentist performing major surgical procedures.

Procedures not otherwise classified.

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	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,021	2,304	2,648	3,032	4,093	3,436	3,658	3,820	3,921
1B	2,526	2,880	3,309	3,789	5,115	4,294	4,572	4,774	4,900
2A	6,063	6,912	7,943	9,095	12,278	10,307	10,974	11,459	11,762
2B	11,116	12,672	14,562	16,674	22,510	19,675	21,009	22,010	22,788
3	13,137	14,976	17,209	19,706	26,602	23,252	24,829	26,011	26,931

b. Area 2

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
1B	2,105	2,400	2,758	3,158	4,263	3,579	3,810	3,978	4,084
2A	5,052	5,759	6,618	7,578	10,230	8,588	9,144	9,548	9,801
2B	9,262	10,559	12,133	13,893	18,756	16,394	17,505	18,339	18,987
3	10,946	12,478	14,339	16,419	22,166	19,374	20,688	21,673	22,439

c. Area 3

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,347	1,536	1,765	2,021	2,728	2,290	2,438	2,546	2,613
1B	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
2A	4,041	4,607	5,294	6,062	8,183	6,870	7,314	7,637	7,840
2B	7,409	8,446	9,706	11,114	15,003	13,114	14,003	14,670	15,188
3	8,756	9,982	11,470	13,134	17,731	15,498	16,549	17,337	17,950

3. Standard Claims Made Program

a. Area 1

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	436	497	571	654	883	741	789	824	846
1B	546	622	715	819	1,106	928	988	1,032	1,059
2A	1,309	1,492	1,715	1,964	2,651	2,225	2,369	2,474	2,539
2B	2,400	2,736	3,144	3,600	4,860	4,248	4,536	4,752	4,920
3	2,836	3,233	3,715	4,254	5,743	5,020	5,360	5,615	5,814

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
1B	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2A	2,618	2,985	3,430	3,927	5,301	4,451	4,739	4,948	5,079
2B	4,800	5,472	6,288	7,200	9,720	8,496	9,072	9,504	9,840
3	5,672	6,466	7,430	8,508	11,486	10,039	10,720	11,231	11,628

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,418	1,617	1,858	2,127	2,871	2,411	2,567	2,680	2,751
1B	1,773	2,021	2,323	2,660	3,590	3,014	3,209	3,351	3,440
2A	4,254	4,850	5,573	6,381	8,614	7,232	7,700	8,040	8,253
2B	7,799	8,891	10,217	11,699	15,793	13,804	14,740	15,442	15,988
3	9,217	10,507	12,074	13,826	18,664	16,314	17,420	18,250	18,895

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,654	1,886	2,167	2,481	3,349	2,812	2,994	3,126	3,209
1B	2,068	2,358	2,709	3,102	4,188	3,516	3,743	3,909	4,012
2A	4,963	5,658	6,502	7,445	10,050	8,437	8,983	9,380	9,628
2B	9,099	10,373	11,920	13,649	18,425	16,105	17,197	18,016	18,653
3	10,753	12,258	14,086	16,130	21,775	19,033	20,323	21,291	22,044

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,818	2,073	2,382	2,727	3,681	3,091	3,291	3,436	3,527
1B	2,273	2,591	2,978	3,410	4,603	3,864	4,114	4,296	4,410
2A	5,454	6,218	7,145	8,181	11,044	9,272	9,872	10,308	10,581
2B	9,999	11,399	13,099	14,999	20,248	17,698	18,898	19,798	20,498
3	11,817	13,471	15,480	17,726	23,929	20,916	22,334	23,398	24,225

b. Area 2

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	364	415	477	546	737	619	659	688	706
1B	455	519	596	683	921	774	824	860	883
2A	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2B	2,000	2,280	2,620	3,000	4,050	3,540	3,780	3,960	4,100
3	2,364	2,695	3,097	3,546	4,787	4,184	4,468	4,681	4,846

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
1B	909	1,036	1,191	1,364	1,841	1,545	1,645	1,718	1,763
2A	2,182	2,487	2,858	3,273	4,419	3,709	3,949	4,124	4,233
2B	4,000	4,560	5,240	6,000	8,100	7,080	7,560	7,920	8,200
3	4,727	5,389	6,192	7,091	9,572	8,367	8,934	9,359	9,690

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
1B	1,477	1,684	1,935	2,216	2,991	2,511	2,673	2,792	2,865
2A	3,545	4,041	4,644	5,318	7,179	6,027	6,416	6,700	6,877
2B	6,500	7,410	8,515	9,750	13,163	11,505	12,285	12,870	13,325
3	7,681	8,756	10,062	11,522	15,554	13,595	14,517	15,208	15,746

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
1B	1,724	1,965	2,258	2,586	3,491	2,931	3,120	3,258	3,345
2A	4,136	4,715	5,418	6,204	8,375	7,031	7,486	7,817	8,024
2B	7,583	8,645	9,934	11,375	15,356	13,422	14,332	15,014	15,545
3	8,962	10,217	11,740	13,443	18,148	15,863	16,938	17,745	18,372

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
1B	1,894	2,159	2,481	2,841	3,835	3,220	3,428	3,580	3,674
2A	4,545	5,181	5,954	6,818	9,204	7,727	8,226	8,590	8,817
2B	8,333	9,500	10,916	12,500	16,874	14,749	15,749	16,499	17,083
3	9,848	11,227	12,901	14,772	19,942	17,431	18,613	19,499	20,188

c. Area 3

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	291	332	381	437	589	495	527	550	565
1B	364	415	477	546	737	619	659	688	706
2A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
2B	1,600	1,824	2,096	2,400	3,240	2,832	3,024	3,168	3,280
3	1,891	2,156	2,477	2,837	3,829	3,347	3,574	3,744	3,877

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	582	663	762	873	1,179	989	1,053	1,100	1,129
1B	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
2A	1,745	1,989	2,286	2,618	3,534	2,967	3,158	3,298	3,385
2B	3,200	3,648	4,192	4,800	6,480	5,664	6,048	6,336	6,560
3	3,781	4,310	4,953	5,672	7,657	6,692	7,146	7,486	7,751

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	945	1,077	1,238	1,418	1,914	1,607	1,710	1,786	1,833
1B	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
2A	2,836	3,233	3,715	4,254	5,743	4,821	5,133	5,360	5,502
2B	5,199	5,927	6,811	7,799	10,528	9,202	9,826	10,294	10,658
3	6,145	7,005	8,050	9,218	12,444	10,877	11,614	12,167	12,597

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,103	1,257	1,445	1,655	2,234	1,875	1,996	2,085	2,140
1B	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
2A	3,309	3,772	4,335	4,964	6,701	5,625	5,989	6,254	6,419
2B	6,066	6,915	7,946	9,099	12,284	10,737	11,465	12,011	12,435
3	7,169	8,173	9,391	10,754	14,517	12,689	13,549	14,195	14,696

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,212	1,382	1,588	1,818	2,454	2,060	2,194	2,291	2,351
1B	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
2A	3,636	4,145	4,763	5,454	7,363	6,181	6,581	6,872	7,054
2B	6,666	7,599	8,732	9,999	13,499	11,799	12,599	13,199	13,665
3	7,878	8,981	10,320	11,817	15,953	13,944	14,889	15,598	16,150

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	1.310	1.310
1000/3000	1.500	1.500
2000/4000	1.700	1.770
3000/5000	1.810	1.890
4000/6000	1.890	1.980
5000/7000	1.940	2.050

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	$100

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

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

NOT AVAILABLE

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	$25

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

AVAILABLE

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

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

5. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

6. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	75%
Standard Claims Made	50%

7. **Dentists Military Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Dental Standards, Quality & Claim Review.	Presence of (1) committees that meet on a routine basis to review dental 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 undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification - 50% / + 50%	

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.

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

Years Since Training	Credit
1	5%
2	5%
3	5%

10. **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%

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

12. **Self-Insured Retention Credits**

NOT AVAILABLE

13. **Experience Rating**

NOT AVAILABLE

14. **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: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

15. **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.

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

19. **Renewal Rate Rule**

NOT AVAILABLE

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

REFER TO QUARTERLY INSTALLMENT OPTION RULE.

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

AVAILABLE

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

Credit
5%

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

AVAILABLE

24. **New to Company Credit Rule**
(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 25% of filed manual rates shall apply to the insureds first, second and third consecutive years of coverage. 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 three year credit program will be granted to an eligible insured during any period of time insured by the Company.

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

AVAILABLE

19. **Renewal Rate Rule**

NOT AVAILABLE

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

REFER TO QUARTERLY INSTALLMENT OPTION RULE.

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

AVAILABLE

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

Credit
5%

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

AVAILABLE

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

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

- 4 PAY - 35% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 9 PAY – 25% Down, 8 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.

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

Installments are not available for Extension Contract Premium.

12. **Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

14. **Full-Time Equivalency Rating**

NOT AVAILABLE

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

AVAILABLE

16. **Accelerated Extension Contract Rating**

NOT AVAILABLE

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

AVAILABLE

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

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

- 4 PAY - 35% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 9 PAY – 25% Down, 8 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.

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

Installments are not available for Extension Contract Premium.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

QUARTERLY INSTALLMENT OPTION

THE FOLLOWING INTEREST FREE INSTALLMENT PAYMENT PLANS ARE AVAILABLE, AT THE INSUREDS REQUEST.

- 4 PAY - 35% DOWN, 3 EQUAL QUARTERLY PAYMENTS THEREAFTER

IF MANUAL PREMIUM IS OVER $150,000

- 9 PAY – 25% DOWN, 8 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.

PREMIUM BEARING ADJUSTMENTS WILL BE SPREAD ACROSS REMAINING INSTALLMENTS IN EQUAL AMOUNTS.

INSTALLMENTS ARE NOT AVAILABLE FOR EXTENSION CONTRACT PREMIUM.

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

QUARTERLY INSTALLMENT OPTION

THE FOLLOWING INTEREST FREE INSTALLMENT PAYMENT PLANS ARE AVAILABLE, AT THE INSUREDS REQUEST.

- 4 PAY - 35% DOWN, 3 EQUAL QUARTERLY PAYMENTS THEREAFTER

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THE FOLLOWING INTEREST FREE INSTALLMENT PAYMENT PLANS ARE AVAILABLE, AT THE INSUREDS REQUEST.

- 4 PAY - 35% DOWN, 3 EQUAL QUARTERLY PAYMENTS THEREAFTER

IF MANUAL PREMIUM IS OVER $150,000

- 9 PAY – 25% DOWN, 8 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.

PREMIUM BEARING ADJUSTMENTS WILL BE SPREAD ACROSS REMAINING INSTALLMENTS IN EQUAL AMOUNTS.

INSTALLMENTS ARE NOT AVAILABLE FOR EXTENSION CONTRACT PREMIUM.

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ALLIED HEALTHCARE PROVIDERS

STANDARD CLAIMS MADE PROGRAM

QUARTERLY INSTALLMENT OPTION

THE FOLLOWING INTEREST FREE INSTALLMENT PAYMENT PLANS ARE AVAILABLE, AT THE INSUREDS REQUEST.

- 4 PAY - 35% DOWN, 3 EQUAL QUARTERLY PAYMENTS THEREAFTER

IF MANUAL PREMIUM IS OVER $150,000

- 9 PAY – 25% DOWN, 8 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.

PREMIUM BEARING ADJUSTMENTS WILL BE SPREAD ACROSS REMAINING INSTALLMENTS IN EQUAL AMOUNTS.

INSTALLMENTS ARE NOT AVAILABLE FOR EXTENSION CONTRACT PREMIUM.

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

Refer to Quarterly Installment Option rule.

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

Credit
5%

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

AVAILABLE

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

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

- 4 PAY - 35% down, 3 equal quarterly payments thereafter

  If manual premium is over $150,000

- 9 PAY – 25% Down, 8 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.

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

Installments are not available for Extension Contract Premium.

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Tuesday, August 29, 2006 12:58 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #06-IL-94
Attachments: 1455_001.pdf

Ms. Neuman,

I have received amended rules that our company would like to submit in relation to the quarterly payments. The attached rules reference the following

- 4 Pay - 25% down, 3 equal quarterly payments thereafter
- For Premium over $150k, 25% down, 9 equal monthly payments there after.
- The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less.

Please let me know if you should have any questions regarding the attachment.

Melissa Coker

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, August 25, 2006 9:54 AM
To: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-94

We are in receipt of your 8/24/06 e-mail. Previously, this filing strictly pertained to dentists. I will assume we will disgard the additional pages provided in regard to physician/surgeon and allied healthcare providers.

Additionally, you have now added page SR-IL-IV-17 and 18 however information on page SR-IL-IV-16 is mostly duplicated on 17. Also, the section on the "New to Company Credit Rule" has been omitted. Since this section is the basis of the filing, I doubt you meant to delete this section. It was previously number as 24 also.

Your prompt attention is requested.

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Thursday, August 24, 2006 1:41 PM
To: Neuman, Gayle
Subject: Rate/Rule Filing #06-IL-94

Ms. Neuman,
Please find our manual pages as you requested below. Please let me know if you should have any questions or concerns after your review.
Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838

melissa.coker@medpro.com

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, August 16, 2006 8:56 AM
To: Nielsen, Kimberly
Subject: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

As you know, the new Medical Professional Liability law in Illinois, PA94-677 (Senate Bill 475), requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

This email is to advise you of the requirements being prescribed by the Secretary and by the Director of the Division of Insurance regarding the quarterly premium payment installment plan you are required to offer to your insureds. In reviewing the filing referenced above, we note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements.

Please amend your rate/rule manual's quarterly installment plan provisions to comply with all of the following prescribed requirements and send me your updated manual pages no later than August 24, 2006.

Quarterly Premium Payment Installment Plan Prescribed Requirements

All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

i) An initial payment of no more than 40% of the estimated total premium due at policy inception;

ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

iii) No interest charges;

iv) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Additionally, please confirm if the company implemented these changes as of June 1, 2006? If not, is the company planning to implement the changes as of the date the review of the filing is completed?

Your immediate attention is requested.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, August 29, 2006 1:42 PM
To: 'Coker, Melissa'
Subject: RE: Rate/Rule Filing #06-IL-94

Ms. Coker,

I have three unanswered questions.

1. Did you implement the rate change effective June 1, 2006?
2. You need to provide a copy of every page in the sections labeled "ILLINOIS – STATE RATE PAGES".
3. This is a dental filing. Please explain why physician/surgeon and allied health care providers are being submitted on this filing.

Your prompt attention is appreciated.

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Tuesday, August 29, 2006 12:58 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #06-IL-94

Ms. Neuman,

I have received amended rules that our company would like to submit in relation to the quarterly payments. The attached rules reference the following

- 4 Pay - 25% down, 3 equal quarterly payments thereafter
- For Premium over $150k, 25% down, 9 equal monthly payments there after.
- The Company may assess installment fees. Such fees will not exceed $25 or 1% of the total policy premium, whichever is less.

Please let me know if you should have any questions regarding the attachment.

Melissa Coker

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, August 25, 2006 9:54 AM
To: Coker, Melissa
Subject: RE: Rate/Rule Filing #06-IL-94

We are in receipt of your 8/24/06 e-mail. Previously, this filing strictly pertained to dentists. I will assume we will disgard the additional pages provided in regard to physician/surgeon and allied healthcare providers.

Additionally, you have now added page SR-IL-IV-17 and 18 however information on page SR-IL-IV-16 is mostly duplicated on 17. Also, the section on the "New to Company Credit Rule" has been omitted. Since this section is the basis of the filing, I doubt you meant to delete this section. It was previously number as 24 also.

Your prompt attention is requested.

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Thursday, August 24, 2006 1:41 PM
To: Neuman, Gayle
Subject: Rate/Rule Filing #06-IL-94

Ms. Neuman,
Please find our manual pages as you requested below. Please let me know if you should have any questions or concerns after your review.
Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838
melissa.coker@medpro.com

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, August 16, 2006 8:56 AM
To: Nielsen, Kimberly
Subject: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

As you know, the new Medical Professional Liability law in Illinois, PA94-677 (Senate Bill 475), requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

This email is to advise you of the requirements being prescribed by the Secretary and by the Director of the Division of Insurance regarding the quarterly premium payment installment plan you are required to offer to your insureds. In reviewing the filing referenced above, we note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements.

Please amend your rate/rule manual's quarterly installment plan provisions to comply with all of the following prescribed requirements and send me your updated manual pages no later than August 24, 2006.

Quarterly Premium Payment Installment Plan Prescribed Requirements

All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment

Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

i) An initial payment of no more than 40% of the estimated total premium due at policy inception;

ii) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

iii) No interest charges;

iv) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Additionally, please confirm if the company implemented these changes as of June 1, 2006? If not, is the company planning to implement the changes as of the date the review of the filing is completed?

Your immediate attention is requested.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, August 24, 2006 1:41 PM
To: Neuman, Gayle
Subject: Rate/Rule Filing #06-IL-94
Attachments: 1431_001.pdf

Ms. Neuman,
Please find our manual pages as you requested below. Please let me know if you should have any questions or concerns after your review.
Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838
melissa.coker@medpro.com

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, August 16, 2006 8:56 AM
To: Nielsen, Kimberly
Subject: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

As you know, the new Medical Professional Liability law in Illinois, PA94-677 (Senate Bill 475), requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

This email is to advise you of the requirements being prescribed by the Secretary and by the Director of the Division of Insurance regarding the quarterly premium payment installment plan you are required to offer to your insureds. In reviewing the filing referenced above, we note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements.

Please amend your rate/rule manual's quarterly installment plan provisions to comply with all of the following prescribed requirements and send me your updated manual pages no later than August 24, 2006.

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filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

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Additionally, please confirm if the company implemented these changes as of June 1, 2006? If not, is the company planning to implement the changes as of the date the review of the filing is completed?

Your immediate attention is requested.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Monday, August 21, 2006 2:17 PM
To: 'Nielsen, Kimberly'
Subject: RE: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

I'm unaware of any previous discussion of our issuing a bulletin/notice and no bulletin/notice is/has been sitting on the Director's desk. However, based on all the changes we've considered in response to SB475, we have recently talked about issuing a company bulletin and if we decide to issue a bulletin, such bulletin would include the quarterly installment provisions that were detailed in my email.

For now though, SB475 allows the Secretary/Director to prescribe the requirements for the premium quarterly installment plan, and the Director has prescribed the requirements as stated in my email. We are advising companies, like yours, of such requirements in order to finalize your outstanding filing as soon as possible.

Perhaps you are confusing a bulletin/notice with our rulemaking process? If so, then please be advised that we are still in the rulemaking process, and the quarterly installment plan requirements that I detailed in my email will be included.

To finalize your filing as soon as possible, please advise that your company's premium quarterly installment payment plan complies with the prescribed requirements as outlined in my email.

From: Nielsen, Kimberly [mailto:Kimberly.Nielsen@medpro.com]
Sent: Wednesday, August 16, 2006 4:11 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #06-IL-94

Gayle -

Thank you for your note below. We were in anticipation of a DOI bulletin/notice explaining how the SB45 was being interpreted by the Director. Last we were aware, this document was sitting on the Directors "desk" for approval. We have not received anything to date on this topic until your e-mail below.

Can you clarify if the information contained in your e-mail below is the same as the clarification information we were expecting on SB475?

Most of day is available tomorrow if a phone call to discuss would be more helpful.

Thank you.

Kim

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Wednesday, August 16, 2006 4:11 PM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #06-IL-94

Gayle -

Thank you for your note below. We were in anticipation of a DOI bulletin/notice explaining how the SB45 was being interpreted by the Director. Last we were aware, this document was sitting on the Directors "desk" for approval. We have not received anything to date on this topic until your e-mail below.

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Most of day is available tomorrow if a phone call to discuss would be more helpful.

Thank you.

Kim

-----Original Message-----
From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, August 16, 2006 8:56 AM
To: Nielsen, Kimberly
Subject: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

As you know, the new Medical Professional Liability law in Illinois, PA94-677 (Senate Bill 475), requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

This email is to advise you of the requirements being prescribed by the Secretary and by the Director of the Division of Insurance regarding the quarterly premium payment installment plan you are required to offer to your insureds. In reviewing the filing referenced above, we note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements.

Please amend your rate/rule manual's quarterly installment plan provisions to comply with all of the following prescribed requirements and send me your updated manual pages no later than August 24, 2006.

Quarterly Premium Payment Installment Plan Prescribed Requirements

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insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

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iv) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

v) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Additionally, please confirm if the company implemented these changes as of June 1, 2006? If not, is the company planning to implement the changes as of the date the review of the filing is completed?

Your immediate attention is requested.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Wednesday, August 16, 2006 7:56 AM
To: 'Kimberly.Nielsen@medpro.com'
Subject: Rate/Rule Filing #06-IL-94

Ms. Nielsen,

As you know, the new Medical Professional Liability law in Illinois, PA94-677 (Senate Bill 475), requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

This email is to advise you of the requirements being prescribed by the Secretary and by the Director of the Division of Insurance regarding the quarterly premium payment installment plan you are required to offer to your insureds. In reviewing the filing referenced above, we note that your quarterly installment plan does not meet and/or address some or all of the following prescribed requirements.

Please amend your rate/rule manual's quarterly installment plan provisions to comply with all of the following prescribed requirements and send me your updated manual pages no later than August 24, 2006.

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Additionally, please confirm if the company implemented these changes as of June 1, 2006? If not, is the company planning to implement the changes as of the date the review of the filing is completed?

Your immediate attention is requested.

Gayle Neuman

Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Friday, June 30, 2006 3:25 PM
To: Neuman, Gayle
Cc: Coker, Melissa
Subject: FW: Dentist - Rate/Rule Filing #06-IL-94 - additional questions

Dear Ms. Neuman:

Thank you for your note below regarding the referenced filing. We hope to be able to respond to your questions/issues soon.

Kimberly Nielsen
Product Manager
260-486-0801

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Monday, June 12, 2006 3:37 PM
To: Coker, Melissa
Subject: Dentist - Rate/Rule Filing #06-IL-94

Ms. Coker,

In regard to the above referenced filing submitted by your letter dated May 25, 2006, please address the following issues:

1. On page SR-IL-IV-9, please explain 5. Extended Reporting Period Coverage Factors. Pursuant to Company Bulletin CB88-50, the extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The chart, as provided, does not clarify what an insured's premium would be.

2. SB475 requires as of January 1, 2006 that insurers have on file and offer a quarterly premium installment payment plan.

On page SR-IL-IV-16, a payment option is included, however it does not indicate the payment will be offered in four quarterly installments (every three months).

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through our website at http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Thursday, June 15, 2006 11:59 AM
To: Neuman, Gayle
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94

Yes, I am sorry for any confusion the following pages should be excluded:

SR-IL-IV-2
SR-IL-IV-3
SR-IL-IV-4
SR-IL-IV-5
SR-IL-IV-6
SR-IL-IV-7
SR-IL-IV-8
SR-IL-IV-9

Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Thursday, June 15, 2006 10:07 AM
To: Coker, Melissa
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94

Page SR-IL-IV-2 contains only territory definitions and page SR-IL-IV-9 contains increased limit factors and extended reporting period factors. Please confirm that these two pages should be withdrawn from this filing.

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Wednesday, June 14, 2006 12:37 PM
To: Neuman, Gayle
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94

Yes, I overlooked the comprehensive pages that we included. Please w/d the SR-IL-IV-2 through SR-IL-IV-9 pages as well from the filing.

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Wednesday, June 14, 2006 10:52 AM
To: Coker, Melissa
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94

Well, there were also rates on pages SR-IL-IV-3 through 8. Should these pages remain in the filing?

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Wednesday, June 14, 2006 9:26 AM
To: Neuman, Gayle
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94

Yes, we submitted 18 manual pages that included our rates on them. These are the pages that should be

withdrawn from the filing.

Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Wednesday, June 14, 2006 10:21 AM
To: Coker, Melissa
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94

Ms. Coker,

Pursuant to your e-mail below, I counted 18 manual pages that should be removed from the filing. Is this correct?

From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Wednesday, June 14, 2006 8:11 AM
To: Neuman, Gayle
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94
Importance: High

Ms. Neuman,

We are still in the process of completing the response below. However, after implementation of the above referenced filing under the file and use provision, we found an inadvertent error. We did no intend to modify the relativity for 2B. Attached are revised exhibit pages of the 5.5 relativity, please disregard the manual pages we sent with the submission (RTS-OCC and RTS-CM0 through RTS-CM4). The class plans that were originally submitted with the filing, were correct and have not been modified or withdrawn from the filing.

If you should have any questions, please let me know.

Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838
melissa.coker@medpro.com

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Monday, June 12, 2006 3:37 PM
To: Coker, Melissa
Subject: Dentist - Rate/Rule Filing #06-IL-94

Ms. Coker,

In regard to the above referenced filing submitted by your letter dated May 25, 2006, please address the following issues:

1. On page SR-IL-IV-9, please explain 5. Extended Reporting Period Coverage Factors. Pursuant to Company Bulletin CB88-50, the extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve

months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The chart, as provided, does not clarify what an insured's premium would be.

2. SB475 requires as of January 1, 2006 that insurers have on file and offer a quarterly premium installment payment plan.

On page SR-IL-IV-16, a payment option is included, however it does not indicate the payment will be offered in four quarterly installments (every three months).

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

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http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm.

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

Neuman, Gayle

From: Coker, Melissa [Melissa.Coker@medpro.com]
Sent: Wednesday, June 14, 2006 8:11 AM
To: Neuman, Gayle
Subject: RE: Dentist - Rate/Rule Filing #06-IL-94
Importance: High

Ms. Neuman,

We are still in the process of completing the response below. However, after implementation of the above referenced filing under the file and use provision, we found an inadvertent error. We did no intend to modify the relativity for 2B. Attached are revised exhibit pages of the 5.5 relativity, please disregard the manual pages we sent with the submission (RTS-OCC and RTS-CM0 through RTS-CM4). The class plans that were originally submitted with the filing, were correct and have not been modified or withdrawn from the filing.

If you should have any questions, please let me know.

Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838
melissa.coker@medpro.com

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Monday, June 12, 2006 3:37 PM
To: Coker, Melissa
Subject: Dentist - Rate/Rule Filing #06-IL-94

Ms. Coker,

In regard to the above referenced filing submitted by your letter dated May 25, 2006, please address the following issues:

1. On page SR-IL-IV-9, please explain 5. Extended Reporting Period Coverage Factors. Pursuant to Company Bulletin CB88-50, the extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The chart, as provided, does not clarify what an insured's premium would be.

2. SB475 requires as of January 1, 2006 that insurers have on file and offer a quarterly premium installment payment plan.

On page SR-IL-IV-16, a payment option is included, however it does not indicate the payment will be offered in four quarterly installments (every three months).

Your prompt attention is appreciated.

Gayle Neuman

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

Classification Revisions - Exhibit A

	(1) **Oral Surgeons** (Anesthesia in Hospital)	(2) **Oral Surgeons** (Anesthesia in Office)
Fireman's Fund	III	III
Pic Wisconsin	3	3
Medical Protective (Current)	2B	3
Medical Protective (Proposed)	2B	2B

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

Classification Revisions - Exhibit B

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Current Class	**Proposed Class**	**Current Relativity**	**Selected Relativity**	**Rate Change Impact**	**Percentage of Book**	**Weighted Rate Effect**
2B	**2B**	5.500	5.250	-4.5%	0.0%	0.0%
3 (Oral Surgeons)	**2B**	6.500	5.250	-19.2%	0.0%	0.0%
Rate Effect Due To Classification Changes						**0.0%**

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

DENTISTS

Classification Revisions - Exhibit C

	Oral Surgeons Relativity
Current Medical Protective Rate Relativity	5.5/6.5
Fireman's Fund	6.0
Pic Wisconsin	6.0
ISO Multistate Analysis	5.0
Indicated OMSNIC Relativity	5.0
Selected Rate Relativity	**5.25**

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	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,021	2,304	2,648	3,032	4,093	3,436	3,658	3,820	3,921
1B	2,526	2,880	3,309	3,789	5,115	4,294	4,572	4,774	4,900
2A	6,063	6,912	7,943	9,095	12,278	10,307	10,974	11,459	11,762
2B	10,610	12,095	13,899	15,915	21,485	18,780	20,053	21,008	21,751
3	13,137	14,976	17,209	19,706	26,602	23,252	24,829	26,011	26,931

b. Area 2

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
1B	2,105	2,400	2,758	3,158	4,263	3,579	3,810	3,978	4,084
2A	5,052	5,759	6,618	7,578	10,230	8,588	9,144	9,548	9,801
2B	8,841	10,079	11,582	13,262	17,903	15,649	16,709	17,505	18,124
3	10,946	12,478	14,339	16,419	22,166	19,374	20,688	21,673	22,439

c. Area 3

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,347	1,536	1,765	2,021	2,728	2,290	2,438	2,546	2,613
1B	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
2A	4,041	4,607	5,294	6,062	8,183	6,870	7,314	7,637	7,840
2B	7,072	8,062	9,264	10,608	14,321	12,517	13,366	14,003	14,498
3	8,756	9,982	11,470	13,134	17,731	15,498	16,549	17,337	17,950

3. Standard Claims Made Program

a. Area 1

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	436	497	571	654	883	741	789	824	846
1B	546	622	715	819	1,106	928	988	1,032	1,059
2A	1,309	1,492	1,715	1,964	2,651	2,225	2,369	2,474	2,539
2B	2,291	2,612	3,001	3,437	4,639	4,055	4,330	4,536	4,697
3	2,836	3,233	3,715	4,254	5,743	5,020	5,360	5,615	5,814

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
1B	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2A	2,618	2,985	3,430	3,927	5,301	4,451	4,739	4,948	5,079
2B	4,582	5,223	6,002	6,873	9,279	8,110	8,660	9,072	9,393
3	5,672	6,466	7,430	8,508	11,486	10,039	10,720	11,231	11,628

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,418	1,617	1,858	2,127	2,871	2,411	2,567	2,680	2,751
1B	1,773	2,021	2,323	2,660	3,590	3,014	3,209	3,351	3,440
2A	4,254	4,850	5,573	6,381	8,614	7,232	7,700	8,040	8,253
2B	7,445	8,487	9,753	11,168	15,076	13,178	14,071	14,741	15,262
3	9,217	10,507	12,074	13,826	18,664	16,314	17,420	18,250	18,895

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,654	1,886	2,167	2,481	3,349	2,812	2,994	3,126	3,209
1B	2,068	2,358	2,709	3,102	4,188	3,516	3,743	3,909	4,012
2A	4,963	5,658	6,502	7,445	10,050	8,437	8,983	9,380	9,628
2B	8,686	9,902	11,379	13,029	17,589	15,374	16,417	17,198	17,806
3	10,753	12,258	14,086	16,130	21,775	19,033	20,323	21,291	22,044

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,818	2,073	2,382	2,727	3,681	3,091	3,291	3,436	3,527
1B	2,273	2,591	2,978	3,410	4,603	3,864	4,114	4,296	4,410
2A	5,454	6,218	7,145	8,181	11,044	9,272	9,872	10,308	10,581
2B	9,545	10,881	12,504	14,318	19,329	16,895	18,040	18,899	19,567
3	11,817	13,471	15,480	17,726	23,929	20,916	22,334	23,398	24,225

b. Area 2

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	364	415	477	546	737	619	659	688	706
1B	455	519	596	683	921	774	824	860	883
2A	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2B	1,909	2,176	2,501	2,864	3,866	3,379	3,608	3,780	3,913
3	2,364	2,695	3,097	3,546	4,787	4,184	4,468	4,681	4,846

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
1B	909	1,036	1,191	1,364	1,841	1,545	1,645	1,718	1,763
2A	2,182	2,487	2,858	3,273	4,419	3,709	3,949	4,124	4,233
2B	3,818	4,353	5,002	5,727	7,731	6,758	7,216	7,560	7,827
3	4,727	5,389	6,192	7,091	9,572	8,367	8,934	9,359	9,690

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
1B	1,477	1,684	1,935	2,216	2,991	2,511	2,673	2,792	2,865
2A	3,545	4,041	4,644	5,318	7,179	6,027	6,416	6,700	6,877
2B	6,204	7,073	8,127	9,306	12,563	10,981	11,726	12,284	12,718
3	7,681	8,756	10,062	11,522	15,554	13,595	14,517	15,208	15,746

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
1B	1,724	1,965	2,258	2,586	3,491	2,931	3,120	3,258	3,345
2A	4,136	4,715	5,418	6,204	8,375	7,031	7,486	7,817	8,024
2B	7,238	8,251	9,482	10,857	14,657	12,811	13,680	14,331	14,838
3	8,962	10,217	11,740	13,443	18,148	15,863	16,938	17,745	18,372

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
1B	1,894	2,159	2,481	2,841	3,835	3,220	3,428	3,580	3,674
2A	4,545	5,181	5,954	6,818	9,204	7,727	8,226	8,590	8,817
2B	7,954	9,068	10,420	11,931	16,107	14,079	15,033	15,749	16,306
3	9,848	11,227	12,901	14,772	19,942	17,431	18,613	19,499	20,188

c. Area 3

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	291	332	381	437	589	495	527	550	565
1B	364	415	477	546	737	619	659	688	706
2A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
2B	1,527	1,741	2,000	2,291	3,092	2,703	2,886	3,023	3,130
3	1,891	2,156	2,477	2,837	3,829	3,347	3,574	3,744	3,877

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	582	663	762	873	1,179	989	1,053	1,100	1,129
1B	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
2A	1,745	1,989	2,286	2,618	3,534	2,967	3,158	3,298	3,385
2B	3,054	3,482	4,001	4,581	6,184	5,406	5,772	6,047	6,261
3	3,781	4,310	4,953	5,672	7,657	6,692	7,146	7,486	7,751

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	945	1,077	1,238	1,418	1,914	1,607	1,710	1,786	1,833
1B	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
2A	2,836	3,233	3,715	4,254	5,743	4,821	5,133	5,360	5,502
2B	4,963	5,658	6,502	7,445	10,050	8,785	9,380	9,827	10,174
3	6,145	7,005	8,050	9,218	12,444	10,877	11,614	12,167	12,597

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,103	1,257	1,445	1,655	2,234	1,875	1,996	2,085	2,140
1B	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
2A	3,309	3,772	4,335	4,964	6,701	5,625	5,989	6,254	6,419
2B	5,790	6,601	7,585	8,685	11,725	10,248	10,943	11,464	11,870
3	7,169	8,173	9,391	10,754	14,517	12,689	13,549	14,195	14,696

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,212	1,382	1,588	1,818	2,454	2,060	2,194	2,291	2,351
1B	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
2A	3,636	4,145	4,763	5,454	7,363	6,181	6,581	6,872	7,054
2B	6,363	7,254	8,336	9,545	12,885	11,263	12,026	12,599	13,044
3	7,878	8,981	10,320	11,817	15,953	13,944	14,889	15,598	16,150

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	1.310	1.310
1000/3000	1.500	1.500
2000/4000	1.700	1.770
3000/5000	1.810	1.890
4000/6000	1.890	1.980
5000/7000	1.940	2.050

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

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

ILLINOIS - AREA 1

DENTISTS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,021	2,304	2,648	3,032	4,093	3,436	3,658	3,820	3,921
1B	2,526	2,880	3,309	3,789	5,115	4,294	4,572	4,774	4,900
2A	6,063	6,912	7,943	9,095	12,278	10,307	10,974	11,459	11,762
2B	10,610	12,095	13,899	15,915	21,485	18,780	20,053	21,008	21,751
3	13,137	14,976	17,209	19,706	26,602	23,252	24,829	26,011	26,931

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ILLINOIS - AREA 2

DENTISTS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
1B	2,105	2,400	2,758	3,158	4,263	3,579	3,810	3,978	4,084
2A	5,052	5,759	6,618	7,578	10,230	8,588	9,144	9,548	9,801
2B	8,841	10,079	11,582	13,262	17,903	15,649	16,709	17,505	18,124
3	10,946	12,478	14,339	16,419	22,166	19,374	20,688	21,673	22,439

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ILLINOIS - AREA 3

DENTISTS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,347	1,536	1,765	2,021	2,728	2,290	2,438	2,546	2,613
1B	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
2A	4,041	4,607	5,294	6,062	8,183	6,870	7,314	7,637	7,840
2B	7,072	8,062	9,264	10,608	14,321	12,517	13,366	14,003	14,498
3	8,756	9,982	11,470	13,134	17,731	15,498	16,549	17,337	17,950

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	436	497	571	654	883	741	789	824	846
1B	546	622	715	819	1,106	928	988	1,032	1,059
2A	1,309	1,492	1,715	1,964	2,651	2,225	2,369	2,474	2,539
2B	2,291	2,612	3,001	3,437	4,639	4,055	4,330	4,536	4,697
3	2,836	3,233	3,715	4,254	5,743	5,020	5,360	5,615	5,814

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
1B	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2A	2,618	2,985	3,430	3,927	5,301	4,451	4,739	4,948	5,079
2B	4,582	5,223	6,002	6,873	9,279	8,110	8,660	9,072	9,393
3	5,672	6,466	7,430	8,508	11,486	10,039	10,720	11,231	11,628

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,418	1,617	1,858	2,127	2,871	2,411	2,567	2,680	2,751
1B	1,773	2,021	2,323	2,660	3,590	3,014	3,209	3,351	3,440
2A	4,254	4,850	5,573	6,381	8,614	7,232	7,700	8,040	8,253
2B	7,445	8,487	9,753	11,168	15,076	13,178	14,071	14,741	15,262
3	9,217	10,507	12,074	13,826	18,664	16,314	17,420	18,250	18,895

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,654	1,886	2,167	2,481	3,349	2,812	2,994	3,126	3,209
1B	2,068	2,358	2,709	3,102	4,188	3,516	3,743	3,909	4,012
2A	4,963	5,658	6,502	7,445	10,050	8,437	8,983	9,380	9,628
2B	8,686	9,902	11,379	13,029	17,589	15,374	16,417	17,198	17,806
3	10,753	12,258	14,086	16,130	21,775	19,033	20,323	21,291	22,044

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,818	2,073	2,382	2,727	3,681	3,091	3,291	3,436	3,527
1B	2,273	2,591	2,978	3,410	4,603	3,864	4,114	4,296	4,410
2A	5,454	6,218	7,145	8,181	11,044	9,272	9,872	10,308	10,581
2B	9,545	10,881	12,504	14,318	19,329	16,895	18,040	18,899	19,567
3	11,817	13,471	15,480	17,726	23,929	20,916	22,334	23,398	24,225

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	364	415	477	546	737	619	659	688	706
1B	455	519	596	683	921	774	824	860	883
2A	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2B	1,909	2,176	2,501	2,864	3,866	3,379	3,608	3,780	3,913
3	2,364	2,695	3,097	3,546	4,787	4,184	4,468	4,681	4,846

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
1B	909	1,036	1,191	1,364	1,841	1,545	1,645	1,718	1,763
2A	2,182	2,487	2,858	3,273	4,419	3,709	3,949	4,124	4,233
2B	3,818	4,353	5,002	5,727	7,731	6,758	7,216	7,560	7,827
3	4,727	5,389	6,192	7,091	9,572	8,367	8,934	9,359	9,690

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

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
1B	1,477	1,684	1,935	2,216	2,991	2,511	2,673	2,792	2,865
2A	3,545	4,041	4,644	5,318	7,179	6,027	6,416	6,700	6,877
2B	6,204	7,073	8,127	9,306	12,563	10,981	11,726	12,284	12,718
3	7,681	8,756	10,062	11,522	15,554	13,595	14,517	15,208	15,746

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

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
1B	1,724	1,965	2,258	2,586	3,491	2,931	3,120	3,258	3,345
2A	4,136	4,715	5,418	6,204	8,375	7,031	7,486	7,817	8,024
2B	7,238	8,251	9,482	10,857	14,657	12,811	13,680	14,331	14,838
3	8,962	10,217	11,740	13,443	18,148	15,863	16,938	17,745	18,372

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

ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
1B	1,894	2,159	2,481	2,841	3,835	3,220	3,428	3,580	3,674
2A	4,545	5,181	5,954	6,818	9,204	7,727	8,226	8,590	8,817
2B	7,954	9,068	10,420	11,931	16,107	14,079	15,033	15,749	16,306
3	9,848	11,227	12,901	14,772	19,942	17,431	18,613	19,499	20,188

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

ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	291	332	381	437	589	495	527	550	565
1B	364	415	477	546	737	619	659	688	706
2A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
2B	1,527	1,741	2,000	2,291	3,092	2,703	2,886	3,023	3,130
3	1,891	2,156	2,477	2,837	3,829	3,347	3,574	3,744	3,877

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

ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	582	663	762	873	1,179	989	1,053	1,100	1,129
1B	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
2A	1,745	1,989	2,286	2,618	3,534	2,967	3,158	3,298	3,385
2B	3,054	3,482	4,001	4,581	6,184	5,406	5,772	6,047	6,261
3	3,781	4,310	4,953	5,672	7,657	6,692	7,146	7,486	7,751

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

ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	945	1,077	1,238	1,418	1,914	1,607	1,710	1,786	1,833
1B	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
2A	2,836	3,233	3,715	4,254	5,743	4,821	5,133	5,360	5,502
2B	4,963	5,658	6,502	7,445	10,050	8,785	9,380	9,827	10,174
3	6,145	7,005	8,050	9,218	12,444	10,877	11,614	12,167	12,597

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

ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,103	1,257	1,445	1,655	2,234	1,875	1,996	2,085	2,140
1B	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
2A	3,309	3,772	4,335	4,964	6,701	5,625	5,989	6,254	6,419
2B	5,790	6,601	7,585	8,685	11,725	10,248	10,943	11,464	11,870
3	7,169	8,173	9,391	10,754	14,517	12,689	13,549	14,195	14,696

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

ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,212	1,382	1,588	1,818	2,454	2,060	2,194	2,291	2,351
1B	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
2A	3,636	4,145	4,763	5,454	7,363	6,181	6,581	6,872	7,054
2B	6,363	7,254	8,336	9,545	12,885	11,263	12,026	12,599	13,044
3	7,878	8,981	10,320	11,817	15,953	13,944	14,889	15,598	16,150

The Medical Protective Company

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 01 2006
SPRINGFIELD, ILLINOIS

RECEIVED
APR - 1 2005
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

March 31, 2005

John Gatlin, Director of Property and Casualty Compliance
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
COMPANY FEIN # 35-0506406
LINE 11 – MEDICAL MALPRACTICE
COMPANY FILING NO. 05-IL-67

ILLINOIS PHYSICIANS & SURGEONS, DENTISTS and ALLIED HEALTH CARE PROVIDERS
Rule Revisions
Add Deductible Credit Rule
Add Aggregate Credit Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Rule Revisions (General Manual and State Rate Pages)
Add Large Group Rating Program
Add Professional Locum Tenens Rating Rule
Add Deductible Credit Rule
Add Aggregate Credit Rule

Claims made [illegible]

PROPOSED EFFECTIVE DATE: UPON APPROVAL

Dear Mr. Gatlin:

The Medical Protective Company wishes to introduce four rating enhancements to its stand-alone product and the Comprehensive Liability Coverage for Health Care Providers programs. *We request an effective date commensurate with the approval date of this submission.*

The accompanying Actuarial Memorandum provides detailed support for the modifications proposes in this submission. Endorsement forms for the corresponding rules will be filed under a separate cover.

Revised manual pages reflecting the aforementioned modifications are enclosed along with the transmittal forms. Upon completion of your review, would you please stamp the duplicate copy of this submission and return it to us in the enclosed self addressed stamped envelope.

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

Sincerely,

Melissa Coker

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838; (260)-486-0733 (fax)
melissa.coker@ge.com

Enclosures

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 M. 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, Eric Clark, 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.

; **FCAS, MAAA & Vice President** 03/31/05
Signature and Title of Authorized Insurance Company Officer Date

; **ACAS** 03/31/05
Signature, Title and Designation of Authorized Actuary Date

Insurance Company FEIN 35-0506406 Filing Number 05-IL-67

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@ge.com

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

THE MEDICAL PROTECTIVE COMPANY

ILLINOIS

EXPLANATORY MEMORANDUM

The Medical Protective Company wishes to introduce four rating enhancements to its stand-alone product and the Comprehensive Liability Coverage for Health Care Providers programs. We request an effective date commensurate with the approval date of this submission. The narrative below outlines the modifications proposed in this submission.

AGGREGATE CREDIT RULE

The Company wishes to introduce the Aggregate Credit Rule for the Physicians & Surgeons, Dentists, Allied Healthcare Provider and Comprehensive Liability Coverage for Healthcare Providers Programs. This rule states that the total amount of credits shall not exceed 50% for one insured. The addition of this rule does not result in a substantive rate impact.

DEDUCTIBLE CREDITS

The Company wishes to introduce Deductible Credits for the Physicians & Surgeons, Allied Healthcare Providers and Comprehensive Liability Coverage for Healthcare Providers Programs. Deductible's will be offered from $50,000 to $500,000, for per occurrence policy limits from $100,000 to $1,000,000. These deductible options can be selected for applicability to Loss or Loss & ALE. Countrywide Loss & ALE Elimination Ratios were utilized in the analysis for the determination of the credit range.

LARGE GROUP RATING

The Company wishes to introduce Large Group Rating for its Comprehensive Liability Coverage for Healthcare Providers Program. Groups comprised of 25 members or more are eligible for application of this rule. The rule includes the definition of group, the corresponding rating rules that may be used in conjunction with the Large Group Rating, and Extension Contract Rating provisions for those insureds that purchase Claims Made coverage.

LOCUM TENENS GROUP RATING

The Company wishes to introduce Locum Tenens Group Rating as part of its Comprehensive Liability Coverage for Heatlhcare Providers Program. These groups provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc). Pricing is based upon the number of hours worked by the provider.

REVISE CLAIM FREE CREDIT RULE

During a recent review of the Company's Claim Free credit program, it was determined that a minor revision detailing how the credit is applied to new business is also being made at this time for Dentists. The credit structure of the rule remains identical to that which is filed.

ADD NON-DISCRETIONARY DEBIT PROGRAM RATING RULE

In response to market needs in certain jurisdictions, the Company wishes to introduce on a countrywide basis the Non-Discretionary Debit Program for Dentist Programs. This rating rule applies debits based upon frequency and/or severity of claims experience. The addition of this rule does not have overall significant rate impact and will afford Medical Protective the opportunity offer renewal to insureds it otherwise may have been forced to non-renew.

REVISE EXTENDED CONTRACT RATING RULE

Due to the addition of the Non-Discretionary Debit Program Rating rule, the Company wishes to clarify the calculation of the Extension Contract Coverage by revising the associated rating rule for its Dentists program. The revisions consist of adding reference to the above mentioned Non-Discretionary Debit Program within this rule. All other aspects of the rule remain unchanged.

Melissa.Coker@ge.com
05/20/2005 12:38 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Filing #05-IL-67

Ms. Neuman,
We should have a response for you today on this item.
Thank you,
Melissa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Friday, May 20, 2005 8:18 AM
To: melissa.coker@ge.com
Subject: Fw: Filing #05-IL-67

Ms. Coker,

We have received no response to the attached e-mail dated 4/5/05. Do you wish to withdraw this filing? Your immediate attention is appreciated.

----- Forwarded by Gayle Neuman/INS on 05/20/2005 08:16 AM -----
Gayle Neuman/INS

04/05/2005 03:27 PM

To melissa.coker@ge.com
cc
Subject Filing #05-IL-67

Ms. Coker,

We are in receipt of the above referenced filing submitted by letter dated March 31, 2005.

1. We require companies provide a copy of the complete rate/rule manual, including any changes made with the filing. 50 Ill. Adm. Code 929.30 requires identification of all changes from superseding filings. Companies are also to provide us with a memorandum indicating (1) the superseded pages which is a revised page that is being replaced with an updated version, (2) pages that are withdrawn (and not replaced), and (3) new pages to be added that do not replace any previously filed page. We require a written statement certifying that nothing else has changed from what was previously filed except for the changes brought to our attention is this filing. Pages in the material provided indicate a 6/01/05 edition date - are these the pages that are being changed at this time? Did you provide all the pages to the manual with your submission? Do you wish the filing to be effective June 1, 2005?

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

May 27, 2005

RECEIVED
MAY 31 2005
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

Ms. Gayle Neuman
State of Illinois
Office of the Insurance Commissioner
320 W. Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY
Rate / Rule Filing: #05-IL-67

Dear Ms. Neuman:

Attached you will find a complete copy of the rate/rule manual, including any changes made with the filing.

Please let me know if we can be of further assistance.

Sincerely

Heather M Clawson

Heather M. Clawson
Actuarial Assistant
260-492-4642

Encl:

Melissa.Coker@medpro.com
08/24/2005 11:44 AM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject FW: Rule Filing #05-IL-67

Dear Ms. Neuman,

Thank you for your questions of July 7th. In response, the General Manual Pages submitted with this filing are those which contain the latest Countywide manual changes (ie: 3/1/05). The State Rate pages carry an edition date close to or similar to the effective date requested for the filing (ie: 6/1/05). These are the edition dates of the manual, and not the effective dates that are a) requested by the Company or b) approved by a State DOI. The edition date is just a sequencing format that is followed to identify revisions that have been made.

At this time, we ask that the effective date of this filing to be in effect as of 11/1/05.

Should you have any additional questions, please contact me.

Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838
melissa.coker@medpro.com

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Thursday, July 07, 2005 2:00 PM
To: melissa.coker@ge.com
Subject: Rule Filing #05-IL-67

Re: IL Physicians & Surgeons, Dentists and Allied Health Care Providers
IL Comprehensive Liability Coverage for Health Care Providers

Ms. Coker,

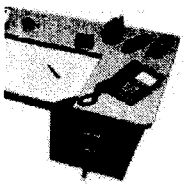
The pages submitted with the initial filing would appear to be the pages being added or changed. Why do they all have different edition dates? Some have January 1 or 15, 2005 - some March 1, 2005 - and some June 1, 2005. If changes are being made or forms are being added, it would seem all these pages should indicate the date you are attempting to file them. Do you wish the filing to be effective June 1, 2005? The cover letter does not disclose such date.

Your prompt assistance is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 01 2006



Gayle Neuman/INS
11/14/2005 07:55 AM

To Melissa.Coker@medpro.com
cc
bcc
Subject RE: Rule Filing #05-IL-67

This filing has not been approved to date. We will make note of your request for the changed effective date.

Melissa.Coker@medpro.com

Melissa.Coker@medpro.com
11/11/2005 02:45 PM

To gayle_neuman@ins.state.il.us
cc
Subject RE: Rule Filing #05-IL-67

Dear Ms. Neuman,

In review, I don't see that I received an approval on this filing. Can you advise if a decision was made? We have not implemented the filing at this time, in order to implement within our internal system and provide adequate notice to insureds, we request the effective date be modified to April 1, 2006.

Please advise.
Thank you,
Melissa Coker

-----Original Message-----
From: Coker, Melissa D. (Medical Protective, non-ge)
Sent: Wednesday, August 24, 2005 11:44 AM
To: 'Gayle_Neuman@ins.state.il.us'
Subject: FW: Rule Filing #05-IL-67

Dear Ms. Neuman,

Thank you for your questions of July 7th. In response, the General Manual Pages submitted with this filing are those which contain the latest Countywide manual changes (ie: 3/1/05). The State Rate pages carry an edition date close to or similar to the effective date requested for the filing (ie: 6/1/05). These are the edition dates of the manual, and not the effective dates that are a) requested by the Company or b) approved by a State DOI. The edition date is just a sequencing format that is followed to identify revisions that have been made.

At this time, we ask that the effective date of this filing to be in effect as of 11/1/05.

Should you have any additional questions, please contact me.

Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838

Melissa.Coker@medpro.com
03/24/2006 01:32 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject FW: Rate/Rule Filing #05-IL-67 - Physicians/Surgeons, Dentists & Allied Healthcare Providers

Dear Ms. Neuman,

Thank you for your email of March 9th, please find our response to your questions below. Please let me know if you should have any additional questions.

Melissa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Thursday, March 09, 2006 3:55 PM
To: Melissa.Coker@medpro.com
Subject: Rate/Rule Filing #05-IL-67 - Physicians/Surgeons, Dentists & Allied Healthcare Providers

Ms. Coker,

Please address the following issues on the above referenced rate/rule filing:

1. In regard to the pending rate/rule filing referenced above, please provide additional information about the filed scheduled rating plan, including the following information:

a) Whether the scheduled rating plan will be applied to all applicants/insureds. If not, provide a specific explanation of which applicants/insureds will be considered.
b) Whether the schedule debits/credits are reviewed periodically to ensure that they are still justified and added/removed accordingly. If the scheduled debits/credits are reviewed periodically, provide the time intervals for such reviews. If not all insureds are reviewed, provide a specific explanation of which insureds will be reviewed and how often.
c) All actuarial justification for determining the amount of any scheduled credit/debit.
d) A blank sample of the scheduled rating form that is kept in each applicant/insured's file to track the justification for receiving any debits/credits.

2. SB 475 requires insurers that issue a medical malpractice policy offer the insured a quarterly premium payment installment plan. The premium payment installment plan must be filed in the rate/rule manual. Please provide us with information, not limited to:
a. Are these quarterly payments each 25% of the premium?
b. Do you charge the insured anything for the payment plan, i.e. installment fees, etc.? Are any other payment installment plans offered?

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.

March 24, 2006

Ms. Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation
320 W. Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY (NAIC# 11843)
Rate Rule Filing 05-IL-67
Response to DOI Questions dated 3/9/06

Dear Ms. Neuman:

Thank you for your e-mail dated March 9, 2006 regarding the above referenced filing. In response to your inquiries, please accept the following. I have restated your questions for your ease in reviewing our response.

1. ***In regard to the pending rate/rule filing referenced above, please provide additional information about the filed scheduled rating plan, including the following information:***

   a) Whether the scheduled rating plan will be applied to all applicants/insureds. If not, provide a specific explanation of which applicants/insureds will be considered.

   The Schedule Rating Plan is available to all insureds which are eligible for the adjustment(s).

   b) Whether the schedule debits/credits are reviewed periodically to ensure that they are still justified and added/removed accordingly. If the scheduled debits/credits are reviewed periodically, provide the time intervals for such reviews. If not all insureds are reviewed, provide a specific explanation of which insureds will be reviewed and how often.

   Insureds receiving Schedule debits and credits are reviewed annually by Underwriting, prior to the insureds renewal, and evaluated for applicability for the upcoming year.

   c) All actuarial justification for determining the amount of any scheduled credit/debit.

   All Schedule Rating modifications are applied utilizing Underwriting judgment.

d) A blank sample of the scheduled rating form that is kept in each applicant/insured's file to track the justification for receiving any debits/credits.

Please find attached the requested SRP form.

2. SB 475 requires insurers that issue a medical malpractice policy offer the insured a quarterly premium payment installment plan. The premium payment installment plan must be filed in the rate/rule manual. Please provide us with information, not limited to:
a. Are these quarterly payments each 25% of the premium?
b. Do you charge the insured anything for the payment plan, i.e. installment fees, etc.? Are any other payment installment plans offered?
c. Will you offer every new insured and every renewal insured such plan(s) after January 1, 2006?

The Company offering each insured an installment option pursuant to SB475. We are of working with the IL Department of Insurance on interpretational issues surrounding SB475 in order for the Company to comply with the same.

3. On pages numbered CFC-CW and NDP-CW, it states some insured's can qualify for credit "in accordance with the company's guidelines". Does this mean in accordance with the "claim free credit" guidelines or some other guideline? We require a written statement certifying that the insurance company does not unfairly discriminate in offering or administering each program.

The Medical Protective Company will offer/apply the Loss Free Credit program and Non Discretionary Debit Program to each insured. The Company does not unfairly discriminate in offering or administering each program.

4. On pages numbered DCR-CW, you are requested to explain the criteria used to determine the percentage of credit for an insured. For example, if an insured would take a $50,000 deductible on a 100,000 limit policy, what criteria determines if the insured gets a 7% discount or a 20% discount? We require a written statement certifying that the insurance company does not unfairly discriminate in offering or administering this program.

Deductible credits are determined by the ratio of the losses eliminated by the deductible to the 1st dollar premium. The ranges reflect the impact of fixed expenses on this calculation. Supplemental Exhibit 1 demonstrates this calculation for two occurrence risks in area 2 (one with no loss free credit and one with a 20% loss free credit) and two claims made risks in area 3 (again, one with no loss free credit and one with a 20% loss free credit). Column (11) indicates that the same percentage of losses are expected to be eliminated by

the deductible. The exhibit then calculates the percentage of premium savings resulting. The percentage of losses eliminated does not correspond to the percentage of premium savings due to the effect of fixed expenses in this calculation. Please see the notes to the exhibit for details regarding this calculation.

5. On pages numbered DCR-CW, it states "...subject to a maximum dollar credit of 85% of the aggregate limit". Should this really say "aggregate deductible limit"?

This statement is correct as shown on the proposed manual pages. Please see the following example for the statement "85% of the aggregate limit".

Example #1:

- Primary Limit: $1,000,000
- Primary Limit Net Premium: $750,000 (This is only possible for insured with loss history subject to the Non-Discretionary debit plan)
- Deductible: $100,000 per Incident $100,000 aggregate
- Selected Percent Credit from Rule Table: 11.50%

The initial credit amount calculation is:

Credit x Net Premium = initial credit amount
0.115 * $750,000 = $86,250

Using the 85% language provision of the rule:

Maximum Dollar Credit x Deductible Aggregate =
Secondary Credit Amount
0.85 * $100,000 = $85,000

- $86,250 is greater than $85,000
- **The credit applied to the policy is capped at $85,000.**

Example #2:

- Primary Limit: $1,000,000
- Primary Limit Net Premium: $750,000 (This is only possible for insured with loss history subject to the Non-Discretionary debit plan)
- Deductible: $100,000 per Incident $300,000 aggregate
- Selected Percent Credit from Rule Table: 11.50%

The initial credit amount calculation is:

Credit x Net Premium = initial credit amount
0.115 * $750,000 = $86,250

Using the 85% language provision of the rule:

Maximum Dollar Credit x Deductible Aggregate =
Secondary Credit Amount
0.85 * $300,000 = $255,000

- $86,250 is less than $255,000
- **The credit applied to the policy is $86,250 (no capping).**

6. The issues listed above should additionally be addressed in the corresponding state rate pages. Additionally, please explain

Please provide additional clarification, as the Company is not sure what is needed/being requested.

7. We additionally request actuarial justification and 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This is the Department's position because the discounts should be actuarially justified.

Please find attached such actuarial justification.

Should you have any additional questions, please do not hesitate to contact me at (800)348-4669. Thank you.

Very truly yours,

Kimberly A. Nielsen
Product Manager & Department Ops Leader

Encl:

Underwriting Referral / Discretionary DR/CR Documentation Form

(Enter All Dates mm/dd/yy) - If needed, modify the structure of the form first, before locking).

Date Submitted: **Underwriter**: **Region**: Select One

Account Type: Select One **Policy Status**: Select One **State**:

State Guideline Level: Select One **Policy/Group # (If Applicable)**: **Date Needed**:

Referral Reason: Select One **Secondary Referral Reason**: Select One

Effective Date: **Account/Group Name**:

☐ **Discretionary DR/CR (SRP)** – ***Check state filings to determine applicable limits.***

	DR/CR Documentation Only (Within Auth.)	Credit 16-30% Discr. Or 36-50% Total	Credit 31%+ Discr. Or 51%+ Total	Debit 16%+ Discr. Or 36%+ Total
UW Manager	☐			
Underwriting Leader		☐	☐	☐

State Specific Consideration	+Debit -Credit Percent	State Specific Per Characteristic Max. Modification	State Specific Combined Max. Modification
Select One		Not Applicable	Not Applicable
Underwriting Comments:			
Select One		Not Applicable	Not Applicable
Underwriting Comments:			
Select One		Not Applicable	Not Applicable
Underwriting Comments:			
Select One		Not Applicable	Not Applicable
Underwriting Comments:			
Select One		Not Applicable	Not Applicable
Underwriting Comments:			

DEDUCTIBLE CREDIT CALCULATION - EXAMPLE
SUPPLEMENTAL EXHIBIT 1

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Area	Class	Product	100/300 Manual Rate	Loss Free Discount	100/300 Charged Rate	Fixed Expenses	Variable Expense Ratio	Expected Losses	ULE Ratio	Loss Elimination Ratio	Expected Losses After Deductible	Rate After Deductible	Deductible Discount [(13) / (6) -1]
2	1B	Occurrence	$ 10,663	20%	$ 8,530	$ 940	0.737	$ 5,347	1.032	0.226	$ 4,010	$ 6,949	-18.54%
2	1B	Occurrence	$ 10,663	0%	$ 10,663	$ 940	0.737	$ 6,919	1.032	0.226	$ 5,189	$ 8,617	-19.19%
3	1B	CM Step 0	$ 2,845	20%	$ 2,276	$ 940	0.737	$ 737	1.032	0.226	$ 553	$ 2,058	-9.58%
3	1B	CM Step 0	$ 2,845	0%	$ 2,845	$ 940	0.737	$ 1,157	1.032	0.226	$ 868	$ 2,503	-12.03%

NOTE:
(7) - Fixed Expenses from Medical Protective's most recent rate filing.
(8) - Variable Expenses from Medical Protective's most recent rate filing.
(10) - ULE Expenses from Medical Protective's most recent rate filing.
(11) - Loss Elimination ratio is the percentage of losses eliminated by a deductible (paid by the insured).
(12) - [{((6)x(8) - (7)) / (10)} x (1.0 - (11))]
(13) - [{(12)+ ((10) - 1.0)x(9) + (7)} / (8)]
(14) - Subject to Minimum and Maximum Credits.

Illinois Rate Certification

I certify that the Company's rates are based on sound actuarial principles and are not inconsistent with the Company's experience. Additionally, I certify that such rates and rating plans adequate, justified, and will not be applied in an unfairly discriminatory manner

James D. Kunce, FCAS, MAAA
Senior Vice President & Chief Actuary

Melissa.Coker@medpro.com
04/06/2006 09:57 AM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Medical Protective Rate/Rule Filing #05-IL-67

Ms. Neuman,

The Medical Protective Company (NAIC # 11843) is a member of ISO, as it reports statistical data quarterly. However The Medical Protective Company is not a subscriber to ISO as a rating organization, in that the Company does not adopt ISO Loss Costs, rules, or forms for Medical Malpractice. Please let me know if you have any additional questions.

Melissa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Thursday, April 06, 2006 10:53 AM
To: Melissa.Coker@medpro.com
Subject: Medical Protective Rate/Rule Filing #05-IL-67

Ms. Coker,

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 or it is in-house?

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through our website at http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm.

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

Neuman, Gayle

From: Neuman, Gayle
Sent: Tuesday, May 30, 2006 11:24 AM
To: 'Coker, Melissa'
Subject: RE: Rate/Rule Filing #05-IL-67

That will be fine.

-----Original Message-----
From: Coker, Melissa [mailto:Melissa.Coker@medpro.com]
Sent: Tuesday, May 30, 2006 10:24 AM
To: Neuman, Gayle
Subject: RE: Rate/Rule Filing #05-IL-67
Importance: High

Ms. Neuman,
I am checking with our actuarial dept. for a response, In review of my inbox, I do not have a copy of your original email from 4/11? I hope to have a response for you shortly, could you please give us until this Friday, 6/2 for a response?
Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Tuesday, May 30, 2006 10:25 AM
To: Coker, Melissa; Melissa.Coker@ge.com
Subject: FW: Rate/Rule Filing #05-IL-67

No response to my 4/11/06 e-mail has been received.

Your immediate attention is required.

-----Original Message-----
From: Gayle Neuman [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Tuesday, April 11, 2006 2:37 PM
To: melissa.coker@ge.com
Subject: Rate/Rule Filing #05-IL-67

Ms. Coker,

We are continuing our review of the above referenced rate/rule filing.
Please address the following:

Company Bulletin CB 88-50 (issued March 3, 1988) stated the extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The company must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit, Division of Insurance Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through our website at http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS.

Neuman, Gayle

From: Nielsen, Kimberly [Kimberly.Nielsen@medpro.com]
Sent: Friday, June 02, 2006 3:05 PM
To: Neuman, Gayle
Cc: Coker, Melissa; Whitcraft, Joel
Subject: FW: Rate/Rule Filing #05-IL-67

Importance: High

il resp #3.pdf (48 KB)

Dear Gayle, please find attached revised Extension Contract Rating Rules which clarify that the factors are applied to the applicable, expiring premium.

If you should have any additional questions, please do not hesitate to contact me at 260-486-0801. Thank you.

-----Original Message-----
From: Coker, Melissa
Sent: Tuesday, May 30, 2006 10:54 AM
To: Nielsen, Kimberly
Subject: FW: Rate/Rule Filing #05-IL-67
Importance: High

I receievd a follow up on the email below.

Melissa

-----Original Message-----
From: Neuman, Gayle [mailto:GNeuman@idfpr.com]
Sent: Tuesday, May 30, 2006 10:25 AM
To: Coker, Melissa; Melissa.Coker@ge.com
Subject: FW: Rate/Rule Filing #05-IL-67

No response to my 4/11/06 e-mail has been received.

Your immediate attention is required.

-----Original Message-----
From: Gayle Neuman [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Tuesday, April 11, 2006 2:37 PM
To: melissa.coker@ge.com
Subject: Rate/Rule Filing #05-IL-67

Ms. Coker,

We are continuing our review of the above referenced rate/rule filing. Please address the following:

Company Bulletin CB 88-50 (issued March 3, 1988) stated the extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The company must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

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 AND SCHEDULE RATING MODIFICATIONS.

The Medical Protective Company
5200 Metcalf
P. O. Box 2991
Overland Park, Kansas 66201-1391

T 800-255-6931, 913-676-5200
F 913-676-6226

RECEIVED
APR 28 2005
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
WITHDRAWN
AUG 16 2006
SPRINGFIELD, ILLINOIS

April 27, 2004

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

NAIC # 350-11843
FEIN 35-0506406

Re: The Medical Protective Company
Healthcare Organization Liability Program
Rule Filing
Proposed Effective Date: June 1, 2005
Our Filing Number: M-HPL-IL-05-00983-1-R

Dear Director McRaith:

[illegible] of this filing is to submit amended manual pages for the Healthcare Organization Liability Program.

The manual pages are revised to clarify and define the schedule rating process. There is no rate impact due to this revision. Although no other revisions are being made at this time, other manual pages are being submitted in order to synchronize the effective date/edition dates of these pages in the manual.

We respectfully request an effective date of June 1, 2005.

Enclosed are copies of the final printed manual pages, a copy of this submission and a return envelope for the return of a file marked copy of the filing. If you have any questions, please contact me at the telephone number or email address below. I appreciate your consideration of this submission.

Sincerely,

Kathy Berke
Product & Regulatory Services Specialist
800-255-6931, Ext. 5342
Fax: 913-676-6226
kathy.berke@ge.com

The Medical Protective Company

April 22, 2005

RECEIVED
APR 25 2005
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUN 01 2005
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
COMPANY FILE NO: 05-IL-69
COMPANY FEIN NO: 35-0506406
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Increase	*+ 2.0%*
Revise Territories	*+ 2.9%*
Overall Rate Increase	*+5.0%*

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revise Section IV- State Rate Pages, Dentists

PROPOSED EFFECTIVE DATE: June 1, 2005

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests **June 01, 2005**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of +5.0 %. In addition, we have enclosed revised manual pages for *Section IV – Dentists* for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

Please find enclosed the required filing forms, actuary certification 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

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@ge.com

Enclosure(s)

+5%

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 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, Eric Clark, 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.

Chief Actuary, SVP, 04/20/05

Signature and Title of Authorized Insurance Company Officer — Date

ACAS, 04/20/05

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 35-0506406 Filing Number 05-IL-69

Insurer's Address 5814 Reed Road

City Fort Wayne State IN Zip Code 46835

Contact Person's:
-Name and E-mail melissa.coker@ge.com

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

Melissa.Coker@ge.com
04/25/2005 02:19 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Illinois Dentists - Rate/Rule Filing #05-IL-69

Ms. Neuman:

1. Yes, pages from 12-16 should remain, and only 1-11 are changing in the State Rate Pages, Section IV.

2. The Company annually reports statistically to Insurance Services Organization (ISO). The Company, however, does not subscribe to ISO Loss Costs, Rules, or forms.

Please let me know if you should have any additional questions.

Sincerely,
Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Monday, April 25, 2005 1:49 PM
To: melissa.coker@ge.com
Subject: Illinois Dentists - Rate/Rule Filing #05-IL-69

Ms. Coker,

We are in receipt of the above referenced filing submitted by letter dated April 22, 2005. The following additional information is required to process this filing:

1. In the currently filed manual, there are pages SR-IL-IV-1 through 16. You are submitting revised pages SR-IL-IV-1 through 11. Do pages 12 through 16 stay or are they to be removed from the manual? We require a written statement certifying that nothing else has changed from what was previously filed except for the changes brought to our attention is this filing.

2. 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?

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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

The Medical Protective Company
5200 Metcalf
P. O. Box 2991
Overland Park, Kansas 66201-1391

T 800-255-6931, 913-676-5200
F 913-676-6226

January 27, 2005

RECEIVED
JAN 28 2005
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

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

NAIC # 350-11843
FEIN 35-0506406

Re: The Medical Protective Company
Healthcare Organization Liability Program
Rate and Rule Filing
Proposed Effective Date: April 15, 2005
Our Filing Numbers: RFF-05-00758

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 15 2005
SPRINGFIELD, ILLINOIS

Dear Commissioner:

The Medical Protective Company (MPCO) wishes to propose the following rate revisions for the Healthcare Facilities program with a requested effective date of April 15, 2005. These rate changes are based on a competitive analysis. The proposed changes and their rate impact are described in the enclosed Explanatory Memorandum, and are further illustrated in the attached exhibits.

Enclosed are 2 copies of the transmittal documents, the revised rate pages and the Exhibits. Enclosed also is a self-addressed stamped envelope for the return of a file marked copy of the filing.

If you have any questions or concerns, please contact me at the numbers listed below. I appreciate your consideration of this submission.

Sincerely,

Theresa Cox
Product & Regulatory Services Specialist
800-255-6931 Ext. 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ge.com

+16.8%

Illinois - Certification of Rates

The company's Hospital Facility rates are based on sound actuarial principles and are not inconsistent with the company's or industry's experience.

Certified Actuary:

Jason Martin, FCAS, MAAA
Healthcare Actuary

Signature

Company Officer:

William E. Daley
Senior Vice President

Theresa.Cox@ge.com
01/31/2005 02:30 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing

gen liab should be on line 17 of annual statement

Gayle:

The premium for Hospital Professional Liability is reported on Line 11 of the annual statement. I have spoken to the actuaries regarding issue #5 in your e-mail below. The actuaries will be responding to your inquiry shortly. Upon your receipt of their response, if you have any additional questions, please let us know. Thank you.

Theresa Cox

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Monday, January 31, 2005 10:14 AM
To: Theresa.Cox@ge.com
Subject: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing

Ms. Cox:

We are in receipt of the above referenced filing submitted by letter dated January 27, 2005. Please address the following:

1. Provide a copy of the complete rate/rule manual, including any changes made with this filing. 50 Ill. Adm. Code 929.30 requires identification of all changes from superseding filings. Please also provide us with a memorandum indicating (1) the superseded pages which is a revised page that is being replaced with an updated version, (2) pages that are withdrawn (and not replaced), and (3) new pages to be added that do not replace any previously filed page.

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

3. We require a written statement certifying that the insurance company does not unfairly discriminate in offering or administering this program.

4. Does the 16.8% rate change increase all healthcare professionals by the same amount, or is 16.8% an average amount?

5. We do not require that general liability rates/rules be filed - only rate increases need to be reported on a RF-3 Summary Sheet. Is the 16.8% increase on the RF-3 based purely on medical malpractice rates? If not, they should be separated by line and would require that you file a new RF-3 form. We additionally ask that you withdraw all general liability rules filed as they are not required by our regulations.

Your response is requested by February 14, 2005.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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Theresa.Cox@ge.com
02/23/2005 04:58 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Gayle:

Attached is a revised form RF-3 showing the breakdown between the General Liability and the Med Mal. Please let me know if you need anything else.
Thank you.

<<Form RF-3 revised. xls.xls>>

Sincerely,
<<...OLE_Obj...>>
Theresa Cox
Product & Regulatory Services Specialist
800-255-6931, x 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ercgroup.com <mailto:Theresa.Cox@ercgroup.com>

Form RF-3 revised. xls.xls

Form (RF-3)

ILLINOIS DEPARTMENT OF INSURANCE
SUMMARY SHEET

Change in company's premium or rate level produced by rate revision effective 04/15/2005

(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 Healthcare Prof. Liab. Line of Insurance	508,608	+16.8%

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):
Rate revisions to the Healthcare Facilities Program

*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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
JAN 28 2005
SPRINGFIELD, ILLINOIS

Theresa Cox - Compliance Specialist
Official-Title

Theresa.Cox@ge.com
03/09/2005 04:03 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Gayle:

On February 23, a revised RF-3 was sent to you showing the breakdown between the General Liability and the Med Mal. I am checking on the status of this filing. Did you need any additional information. Please advise. Thank you.

Theresa Cox

Theresa.Cox@ge.com
03/11/2005 09:16 AM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing Revised Form RF-3

2:00 will be fine. At what phone number should I contact you

Theresa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Friday, March 11, 2005 8:47 AM
To: Theresa.Cox@ge.com
Subject: RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing Revised Form RF-3

Theresa,

You are Central Standard Time too, right? How about 2:00 p.m. on Monday (so we are through the lunch hours)? My telephone number is (217) 524-6497. Please confim the time.

Theresa.Cox@ge.com
03/11/2005 08:28 AM

To Gayle_Neuman@ins.state.il.us
cc Nancy.Kelley@ge.com
Subject RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing Revised Form RF-3

Gayle:

We would like to schedule a conference call for Monday, March 14th at 1:00 p.m. to discuss your questions regarding our rate filing. Would you be available? If so, at which phone number should we contact you.

Theresa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Thursday, March 10, 2005 7:49 AM
To: Theresa.Cox@ge.com
Subject: Fw: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form

RF-3

Theresa,

Here is a copy of my 2/24/05 e-mail. We are awaiting a response to this.

----- Forwarded by Gayle Neuman/INS on 03/10/2005 07:46 AM -----

Gayle Neuman/INS

To Theresa.Cox@ge.com

02/24/2005 02:07 PM

cc

Subject Re: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Link

Theresa,

Thank you for having separated the general liability rates from the medical malpractice rates. Can you explain the numbers on the corrected RF-3 Summary Sheet provided vs. your 2/17/05 e-mail indicating the overall premium increase was 18.3%?

Theresa.Cox@ge.com

To Gayle_Neuman@ins.state.il.us

02/23/2005 04:58 PM

cc

Subject Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Gayle:

Attached is a revised form RF-3 showing the breakdown between the General Liability and the Med Mal. Please let me know if you need anything else.
Thank you.

<<Form RF-3 revised. xls.xls>>

Sincerely,

<<...OLE_Obj...>>

Theresa Cox
Product & Regulatory Services Specialist
800-255-6931, x 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ercgroup.com <mailto:Theresa.Cox@ercgroup.com>

State of Illinois
Financial and Professional Regulation
Division of Insurance
Report of *Ex Parte* Communication

Name of employee making report: Gayle Neuman

Job Title of employee making report: Ins. Analyst IV

Date of communication: 3/14/05

Date of First Notice (if applicable): n/a

Mode of communication (e.g. in person, telephone, fax, e-mail, mail): telephone

On whose behalf communication is made: Medical Protective

Person(s) with whom communication occurred: Theresa Cox, Nancy Kelly, + Jason Martin (actuary). My supervisor, John Gatlin was also involved.

Summary of Nature and Substance of communication: We requested gen. liab. figures be separated from med mal on RF-3. After updated RF-3 was received, we requested further clarification.

What action, if any, the person(s) requested:

Responses made to communication: They will send info requested within the week. - deductible info is involved.

Other Pertinent Information:

Please attach any and all documents to this form including e-mails, faxes, papers or other documents.

Theresa.Cox@ge.com
03/15/2005 01:14 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing Revised Form RF-3

Gayle:

Thank you for your time yesterday. Attached, please find our response to the issues your presented. Hopefully, we have now provided the information that you and Mr. Gatlin were requesting.

Theresa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Friday, March 11, 2005 8:47 AM
To: Theresa.Cox@ge.com
Subject: RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing Revised Form RF-3

Theresa,

You are Central Standard Time too, right? How about 2:00 p.m. on Monday (so we are through the lunch hours)? My telephone number is (217) 524-6497. Please confim the time.

Theresa.Cox@ge.com
03/11/2005 08:28 AM

To Gayle_Neuman@ins.state.il.us
cc Nancy.Kelley@ge.com
Subject RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing Revised Form RF-3

Gayle:

We would like to schedule a conference call for Monday, March 14th at 1:00 p.m. to discuss your questions regarding our rate filing. Would you be available? If so, at which phone number should we contact you.

Theresa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Thursday, March 10, 2005 7:49 AM
To: Theresa.Cox@ge.com
Subject: Fw: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Theresa,

Here is a copy of my 2/24/05 e-mail. We are awaiting a response to this.

----- Forwarded by Gayle Neuman/INS on 03/10/2005 07:46 AM -----

Gayle Neuman/INS

To Theresa.Cox@ge.com

02/24/2005 02:07 PM

cc

Subject Re: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Link

Theresa,

Thank you for having separated the general liability rates from the medical malpractice rates. Can you explain the numbers on the corrected RF-3 Summary Sheet provided vs. your 2/17/05 e-mail indicating the overall premium increase was 18.3%?

Theresa.Cox@ge.com

To Gayle_Neuman@ins.state.il.us

02/23/2005 04:58 PM

cc

Subject Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing Revised Form RF-3

Gayle:

Attached is a revised form RF-3 showing the breakdown between the

General Liability and the Med Mal. Please let me know if you need anything
else.
Thank you.

<<Form RF-3 revised. xls.xls>>

Sincerely,

<<...OLE_Obj...>>
Theresa Cox
Product & Regulatory Services Specialist
800-255-6931, x 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ercgroup.com <mailto:Theresa.Cox@ercgroup.com>

Response sent to DOI 3-15-05.doc

THE MEDICAL PROTECTIVE COMPANY

FOLLOW-UP TO ILLINOIS DEPARTMENT OF INSURANCE
ILLINOIS
HOSPITAL PROFESSIONAL LIABILITY

Please find the Medical Protective Company's (MPCO) follow-up to our conversation with Mr. Gatlin and Ms. Neuman on Monday, March 14, 2005.

Our original RF-3 form referenced a 16.8% increase in rates. This increase, specifically broken down on page 4 of our memorandum, did include General Liability information.

On February 23, 2005, we revised the RF-3 form to separate the Hospital Professional Liability (HPL) and General Liability (GL) coverages. Both HPL and GL share the ILF increase of 18.3%. However, the distribution of the in-force deductibles varies for the coverages and yields different effects. The differences in the increases are summarized as follows:

Original RF-3 form		Revised RF-3 (HPL)		Revised RF-3 (GL)	
ILF	18.3%	ILF	18.3%	ILF	18.3%
Deductible	-1.3%	Deductible	-1.5%	Deductible	-0.7%
Overall	16.8%	Overall	16.6%	Overall	17.5%

Per our discussion, future filings will separate the coverages when measuring effects.

Theresa.Cox@ge.com
03/16/2005 08:28 AM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Fil ing

Gayle:

1. Attached is a copy of Section I of the General Manual that is already approved and on file in Illinois. Section I of the General Manual is shared between Physicians, Sections II-V, and Hospitals, Section VI-IX. Extended Reporting Endorsements are referred to on page GM-I-CW-5 of the manual. Our filing was only proposing a change in the factors and not in the manner in which they are applied.
2. The 16.6% represents an average increase. Premium increases will depend on the deductible option of each account.

Thanks

Theresa

-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Tuesday, March 15, 2005 3:34 PM
To: Theresa.Cox@ge.com
Subject: Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing

Ms. Cox,

In regard to the Rate/Rule Manual, there is no information about the extended reporting period coverage (except in the Illinois State Rate Pages) such as (1) the period of the e.r.p., (2) if limits are reinstated, (3) if the premium will be priced as a factor of (a) the last 12 months' premium, (b) the premium in effect at policy issuance, or (c) the expiring annual premium, or (4) coverage available for retirement, death or disability.

In regard to the premium increase, do all insureds effected by this filing receive the same increase or is the 16.6% an average increase amount?

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE DESTROY IT AND NOTIFY US

BY SENDING AN E-MAIL TO: gayle_neuman@ins.state.il.us

SECTION1.General Rules.doc

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the following health care providers:

Section

II. Corporations, Partnerships and Associations
III. Physicians and Surgeons
IV. Dentists
V. Allied Health Care Providers
VI. Health Care Facilities

B. This manual also specifies rules, rates, premiums, classifications and territories for the purpose of providing the following optional associated coverages to health care providers:

Section

VII. General Liability
VIII. Managed Care Entity Liability
IX. Pollution Liability

II. APPLICATION OF GENERAL RULES

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the respective Section or State Rate Pages.

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

III. POLICY TERM

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

IV. LOCATION OF PRACTICE

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

V. PREMIUM COMPUTATION

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

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

VI. FACTORS OR MULTIPLIERS

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

VII. WHOLE DOLLAR RULE

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

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

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

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

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

C. The Company may waive an additional premium of $100 or less for coverages related to Healthcare facilities. This waiver only applies to cash exchange due on an endorsement effective date.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. a policy is canceled at the Company's request;

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider and is shown on the appropriate State Rate Pages.

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

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate State Rate Pages.

XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the State Rate Pages.

XIII. COVERAGE

Coverage may be provided on either an Occurrence or Claims-Made basis, unless noted otherwise in the respective section or State Rate Pages. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Occurrence or Standard Claims-Made, subject to availability and identified on the State Rate Pages.

XIV. BASIC LIMITS OF LIABILITY

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

XV. INCREASED LIMITS OF LIABILITY

A. Individual Limits of Liability

1. Increased Limits factors shall be those shown as applicable for the respective insureds and be used to develop the applicable premium.

B. Shared Limits of Liability

1. Limits of Liability may be increased on a shared limits basis excess of an individual limit per insured.

2. The rate for the shared excess limits shall be computed in the following manner:

a. The rate for the individual limit of liability and the total limit of liability shall be calculated in accordance with the State Rate Pages. The total limit of liability is the sum of the individual per occurrence limit and the shared per occurrence limit.

b. The initial shared limits rate is the difference between the total limits rate and the individual limits rate .

c. The initial shared limits rate may be modified subject to the restrictions identified on the State Rate Pages, based on the following objective considerations:

i. The number and distribution by classification of insureds.

ii. The amount of the shared limit and its relationship to the size and distribution of the group.

iii. The amount of the individual limit (attachment point) underlying the shared limit.

3. The minimum individual limit over which a shared excess limit may be provided is identified on the State Rate Pages.

4. Requests for total limits of liability (the sum of the individual per health care occurrence limit and the shared excess per health care occurrence limit) that exceed the maximum limit of liability identified on the State Rate Pages shall be referred to the Company and (a) rated.

XVI. PRIOR ACTS COVERAGE

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

XVII. EXTENDED REPORTING PERIOD COVERAGE (Claims-Made Coverage only)

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

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Experience, Part Time and Schedule Rating Modifications.

D. Premium must be paid, in accordance with state statutes, promptly when due.

XVIII. GROUP PRACTICE

For the purpose of these rules, group practice shall be defined as a group of entities, physicians, dentists and/or allied health care providers rendering out-patient care who:

A. number 2 or more;

B. are organized as a legal entity;

C. share common facilities (including multiple locations) and support personnel.

XIX. MEMBERSHIP IN QUALIFIED ASSOCIATIONS

A. The unique characteristics of medical/dental practices and their membership in qualified professional associations shall make them eligible for premium modifications in addition to those available to all other groups.

B. Members of a qualified medical/dental group professional association shall be eligible for additional premium modifications.

1. Membership Credit

   a. A premium credit, identified on the State Rate Pages, shall be given to those insureds whose group is a member of a qualified association.
   b. A Qualified Association may include State Medical or Dental Societies.

2. Renewal Rate Rule

   a. If the group practice generates a manual premium in excess of $50,000, 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 and loss/claim free credit and non-discretionary credits will be applied in the usual manner.

   b. Only one consecutive renewal may receive application of this rule. The group practice may again qualify for this rule after the payment of one renewal premium based upon currently filed rates.

Theresa.Cox@ge.com
02/17/2005 12:38 PM

800-255-6931
X. 6181

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Filing #RFF-05-00758

Gayle:

The overall premium increase is 18.3% as reflected in our Explanatory Memorandum. By applying different Deductibles and Self-Insured Retentions (depending upon what deductible or SIR each policyholder had), we get an average increase of 16.8%. I see where you are coming from. You want to make sure that the increase in not discriminatorily applied. The overall premium increase is 18.3% and that 18.3% is applied to all healthcare professionals. The differing deductible and SIR credits would make the 16.8% and average. Does this help? If not, please call me at 800-255-6931 Ext. 6181 and we can discuss further.

Theresa
-----Original Message-----
From: Gayle_Neuman@ins.state.il.us [mailto:Gayle_Neuman@ins.state.il.us]
Sent: Thursday, February 17, 2005 8:27 AM
To: Theresa.Cox@ge.com
Subject: Filing #RFF-05-00758

Ms. Cox:

We are in receipt of your response to my previous e-mail. I was not clear enough on question #4. Does the 16.8% rate change increase all healthcare professionals by the same amount, or is 16.8% an average amount? What I am trying to ask is does every insured/policy who qualifies for a healthcare organization policy get a 16.8% increase? Or do some get (for example) a 25% increase and others get a 7% decrease? I am only asking about a policyholder who has a policy that would be in the category of this filing.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
fax (217) 524-2122

Please refer to the Property and Casualty Review Requirement Checklists before submitting a paper filing or an electronic filing (SERFF). The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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RECEIVED
FEB 15 2005
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

THE MEDICAL PROTECTIVE COMPANY

RESPONSE TO ILLINOIS DEPARTMENT OF INSURANCE
ILLINIOS
HOSPITAL PROFESSIONAL LIABILITY

Filing #RFF-05-00758 Healthcare Organization Rate & Rule Filing

Attached are the Medical Protective Company's (MPCO) responses to the Illinois Department of Insurance questions regarding the filing to revise our Hospital Professional Liability rates.

1. Provide a copy of the complete rate/rule manual, including any changes made with this filing. 50 Ill. Adm. Code 929.30 requires identification of all changes from superseding filings. Please also provide us with a memorandum indicating (1) the superseded pages which is a revised page that is being replaced with an updated version, (2) pages that are withdrawn (and not replaced), and (3) new pages to be added that do not replace any previously filed page.

   Response:

   Attached Exhibit A

2. 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?

   Response:

   The Company reports to Insurance Services Office (ISO).

3. We require a written statement certifying that the insurance company does not unfairly discriminate in offering or administering this program.

   Response:

   Statement attached Exhibit B

4. Does the 16.8% rate change increase all healthcare professionals by the same amount, or is 16.8% an average amount? The rate change for Hospital Professional Liability (HPL) is a 16.8% increase.

   Response:

   General Liability for our insured hospitals will be affected in the same way since it uses HPL premium as its base. However, Physician Professional Liability (PPL) coverage offered in conjunction with a HPL policy hospital will not be

affected as it is based on individual physician rates that are not subject to this filing.

5. We do not require that general liability rates/rules be filed - only rate increases need to be reported on a RF-3 Summary Sheet. Is the 16.8% increase on the RF-3 based purely on medical malpractice rates? If not, they should be separated by line and would require that you file a new RF-3 form. We additionally ask that you withdraw all general liability rules filed as they are not required by our regulations.

Response:

We offer General Liability coverage to our insureds as defined in our Comprehensive Liability Coverage for Health Care Providers manual.(See Section VII of the attached Manual). It is not regarded as a stand-alone commercial liability program. The 16.8% increase is based on medical malpractice rates.

I hope our responses have adequately addressed your concerns. If not, please let me know. Thank you for your continued review of our filing.

Sincerely,

Theresa Cox
Product & Regulatory Services Specialist
800-255-6931 Ext. 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ge.com

EXHIBIT "A"

MEMORANDUM

Superseded Pages	Replaced with:
SR-IL-VI-1 Effective Date: 04-15-04	SR-IL-VI-1 Effective Date: 04-15-05
SR-IL-VI-2 Effective Date: 04-15-04	SR-IL-VI-2 Effective Date: 04-15-05
SR-IL-VI-3 Effective Date: 04-15-04	SR-IL-VI-3 Effective Date: 04-15-05
SR-IL-VI-4 Effective Date: 04-15-04	SR-IL-VI-4 Effective Date: 04-15-05
SR-IL-VI-5 Effective Date: 04-15-04	SR-IL-VI-5 Effective Date: 04-15-05
SR-IL-VI-6 Effective Date: 04-15-04	SR-IL-VI-6 Effective Date: 04-15-05
SR-IL-VI-7 Effective Date: 04-15-04	SR-IL-VI-7 Effective Date: 04-15-05
SR-IL-VI-8 Effective Date: 04-15-04	SR-IL-VI-8 Effective Date: 04-15-05
SR-IL-VII-1 Effective Date: 04-15-04	SR-IL-VII-1 Effective Date: 04-15-05
SR-IL-VII-2 Effective Date: 04-15-04	SR-IL-VII-2 Effective Date: 04-15-05
SR-IL-VII-3 Effective Date: 04-15-04	SR-IL-VII-3 Effective Date: 04-15-05
SR-IL-VII-4 Effective Date: 04-15-04	SR-IL-VII-4 Effective Date: 04-15-05
SR-IL-VII-5 Effective Date: 04-15-04	SR-IL-VII-5 Effective Date: 04-15-05
SR-IL-VIII-1 Effective Date: 04-15-04	SR-IL-VIII-1 Effective Date: 04-15-05
SR-IL-VIII-2 Effective Date: 04-15-04	SR-IL-VIII-2 Effective Date: 04-15-05
SR-IL-VIII-3 Effective Date: 04-15-04	SR-IL-VIII-3 Effective Date: 04-15-05
SR-IL-VIII-4 Effective Date: 04-15-04	SR-IL-VIII-4 Effective Date: 04-15-05
SR-IL-VIII-5 Effective Date: 04-15-04	SR-IL-VIII-5 Effective Date: 04-15-05
SR-IL-VIII-6 Effective Date: 04-15-04	SR-IL-VIII-6 Effective Date: 04-15-05
SR-IL-IX-1 Effective Date: 04-15-04	SR-IL-IX-1 Effective Date: 04-15-05
SR-IL-IX-2 Effective Date: 04-15-04	SR-IL-IX-2 Effective Date: 04-15-05
SR-IL-IX-3 Effective Date: 04-15-04	SR-IL-IX-3 Effective Date: 04-15-05
SR-IL-IX-4 Effective Date: 04-15-04	SR-IL-IX-4 Effective Date: 04-15-05

Withdrawn Pages: None

New Pages added not replacing any previously filed page: None

THE MEDICAL PROTECTIVE COMPANY

RATE AND RULE MANUAL

ILLINOIS

HEALTH CARE FACILITIES

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 coverage for Health Care Facilities.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. ELIGIBILITY

For the purpose of these rules, health care facilities shall be defined as entities such as hospitals and other health care organizations, identified in the classification schedule, as well as individual health care providers including, but not limited to, employed physicians, surgeons, residents, dentists and ancillary personnel which meet the Company's underwriting guidelines.

III. BASIC LIMITS OF LIABILITY

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

A. Occurrence Coverage

$200,000 Each Health Care Occurrence
$600,000 Aggregate

B. Claims-Made Coverage

$200,000 Each Health Care Occurrence
$600,000 Aggregate

IV. PREMIUM COMPUTATION

A. Basic Limits Premium

Basic limits premium is computed by first multiplying the basic limits rates in effect at policy inception by exposures for beds, visits and ancillary services (if any). Next, charges for additional exposures are calculated under the rules in sections B through H below. The sum of the premium for all such charges shall be further modified by an experience and schedule rating modification factor and then by the applicable increase limits factor. *The sum of the premiums may be adjusted to a net of commission basis to provide for the appropriate brokerage expense associated with the particular facility.*

B. Employee Coverage

All employees not rated separately will be covered for a charge of 10% of the premium developed for beds and visits.

C. Employed Physicians, Surgeons and Dentists

The base rates used for employed physicians, surgeons and dentists will be those filed by MPCo for its individual professional liability programs. Different modification factors will be applied to that rate depending on whether a shared limit of liability or a separate limit of liability is provided. Refer to state rate pages.

1. Rates are filed for each class of physician and dentist. Determine the class from the Physician and Surgeons or Dentists Classification Schedule. If two or more classes apply to the same individual, apply the highest-rated class.

2. Determine the number of exposures for each classification. If a shared limit is provided, this is done by counting each full time employed physician or dentist as one. Part time physicians or dentists are counted by the average number of hours worked each week divided by 40. In no case will a part time physician or dentist ever count for more than one FTE.

   If a separate limit is provided each physician, surgeon and dentist will count as one exposure.

3. Multiply the rate for the appropriate rating territory for each classification in 1. above by the total number of exposures for each classification, and multiply that result by the appropriate modification (separate/shared) factor.

D. Contract Physicians, Surgeons and Dentists

Contract physicians, surgeons and dentists can be covered under the same rules as employed physicians, surgeons and dentists.

E. Residents (PGY-2 and above)

Residents shall be rated under the same rules as employed physicians, surgeons and dentists with an appropriate modification factor. Refer to state rate pages.

F. Interns (PGY-1)

There will be no additional charge for employed interns.

G. Ancillary Personnel

1. Certified Registered Nurse Anesthetists (CRNA's) will be charged the base rate used by MPCo for its individual CRNA programs, with an appropriate modification factor. Refer to state rate pages.

2. Nurse Midwives will be charged the base rate used by MPCo for its individual Nurse Midwives programs, with an appropriate modification factor. Refer to state rate pages.

H. Faculty/Teaching

Faculty/Teaching physicians, surgeons and dentists will be rated under the same rules as employed physicians, surgeons and dentists with an appropriate modification factor. Refer to state rate pages.

I. Underlying Insurance

All rating rules will remain the same, for excess limits of insurance, whether the underlying coverage is provided by MPCo or another insurance carrier.

V. CLASSIFICATIONS

A. The basis of premium for each manual classification is defined below and the unit of exposure indicated.

1. "Beds" mean the daily average number of occupied beds used by patients during the policy period. This number is determined by dividing total patient days by 365 days for each class of bed. The unit of exposure is an "occupied bed".

2. "Visits" mean the total number of visits to any covered facilities by outpatients (patients not receiving bed and board services) during the policy period. The unit of exposure is "each 100 visits".

3. "Employed physicians, surgeons and dentists" are those health care providers regularly employed by a facility who receive reimbursement for services from the facility and not from patients. The unit of exposure for a shared limit of liability is "per full-time equivalent person" computed by dividing the number of hours worked per week by 40. A full-time employee's "full-time equivalent" should be equal to one. The unit of exposure for a separate limit of liability is "per person".

4. "Contract physicians, surgeons and dentists " are those physicians under contract with a facility to provide professional services to patients of that facility. The unit of exposure is the same as employed physicians.

5. "Residents" are second-year or above postgraduate (PGY-2 and above) students. The unit of exposure is the same as employed physicians, surgeons and dentists.

6. "Interns" are first-year postgraduate (PGY-1) students. There will be no additional charge for such persons.

7. "Faculty/teaching physicians" are those employed or contracted physicians whose primary responsibility is to provide instruction in an authorized training program in the health professions. The unit of exposure is the same as employed physicians, surgeons and dentists.

8. "Ancillary Employees" means any employed allied health care providers specified in the state exception pages as chargeable exposures. The unit of exposure is "per full-time equivalent person" computed by dividing the number of hours worked per week by part-time employees by 40. A full-time employee's "full-time equivalent" shall be equal to one.

9. "Ancillary Services" means any one of the following services provided to non-related entities or persons, other than patients, at covered facilities: wellness and fitness centers, and pharmacies. The unit of exposure is "$1000 of annual revenue".

VI. PREMIUM MODIFICATIONS

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

A. Experience Rating

1. Eligibility

   The term "risk" as used in this plan, means the exposures of any one (or more) insured facilities which is to be rated. Allied or subsidiary risks may be included if the insured holds a majority financial interest therein and the allied or subsidiary risks are being insured under the policy being rated.

2. Experience Used

   The experience rating plan uses the latest complete five years of experience for the facility being rated. Experience incurred by carriers other than MPCo, or self-insured experience, may be used subject to the time frame described above, and given credence in accordance with its apparent reliability and verifiability.

3. Determination of Experience Modifier

a. Basic Limits Premium

The term "basic limits premium" is defined as follows for experience rating purposes:

The premium developed for all facility liability exposures, including ancillary personnel, ancillary services, employed physicians, surgeons and dentists, additional insureds, and standard general liability.

b. Basic Limits Premium Subject to Experience Rating

The basic limits premium subject to experience rating (subject premium) is the policy period premium at present rates as defined in 3.a, detrended or otherwise adjusted and then summed for all experience years. This value is used in 3.e to calculate the "actual loss ratio".

c. Bed Equivalent Exposures

Bed equivalent exposures is the measure of the size of the facility, and will be used to determine the risk's Credibility and Adjusted Expected Loss Ratio (AELR) from the experience rating table. Bed equivalent exposures are calculated by dividing the average of the latest five years premium used for experience rating for the current policy period as described in 3.b by the basic limits acute care bed rate.

d. Losses Subject to Experience Rating

All paid and outstanding losses and Allocated Loss Adjustment Expense (ALE) for the experience period, adjusted according to the following provisions:

i. Loss Development

Paid loss and ALE will not be subject to loss development. Outstanding loss and ALE may be from other insurance carriers or MPCo and consideration must be given to the expected case development patterns of other carriers. These patterns vary from carrier to carrier. MPCo will determine the appropriate factors based on its analysis of rate filings, annual statements, and any other public information which may be available.

ii. Loss Limitation

After the individual losses are developed, each loss will be subject to limitation by the Maximum Single Loss Amount (MSL). The MSL is the lesser of the premium as developed in 3.a, or the limits used in experience rating premium. Loss amounts greater than the MSL will be loaded into the rating plan at the amount of the MSL.

iii. IBNR for Occurrence Policies

If the present policy and the experience are on an occurrence basis, the amount will be loaded for IBNR losses and ALE. This load will be a function of the detrended premium for the experience periods and will decrease for the less recent experience periods.

e. Actual Loss Ratio

The actual loss ratio for the risk is determined by dividing the losses subject to experience rating in 3.d by the subject premium for experience rating in 3.b. This calculation yields a single average loss ratio for all years in the experience period.

f. Adjusted Expected Loss Ratio and Credibility

These values are obtained from the table by using the number of bed equivalent exposures calculated in 3.c.

g. Experience Modifier

The experience modifier is calculated as follows:

$$\text{Credibility} \times \frac{(\text{Actual loss ratio} - \text{AELR})}{\text{AELR}} = \text{Experience Modifier}$$

If the experience modifier is negative, it is a credit. If positive, it is a debit. The maximum credit under this plan will be 50% and the maximum debit will be 100%. This credit or debit will be multiplied by the amount of schedule credit or debit from the schedule rating plan, and that result will be the percentage by which the basic limits premium must be adjusted to arrive at the final basic limits premium for the risk.

B. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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.

C. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Deductibles shall be offered to qualified insureds.

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 occurrence deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate deductible limit.

1. 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 occurrence SIR limit.

      ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

GENERAL LIABILITY

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 General Liability and Employee Benefits Liability coverage for Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

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

A. Occurrence Coverage

$200,000 Each Occurrence
$600,000 Aggregate

B. Claims-Made Coverage

$200,000 Each Occurrence
$600,000 Aggregate

III. PREMIUM COMPUTATION

A. General Liability

1. The standard General Liability premium will be a percentage of the PL premium, at the corresponding limit, developed for the corresponding health care provider(s). Refer to the state rate pages to determine the percentage applicable.

2. The standard General Liability premium may be subject to an additional charge if the insured elects to include *Employer's Liability or* Patients' Property Liability or increase the sublimits for the other miscellaneous coverages. Refer to the state rate pages to determine the specific premium charge for the following miscellaneous coverages:

   i. Employer's Liability

   ii. Fire Damage Legal Liability

   iii. Medical Payments

   iv. Patients' Property Liability

B. Employee Benefits Liability

Refer to the state rate pages to determine the specific premium charge.

IV. CLASSIFICATIONS

General Liability and Employee Benefits Liability coverage shall be classified in accordance with the following types of health care providers:

A. Corporations, Partnerships and Associations

B. Physicians and Surgeons

C. Dentists

D. Allied Health Care Providers

E. Health Care Facilities.

V. PREMIUM MODIFICATIONS

A. General Liability Exposure Modification Table

1. The standard General Liability (GL) premium will be a percentage (see state rate pages) of the corresponding Professional Liability (PL) premium, subject to specific considerations identified on the State Rate Pages.

2. The GL exposure modifier will be subject to the maximum modification shown on the State Rate Pages. This modifier will be applied to the percentage rate to arrive at the standard GL charge.

B. Experience Rating

1. The standard General Liability premium shall be subject to an Experience Modifier based upon the modifier derived in the determination of the corresponding PL premium.

2. Refer to the applicable health care provider section to determine applicability.

C. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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 applicable schedule of modifications may be found in the State Rate Pages for the corresponding health care providers.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Deductibles shall be offered to qualified insureds.

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 occurrence deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate deductible limit.

e. The applicable deductible credit schedule may be found in the State Rate Pages for the corresponding health care providers.

1. 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 occurrence SIR limit.

      ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

   e. The applicable SIR credit schedule may be found in the State Rate Pages for the corresponding health care providers.

MANAGED CARE

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 errors and omissions liability coverage for Managed Care Entities.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. MANAGED CARE ENTITIES

For the purpose of these rules, Managed Care Entities (MCE) shall be defined as entities created to integrate the financing and delivery of health care services by means of contracts with selected health care providers to a population of enrolled members. Some examples of these entities are health maintenance organizations, preferred provider organizations and exclusive provider organizations.

III. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for coverage, unless modified on a state exception basis, under this program shall be:

A. Claims-Made Coverage

$200,000 Each Managed Care Occurrence
$600,000 Aggregate

IV. PREMIUM COMPUTATION

A. Exposure Unit

"Enrollees" means the average number of insured persons enrolled by the MCE during the policy period on an annualized basis. The unit of exposure is "100 enrollees".

From time to time, MCE's may contract to provide services for non-owned entities on a third party administration (TPA) basis. In the event that coverage is provided for an MCE performing TPA services for a non-owned entity, the enrollee count of that non-owned entity will be modified for the level of service being provided by the insured MCE. The enrollee count will be modified by the exposure adjustment factor, which is the sum of the adjustment factors for each of five categories of services provided. The following table identifies the adjustment factors for each of the five categories of service.

Utilization Review	45%	Business Services	10%
Peer Review and Credentialing	45%	Business Consulting	10%
Claims Handling	20%		

The number of enrollees, for rating purposes of a non-owned entity, will be the enrollees times the sum of the applicable exposure adjustment factors.

B. Basic Limits Premium

Basic limits premium is computed by first multiplying the basic limits rates in effect at policy inception by the number of enrollees. Next, the premium shall be modified by a schedule rating modification factor and then by the applicable increased limits factor.

C. Underlying Insurance

All rating rules will remain the same for excess limits of insurance, whether the underlying coverage is provided by MPCo or another insurance carrier.

V. CLASSIFICATIONS

A. Health Maintenance Organizations (HMO's)

For the purpose of these rules, an HMO shall be defined as an entity which accepts a fixed amount from an employer or the government per covered person to provide all the benefits the person's plan contains. All other managed care organizations will be rated as non-HMO's.

VI. PREMIUM MODIFICATIONS

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

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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 on the State Rate Pages.

B. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Deductibles shall be offered to qualified insureds.

   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 occurrence deductible limit.

      ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% 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 occurrence SIR limit.

      ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

POLLUTION LIABILITY

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 Pollution Liability for Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. ELIGIBILITY

Eligibility is limited to health care providers which meet MPCo's underwriting guidelines.

III. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Liability Coverage under this program shall be:

A. Claims-Made Coverage

$200,000 Each Pollution Occurrence
$200,000 Aggregate

IV. PREMIUM COMPUTATION

A. Pollution Liability premium will be a percentage of the Professional Liability (PL) premium developed for the applicable health care provider. Refer to State Rate Pages to determine the percentage applicable.

B. Basic Limits Premium

Basic limits premium is computed by multiplying the PL premium at basic limits rates by the appropriate premium percentage. Next, the premium shall be modified by a schedule rating modification factor and then by the applicable increased limits factor.

V. CLASSIFICATIONS

Pollution Liability coverage shall be classified in accordance with the following types of health care providers:

A. Corporations, Partnerships and Associations

B. Physicians and Surgeons

C. Dentists

D. Allied Health Care Providers

E. Health Care Facilities.

VI. PREMIUM MODIFICATIONS

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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. Retention Amounts

1. A minimum $5,000 retention is required for all insureds.

2. A higher retention amount may be elected by the insured. Retention amounts can only be revised at policy renewal.

3. The retention amounts shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

   a. The retention amounts are expressed as a function of the per occurrence retention limit.

   b. The credits assume no aggregate limit on the retention amount.

CHANGES MADE

TO

ILLINOIS RATE AND RULE MANUAL

FILING NO. RFF-05-00758

3. Increased Limits Factors

Limits ($000)	Factor
200/600	1.000
1000/1000	1.704
1000/3000	1.893

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor PL Relativity
0	0.50
1	0.75
2	0.90
3	0.95
Mature	1.00
CM to Occ Relativity	0.93

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor PL Relativity
1	0.80
2	1.25
3	1.85
4	2.00
Mature	2.00

6. Prior Acts Nose Coverage

Years Retro. Date Precedes Inception Date	Factor Based on the Occurrence Rate
1	0.61
2	0.92
3	1.05
4	1.25
Mature	1.35

7. Additional limits of liability

Not Applicable

3. Increased Limits Factors

Limits ($000)	Factor
200/600	1.000
1000/1000	1.440
1000/2000	1.584
1000/3000	1.600

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor PL Relativity
0	0.50
1	0.75
2	0.90
3	0.95
Mature	1.00
CM to Occ Relativity	0.93

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor PL Relativity
1	0.70
2	1.15
3	1.50
4	1.70
Mature	1.80

6. Prior Acts Nose Coverage

Years Retro. Date Precedes Inception Date	Factor Based on the Occurrence Rate
1	0.61
2	0.92
3	1.05
4	1.25
Mature	1.35

7. Additional limits of liability

Not Applicable

Approved by
SR-IL-VI-3
4-15-05

B. Manual Rates

1. Territory Definitions

Rating Area	Relativity
Area 1 - Cook, Lake, Madison, St. Clair, & Will counties	3.000
Area 2 - Jackson, Vermillion, DuPage, Kane, & McHenry counties	1.750
Area 3 - Champaign, Kankakee, Macon, Sangamon, Winnebego	1.400
Area 4 - Remainder of State	1.000

2. HPL Premium Basis

a. Occurrence Program

Acute Care Bed Rate at $200,000/$600,000: $1,290

b. Standard Claims-Made Program

Acute Care Bed Rate at $200,000/$600,000: $1,200

c. Classification Relativity Factors:

Classification	Relativity
Acute Care Beds	1.0000
Bassinets	1.0000
Maternity Beds	1.0000
Neo Natal Beds	1.2000
Psychiatric Beds	0.7500
Chemical Dependency and Rehabilitation Beds	0.2500
Long Term Care Beds	0.2000
Births	0.0400
Inpatient Surgeries	0.0180
Per 100 Visits:	
Outpatient Surgeries	0.4500
ER Visits - Employed Physicians	0.2000
ER Visits - Contracted Physicians with appropriate limits	0.2000
Clinic Visits	0.0500
Home Health Visits	0.0250
Psychiatric Visits	0.0380
Wellness Center Visits	0.0050
All Other Outpatient Visits	0.0500
Ancillary Services (Per (000's) annual revenue)	
Pharmacies	0.0010
Wellness and Fitness Centers	0.0010

B. Manual Rates

1.

Territory Definitions	Relativity
Area 1 - Cook, Madison, St. Clair, & Will counties	3.00
Area 2 - Lake, Jackson, Vermillion, DuPage, Kane, & McHenry counties	1.75
Area 3 - Remainder of State	1.00

2. HPL Premium Basis

a. Occurrence Program

Acute Care Bed Rate at $200,000/$600,000: $1,290

b. Standard Claims-Made Program

Acute Care Bed Rate at $200,000/$600,000: $1,200

c. Classification Relativity Factors:

Classification	Relativity
Acute Care Beds	1.0000
Bassinets	1.0000
Maternity Beds	1.0000
Neo Natal Beds	1.2000
Psychiatric Beds	0.7500
Chemical Dependency and Rehabilitation Beds	0.2500
Long Term Care Beds	0.2000
Births	0.0400
Inpatient Surgeries	0.0180
Per 100 Visits:	
Outpatient Surgeries	0.4500
ER Visits - Employed Physicians	0.2000
ER Visits - Contracted Physicians with appropriate limits	0.2000
Clinic Visits	0.0500
Home Health Visits	0.0250
Psychiatric Visits	0.0380
Wellness Center Visits	0.0050
All Other Outpatient Visits	0.0500
Ancillary Services (Per (000's) annual revenue)	
Pharmacies	0.0010
Wellness and Fitness Centers	0.0010

Replaced by SR-IL-VI-2 04-15-05

D. Premium Modifications

1. Experience Rating Plan

TABLE OF ADJUSTED EXPECTED LOSS RATIOS AND CREDIBILITY

BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES**	AELR *	CREDIBILITY
10 - 11	21.26%	10.25%	49 - 50	44.29%	22.25%	88 - 89	55.07%	29.75%
11 - 12	22.22%	10.72%	50 - 51	44.67%	22.47%	89 - 90	55.26%	29.92%
12 - 13	23.14%	11.18%	51 - 52	45.05%	22.69%	90 - 91	55.44%	30.08%
13 - 14	24.02%	11.62%	52 - 53	45.42%	22.91%	91 - 92	55.62%	30.25%
14 - 15	24.87%	12.04%	53 - 54	45.78%	23.13%	92 - 93	55.79%	30.41%
15 - 16	25.69%	12.45%	54 - 55	46.14%	23.35%	93 - 94	55.96%	30.58%
16 - 17	26.48%	12.85%	55 - 56	46.49%	23.56%	94 - 95	56.13%	30.74%
17 - 18	27.24%	13.23%	56 - 57	46.83%	23.77%	95 - 96	56.29%	30.90%
18 - 19	27.98%	13.60%	57 - 58	47.17%	23.98%	96 - 97	56.46%	31.06%
19 - 20	28.70%	13.96%	58 - 59	47.50%	24.19%	97 - 98	56.61%	31.23%
20 - 21	29.40%	14.32%	59 - 60	47.83%	24.39%	98 - 99	56.77%	31.38%
21 - 22	30.08%	14.66%	60 - 61	48.15%	24.60%	99 - 100	56.92%	31.54%
22 - 23	30.75%	15.00%	61 - 62	48.46%	24.80%	100 - 105	57.36%	32.02%
23 - 24	31.40%	15.33%	62 - 63	48.77%	25.00%	105 - 110	58.03%	32.79%
24 - 25	32.03%	15.65%	63 - 64	49.07%	25.20%	110 - 115	58.64%	33.54%
25 - 26	32.65%	15.97%	64 - 65	49.37%	25.40%	115 - 120	59.20%	34.28%
26 - 27	33.25%	16.28%	65 - 66	49.66%	25.59%	120 - 125	59.70%	35.00%
27 - 28	33.84%	16.58%	66 - 67	49.95%	25.79%	125 - 130	60.15%	35.71%
28 - 29	34.42%	16.88%	67 - 68	50.23%	25.98%	130 - 135	60.56%	36.40%
29 - 30	34.98%	17.18%	68 - 69	50.51%	26.17%	135 - 140	60.94%	37.08%
30 - 31	35.54%	17.46%	69 - 70	50.78%	26.36%	140 - 145	61.28%	37.75%
31 - 32	36.08%	17.75%	70 - 71	51.04%	26.55%	145 - 150	61.58%	38.41%
32 - 33	36.61%	18.03%	71 - 72	51.31%	26.74%	150 - 160	62.00%	39.37%
33 - 34	37.13%	18.30%	72 - 73	51.56%	26.93%	160 - 170	62.46%	40.62%
34 - 35	37.65%	18.57%	73 - 74	51.82%	27.11%	170 - 180	62.85%	41.83%
35 - 36	38.15%	18.84%	74 - 75	52.06%	27.29%	180 - 190	63.18%	43.01%
36 - 37	38.64%	19.10%	75 - 76	52.30%	27.48%	190 - 200	63.46%	44.16%
37 - 38	39.12%	19.36%	76 - 77	52.54%	27.66%	200 - 225	63.85%	46.10%
38 - 39	39.60%	19.62%	77 - 78	52.78%	27.84%	225 - 250	64.25%	48.73%
39 - 40	40.07%	19.87%	78 - 79	53.01%	28.02%	250 - 275	64.53%	51.23%
40 - 41	40.52%	20.12%	79 - 80	53.23%	28.20%	275 - 300	64.73%	53.62%
41 - 42	40.97%	20.37%	80 - 81	53.45%	28.37%	300 - 400	65.04%	59.16%
42 - 43	41.41%	20.62%	81 - 82	53.67%	28.55%	400 - 500	65.26%	67.08%
43 - 44	41.85%	20.86%	82 - 83	53.88%	28.72%	500 - 600	65.36%	74.16%
44 - 45	42.27%	21.10%	83 - 84	54.09%	28.90%	600 - 700	65.41%	80.62%
45 - 46	42.69%	21.33%	84 - 85	54.29%	29.07%	700 - 800	65.44%	86.60%
46 - 47	43.10%	21.56%	85 - 86	54.49%	29.24%	800 - 900	65.46%	92.20%
47 - 48	43.50%	21.79%	86 - 87	54.69%	29.41%	900 - 1,000	65.47%	97.47%
48 - 49	43.90%	22.02%	87 - 88	54.88%	29.58%	1,000 +	65.50%	100.00%

NOTES :

* AELR is the adjusted expected loss ratio.

** This is the average number of bed equivalent exposures for the latest five policy years.

D. Premium Modifications

1. Experience Rating Plan

TABLE OF ADJUSTED EXPECTED LOSS RATIOS AND CREDIBILITY

BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES**	AELR *	CREDIBILITY
10 - 11	22.53%	10.25%	49 - 50	46.93%	22.25%	88 - 89	58.35%	29.75%
11 - 12	23.55%	10.72%	50 - 51	47.33%	22.47%	89 - 90	58.55%	29.92%
12 - 13	24.52%	11.18%	51 - 52	47.73%	22.69%	90 - 91	58.74%	30.08%
13 - 14	25.45%	11.62%	52 - 53	48.12%	22.91%	91 - 92	58.93%	30.25%
14 - 15	26.35%	12.04%	53 - 54	48.51%	23.13%	92 - 93	59.11%	30.41%
15 - 16	27.22%	12.45%	54 - 55	48.88%	23.35%	93 - 94	59.29%	30.58%
16 - 17	28.05%	12.85%	55 - 56	49.25%	23.56%	94 - 95	59.47%	30.74%
17 - 18	28.86%	13.23%	56 - 57	49.62%	23.77%	95 - 96	59.65%	30.90%
18 - 19	29.65%	13.60%	57 - 58	49.98%	23.98%	96 - 97	59.82%	31.06%
19 - 20	30.41%	13.96%	58 - 59	50.33%	24.19%	97 - 98	59.98%	31.23%
20 - 21	31.15%	14.32%	59 - 60	50.67%	24.39%	98 - 99	60.15%	31.38%
21 - 22	31.88%	14.66%	60 - 61	51.01%	24.60%	99 - 100	60.31%	31.54%
22 - 23	32.58%	15.00%	61 - 62	51.35%	24.80%	100 - 105	60.77%	32.02%
23 - 24	33.27%	15.33%	62 - 63	51.67%	25.00%	105 - 110	61.49%	32.79%
24 - 25	33.94%	15.65%	63 - 64	51.99%	25.20%	110 - 115	62.14%	33.54%
25 - 26	34.59%	15.97%	64 - 65	52.31%	25.40%	115 - 120	62.72%	34.28%
26 - 27	35.23%	16.28%	65 - 66	52.62%	25.59%	120 - 125	63.25%	35.00%
27 - 28	35.85%	16.58%	66 - 67	52.92%	25.79%	125 - 130	63.73%	35.71%
28 - 29	36.47%	16.88%	67 - 68	53.22%	25.98%	130 - 135	64.17%	36.40%
29 - 30	37.07%	17.18%	68 - 69	53.51%	26.17%	135 - 140	64.57%	37.08%
30 - 31	37.65%	17.46%	69 - 70	53.80%	26.36%	140 - 145	64.93%	37.75%
31 - 32	38.23%	17.75%	70 - 71	54.08%	26.55%	145 - 150	65.25%	38.41%
32 - 33	38.79%	18.03%	71 - 72	54.36%	26.74%	150 - 160	65.69%	39.37%
33 - 34	39.35%	18.30%	72 - 73	54.63%	26.93%	160 - 170	66.18%	40.62%
34 - 35	39.89%	18.57%	73 - 74	54.90%	27.11%	170 - 180	66.60%	41.83%
35 - 36	40.42%	18.84%	74 - 75	55.16%	27.29%	180 - 190	66.94%	43.01%
36 - 37	40.94%	19.10%	75 - 76	55.42%	27.48%	190 - 200	67.24%	44.16%
37 - 38	41.45%	19.36%	76 - 77	55.67%	27.66%	200 - 225	67.65%	46.10%
38 - 39	41.96%	19.62%	77 - 78	55.92%	27.84%	225 - 250	68.08%	48.73%
39 - 40	42.45%	19.87%	78 - 79	56.16%	28.02%	250 - 275	68.37%	51.23%
40 - 41	42.94%	20.12%	79 - 80	56.40%	28.20%	275 - 300	68.59%	53.62%
41 - 42	43.41%	20.37%	80 - 81	56.63%	28.37%	300 - 400	68.92%	59.16%
42 - 43	43.88%	20.62%	81 - 82	56.86%	28.55%	400 - 500	69.15%	67.08%
43 - 44	44.34%	20.86%	82 - 83	57.09%	28.72%	500 - 600	69.25%	74.16%
44 - 45	44.79%	21.10%	83 - 84	57.31%	28.90%	600 - 700	69.31%	80.62%
45 - 46	45.23%	21.33%	84 - 85	57.52%	29.07%	700 - 800	69.34%	86.60%
46 - 47	45.67%	21.56%	85 - 86	57.74%	29.24%	800 - 900	69.35%	92.20%
47 - 48	46.09%	21.79%	86 - 87	57.95%	29.41%	900 - 1,000	69.37%	97.47%
48 - 49	46.51%	22.02%	87 - 88	58.15%	29.58%	1,000 +	69.40%	100.00%

NOTES :

* AELR is the adjusted expected loss ratio.

** This is the average number of bed equivalent exposures for the latest five policy years.

Replaced by SR-IL-VI-5 04-15-05

3. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.5%
10,000	10.3%	13.8%
25,000	17.9%	22.9%
50,000	28.7%	36.1%
100,000	42.2%	53.9%
250,000	61.6%	83.5%
300,000	66.4%	88.3%

Notes:

a) The deductible amount applies per health care occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

b) Deductibles shall apply to indemnity only or to indemnity and defense costs.

c) Once a deductible is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower deductible.

d) Deductible amounts not shown will be interpolated using standard actuarial techniques.

3. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.1%
10,000	9.6%	12.1%
25,000	16.4%	22.1%
50,000	25.6%	32.8%
100,000	36.2%	50.8%
250,000	57.6%	74.0%
300,000	60.2%	76.8%

Notes:

a) The deductible amount applies per health care occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

b) Deductibles shall apply to indemnity only or to indemnity and defense costs.

c) Once a deductible is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower deductible.

d) Deductible amounts not shown will be interpolated using standard actuarial techniques.

4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	59.4%
200,000	72.3%
250,000	86.8%
300,000	92.0%

Notes:

a) The SIR amount applies per health care occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

b) SIR's shall apply to indemnity and defense costs.

c) Once a SIR is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower SIR.

d) SIR amounts not shown will be interpolated using standard actuarial techniques.

4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	54.6%
200,000	67.8%
250,000	74.4%
300,000	76.5%

Notes:

a) The SIR amount applies per health care occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

b) SIR's shall apply to indemnity and defense costs.

c) Once a SIR is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower SIR.

d) SIR amounts not shown will be interpolated using standard actuarial techniques.

Replaced by SR-IL-VI-7 04-15-03

B. Manual Rates

1. Territory Definitions

Rating Area	Relativity
Area 1 - Refer to Healthcare Facilities	2.915
Area 2 - Refer to Healthcare Facilities	1.848
Area 3 - Refer to Healthcare Facilities	1.530
Area 4 - Refer to Healthcare Facilities	1.000

2. MCO Premium Basis (Standard Claims-Made Program)

a. Non-HMO Basic Limits Rate per 100 Enrollees: $68.85

b. HMO Relativity Factor 1.75

3. Increased Limits Factors

Limits	Factor
200,000/600,000	1.000
1,000,000/1,000,000	1.537
2,000,000/2,000,000	1.777
3,000,000/3,000,000	1.906
4,000,000/4,000,000	1.989
5,000,000/5,000,000	2.061

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor
0	0.500
1	0.750
2	0.900
3	0.950
Mature	1.000

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor
1	0.800
2	1.250
3	1.850
4	2.000
Mature	2.000

B. Manual Rates

1. Territory Definitions

Refer to Healthcare Facilities

2. Standard Claims Made Program

a. HMO's

	Area 1	Area 2	Area 3
Basic Limit Rates per 100 Enrollees	329.66	202.50	123.46

b. All Other

	Area 1	Area 2	Area 3
Basic Limit Rates per 100 Enrollees	188.38	115.71	70.55

3. Increased Limits Factors

Limits	Factor
200,000/600,000	1.000
1,000,000/1,000,000	1.440

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor
0	0.500
1	0.750
2	0.900
3	0.950
Mature	1.000

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor
1	0.700
2	1.150
3	1.500
4	1.700
Mature	1.800

Approved by
SR-IL-VIII-2
04-15-05

2. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.5%
10,000	10.3%	13.8%
25,000	17.9%	22.9%
50,000	28.7%	36.1%
100,000	42.2%	53.9%
250,000	61.6%	83.5%
300,000	66.4%	88.3%

Notes:

a) The coverage is claims made. Once a deductible is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower deductible.

b) Deductibles shall apply to indemnity only or to indemnity and defense costs.

c) Deductible credits apply to the basic limits premium.

d) The deductible amount applies per occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

e) Deductible amounts not shown will be interpolated using standard actuarial techniques.

2. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.1%
10,000	9.6%	12.1%
25,000	16.4%	22.1%
50,000	25.6%	32.8%
100,000	36.2%	50.8%
250,000	57.6%	74.0%
300,000	60.2%	76.8%

Notes:

a) The coverage is claims made. Once a deductible is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower deductible.

b) Deductibles shall apply to indemnity only or to indemnity and defense costs.

c) Deductible credits apply to the basic limits premium.

d) The deductible amount applies per occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

e) Deductible amounts not shown will be interpolated using standard actuarial techniques.

Replaced by SR-IL-VIII-5 04-15-03

4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	59.4%
200,000	72.3%
250,000	86.8%
300,000	92.0%

Notes:

a) The coverage is claims made. Once an SIR is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower SIR.

b) SIR's shall apply to indemnity and defense costs.

c) SIR credits apply to the basic limits premium.

d) The SIR amount applies per occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

e) SIR amounts not shown will be interpolated using standard actuarial techniques.

4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	54.6%
200,000	67.8%
250,000	74.4%
300,000	76.5%

Notes:

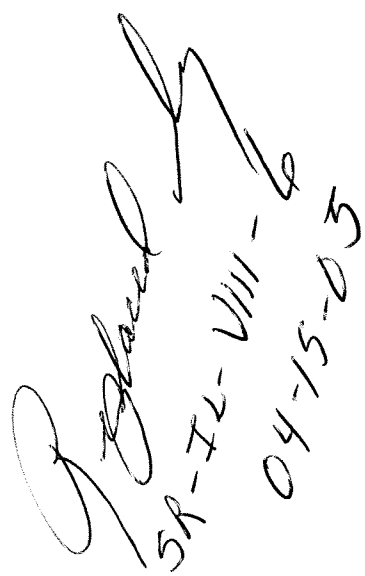
a) The coverage is claims made. Once an SIR is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower SIR.

b) SIR's shall apply to indemnity and defense costs.

c) SIR credits apply to the basic limits premium.

d) The SIR amount applies per occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

e) SIR amounts not shown will be interpolated using standard actuarial techniques.



e. Loss Activity

Considerations	Max. Credit	Max. Debit
Governmental sanctions or claims	25%	25%
Loss experience	25%	25%
Unreported claims, such as voluntary cleanup	10%	10%

f. Maximum Modification: 50%

2. Retention Amounts

Retention Amount		Credit Applicable to the 200/600 Limits Premium
Per Pollution Occurrence	Aggregate	
5,000	none	0.0%
10,000	none	12.1%
25,000	none	22.1%

Notes:

a) The coverage is claims made. Once a retention is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower retention.

b) Retention amounts include both indemnity and allocated loss adjustment expense.

c) Retention credits apply to the basic limits premium.

d) Retention amounts not shown will be interpolated using standard actuarial techniques.

SR-IX-4
04-15-05

EXHIBIT "B"

Illinois – Certification of Rates

The Medical Protective Company's Hospital Facilities rates are based on sound actuarial principles and are not inconsistent with The Medical Protective Company's or industry's experience. The Medical Protective Company does not unfairly discriminate in offering or administering this program.

Certified Actuary:

Jason Martin, FCAS, MAAA
Healthcare Actuary

Signature

Company Officer:

William E. Daley
Senior Vice President

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor (based on CM)
1	0.800
2	1.250
3	1.850
4	2.000
Mature	2.000

C. Policy Writing Minimum Premium

POL	$1,500

D. Premium Modifications

1. Schedule Rating Plan

a. Risk Management/QA/Loss Control Program

Considerations	Max. Credit	Max. Debit
Existence of an environmental safety program	10%	10%
Required safety features in place (pollution controls)	10%	10%
Preventative equipment maintenance (oil tanks/gas cylinders) by outside contractors	10%	10%
Risk assessment previously conducted:		
Five or more years ago	0%	5%
Two or more years ago	5%	0%

b. Incinerators

Considerations	Max. Credit	Max. Debit
Incineration of medical waste for others	0%	25%

c. Disposal of Waste

Considerations	Max. Credit	Max. Debit
On site disposal of waste	0%	15%
Off site disposal of waste	15%	0%

d. Storage Tanks

Considerations	Max. Credit	Max. Debit
Above ground storage tanks filled with hazardous materials	10%	10%

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor (based on CM)
1	0.700
2	1.150
3	1.500
4	1.700
Mature	1.800

Replaced by SR-IL-IX-3 04-15-09

C. Policy Writing Minimum Premium

POL	$500

D. Premium Modifications

1. Schedule Rating Plan

a. Risk Management/QA/Loss Control Program

Considerations	Max. Credit	Max. Debit
Existence of an environmental safety program	10%	10%
Required safety features in place (pollution controls)	10%	10%
Preventative equipment maintenance (oil tanks/gas cylinders) by outside contractors	10%	10%
Risk assessment previously conducted:		
Five or more years ago	0%	5%
Two or more years ago	5%	0%

b. Incinerators

Considerations	Max. Credit	Max. Debit
Incineration of medical waste for others	0%	25%

c. Disposal of Waste

Considerations	Max. Credit	Max. Debit
On site disposal of waste	0%	15%
Off site disposal of waste	15%	0%

d. Storage Tanks

Considerations	Max. Credit	Max. Debit
Above ground storage tanks filled with hazardous materials	10%	10%

e. Loss Activity

Considerations	Max. Credit	Max. Debit
Governmental sanctions or claims	25%	25%
Loss experience	25%	25%
Unreported claims, such as voluntary cleanup	10%	10%

f. Maximum Modification: 50%

2. Retention Amounts

Retention Amount		Credit Applicable to the 200/600 Limits Premium
Per Pollution Occurrence	Aggregate	
5,000	none	0.0%
10,000	none	13.8%
25,000	none	22.9%

Notes:

a) The coverage is claims made. Once a retention is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower retention.

b) Retention amounts include both indemnity and allocated loss adjustment expense.

c) Retention credits apply to the basic limits premium.

d) Retention amounts not shown will be interpolated using standard actuarial techniques.

Melissa.Coker@ge.com
08/05/2004 01:12 PM

To Gayle_Neuman@ins.state.il.us
cc
bcc
Subject RE: Rate/Rule Filing 04-IL-63 - IL Physicians & Surgeons

Dear Ms. Neuman:

Please find attached an updated spreadsheet to reflect the revisions to the Physicians & Surgeons filing for your review. After another review of the spreadsheet, we found several items that needed amending.

Please let me know if you should have any additional questions regarding the attachment.

Thank you,

Melissa Coker, Compliance Specialist
The Medical Protective Company
260-486-0838

manual page revisions for DOI revised.xls

The Medical Protective Company
Illinois Physician & Surgeon Manual Pages

General Name	Current Pages	Superseded Pages	Revised Page	Withdrawn Pages	Added Pages
Program: OCCURRENCE PROGRAM					
Territories	RT-IL (04/01/03)				
Rate Pages - Area 1	RTS-OCC; IL-04-1 - Area 1	X	RTS-OCC; IL-04-2 - Area 1		
Rate Pages - Area 2	RTS-OCC; IL-04-1 - Area 2	X	RTS-OCC; IL-04-2 - Area 2		
Rate Pages - Area 3	RTS-OCC; IL-04-1 - Area 3	X	RTS-OCC; IL-04-2 - Area 3		
Rate Pages - Area 4	RTS-OCC; IL-04-1 - Area 4	X	RTS-OCC; IL-04-2 - Area 4		
Rate Pages - Area 5	RTS-OCC; IL-04-1 - Area 5	X	RTS-OCC; IL-04-2 - Area 5		
Increase Limit Factors	ILF-IL; IL-04-1				
Excess Limit Factors	ELF-IL-IL-04-1				
Classifications	PRC-IL; 01/01/04				
Deferred Premium Payment Rule	DPP-CW 01/15/03				
Full Time Equivalency Rule	FTE-CW 01/15/03				
Leave of Absence Credit Rule	LAC-CW 01/01/03				
Locum Tenens	LT-CW 01/01/03				
Loss Free Credit Rule	LFC-CW 01/01/03			X	
Claim Free Credit Rule	CFC-CW 01/01/05				X
Minimum Premium Rule	MPR-CW 01/01/03				
Membership Association Credit Rule	MAC-CW 01/01/03				
New to Practice Credit Rule	NPC-CW 01/01/03				
Non-Discretionary Debit Rule	NDP-CW 01/01/04				X
Partnership Corporation Rating Rule	PCC-IL 01/01/04	X	PCC-IL 10/01/04		
Part Time Practice Rule	PTP-CW 01/01/03				
Risk Management Credit Rule	RMC-CW 01/15/03				
Solo Corporation Rating Rule	SCC-CW 01/01/03				
Schedule Rating Plan	SRP-IL 01/01/03				
PROGRAM: STANDARD CLAIMS MADE PROGRAM					

The Medical Protective Company
Illinois Physician & Surgeon Manual Pages

General Name	Current Pages	Superseded Pages	Revised Page	Withdrawn Pages	Added Pages
Territories	RT-IL (04/01/03)				
Rate Pages - Area 1	RTS-CM0; IL-04-1 - Area 1	X	RTS-CM0; IL-04-2 - Area 1		
Rate Pages - Area 2	RTS-CM0; IL-04-1 - Area 2	X	RTS-CM0; IL-04-2 - Area 2		
Rate Pages - Area 3	RTS-CM0; IL-04-1 - Area 3	X	RTS-CM0; IL-04-2 - Area 3		
Rate Pages - Area 4	RTS-CM0; IL-04-1 - Area 4	X	RTS-CM0; IL-04-2 - Area 4		
Rate Pages - Area 5	RTS-CM0; IL-04-1 - Area 5	X	RTS-CM0; IL-04-2 - Area 5		
Rate Pages - Area 1	RTS-CM1; IL-04-1 - Area 1	X	RTS-CM1; IL-04-2 - Area 1		
Rate Pages - Area 2	RTS-CM1; IL-04-1 - Area 2	X	RTS-CM1; IL-04-2 - Area 2		
Rate Pages - Area 3	RTS-CM1; IL-04-1 - Area 3	X	RTS-CM1; IL-04-2 - Area 3		
Rate Pages - Area 4	RTS-CM1; IL-04-1 - Area 4	X	RTS-CM1; IL-04-2 - Area 4		
Rate Pages - Area 5	RTS-CM1; IL-04-1 - Area 5	X	RTS-CM1; IL-04-2 - Area 5		
Rate Pages - Area 1	RTS-CM2; IL-04-1 - Area 1	X	RTS-CM2; IL-04-2 - Area 1		
Rate Pages - Area 2	RTS-CM2; IL-04-1 - Area 2	X	RTS-CM2; IL-04-2 - Area 2		
Rate Pages - Area 3	RTS-CM2; IL-04-1 - Area 3	X	RTS-CM2; IL-04-2 - Area 3		
Rate Pages - Area 4	RTS-CM2; IL-04-1 - Area 4	X	RTS-CM2; IL-04-2 - Area 4		
Rate Pages - Area 5	RTS-CM2; IL-04-1 - Area 5	X	RTS-CM2; IL-04-2 - Area 5		
Rate Pages - Area 1	RTS-CM3; IL-04-1 - Area 1	X	RTS-CM3; IL-04-2 - Area 1		
Rate Pages - Area 2	RTS-CM3; IL-04-1 - Area 2	X	RTS-CM3; IL-04-2 - Area 2		
Rate Pages - Area 3	RTS-CM3; IL-04-1 - Area 3	X	RTS-CM3; IL-04-2 - Area 3		
Rate Pages - Area 4	RTS-CM3; IL-04-1 - Area 4	X	RTS-CM3; IL-04-2 - Area 4		
Rate Pages - Area 5	RTS-CM3; IL-04-1 - Area 5	X	RTS-CM3; IL-04-2 - Area 5		
Rate Pages - Area 1	RTS-CM4; IL-04-1 - Area 1	X	RTS-CM4; IL-04-2 - Area 1		
Rate Pages - Area 2	RTS-CM4; IL-04-1 - Area 2	X	RTS-CM4; IL-04-2 - Area 2		
Rate Pages - Area 3	RTS-CM4; IL-04-1 - Area 3	X	RTS-CM4; IL-04-2 - Area 3		
Rate Pages - Area 4	RTS-CM4; IL-04-1 - Area 4	X	RTS-CM4; IL-04-2 - Area 4		
Rate Pages - Area 5	RTS-CM4; IL-04-1 - Area 5	X	RTS-CM4; IL-04-2 - Area 5		
Increase Limit Factors	ILF-IL; IL-04-1				
Excess Limit Factors	ELF-IL-IL-04-1				
Claims Made Factors	CMF-IL; IL-03-1				
Extension Contract Factors	ECF-IL; IL-98-1				
Classifications	PRC-IL; 01/01/04	X	PRC-IL; 01/01/04		
Accelerated Extension Contract Rule	AEC-CW 01/01/03				

The Medical Protective Company
Illinois Physician & Surgeon Manual Pages

General Name	Current Pages	Superseded Pages	Revised Page	Withdrawn Pages	Added Pages
Deferred Premium Payment Rule	DPP-CW 01/15/03				
Extension Contract Rating	ECR-CW 01/01/03	X	ERC-CW 01/01/03		
Full Time Equivalency Rule	FTE-CW 01/15/03				
Leave of Absence Credit Rule	LAC-CW 01/01/03				
Locum Tenens	LT-CW 01/01/03				
Loss Free Credit Rule	LFC-CW 01/01/03			X	
Claim Free Credit Rule	CFC-CW 01/01/05				X
Membership Association Credit Rule	MAC-CW 01/01/03				
Minimum Premium Rule	MPR-CW 01/01/03				
New to Practice Credit Rule	NPC-CW 01/01/03				
Non-Discretionary Debit Rule	NDP-CW 01/01/04				X
Prior Acts	PAC-CW 01/01/03				
Partnership Corporation Rating Rule	PCC-IL 01/01/04	X	PCC-IL 10/01/04		
Part Time Practice Rule	PTP-CW 01/01/03				
Risk Management Credit Rule	RMC-CW 01/15/03				
Solo Corporation Rating Rule	SCC-CW 01/01/03				
Slot Rating Rule	SRR-CW 01/01/03				
Schedule Rating Plan	SRP-IL 01/01/03				
PROGRAM: COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS					
General Manual - Section I	GM-I-CW 01/01/03				
General Manual - Section II	GM-II-CW 01/01/03				
State Rate Pages - Section II	SR-II-IL 01/01/04	X	SR-II-IL 10/01/04		
General Manual - Section III	GM-III-CW 01/01/03				
State Rate Pages - Section II	SR-III-IL 01/01/04	X	SR-III-IL 10/01/04		

The Medical Protective Company
Illinois Physician & Surgeon Manual Pages

General Name	Current Pages	Superseded Pages	Revised Page	Withdrawn Pages	Added Pages
General Manual - Section IV	GM-IV-CW 01/01/03				
State Rate Pages - Section IV	SR-IV-IL 06/01/04				
General Manual - Section V	GM-V-CW 01/01/03				
State Rate Pages - Section V	SR-V-IL 09/01/03				

The Medical Protective Company

June 15, 2004

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
RECEIVED
JUN 16 2004
SPRINGFIELD, ILLINOIS

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
LINE 11 – MEDICAL MALPRACTICE
COMPANY FILING NO. 04-IL-63
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Base Rate Increase + 15.6%
Revise Partnership or Corporation Rating Rule
Revise Claim Free Credit Rule
Revise Extension Contract Rating Rule
Add Non-Discretionary Debit Rule

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revised General Manual – Sections I, II, III and V
Revised State Rate Pages – Sections II, III and V

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

PROPOSED EFFECTIVE DATE: OCTOBER 1, 2004

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate and rule filing applicable to its Illinois Physicians & Surgeons and its Illinois Comprehensive Liability Coverage for Health Care Providers program. The company requests **October 1, 2004,** as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Physicians & Surgeons programs through a base rate increase of 15.6%. The accompanying Actuarial Memorandum provides support for the various changes including revised rules.

In addition, we have enclosed revised General Manual pages for Section I (*General Rules*), II (*Corporations, Partnerships & Associations*), III (*Physicians & Surgeons*) and V (*Allied Health Care Providers*) for the Company's Comprehensive Liability Coverage for Health Care Providers program. Additionally, corresponding Section III (*Physicians & Surgeons*) and V (*Allied Health Care Providers*) State Rate pages are enclosed. The rates and rules used for this program mirror those used for the Company's individual Physicians & Surgeon and Allied Health Care Providers Programs, and therefore are being included in this submission for manual purposes only to reflect the changes noted above.

Along with the Actuarial Memorandum, please find enclosed revised manual rule pages, the required forms, 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 contact me. Thank you.

Sincerely,

Melissa Coker

1 15.6%

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3563
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Enclosure(s)

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.

Signature and Title of Authorized Insurance Company Officer — Date 7/1/04

FCAS MAAA

Signature, Title and Designation of Authorized Actuary — Date 6/30/04

Insurance Company FEIN 35 - 0506406 Filing Number __04-IL-63_____

Insurer's Address _____5814 Reed Road _____

City _____Fort Wayne_____State_____IN_____ Zip Code__46825__

Contact Person's:
-Name and E-mail ____Melissa Coker – Melissa.coker@ge.com_____

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

The Medical Protective Company

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUN 01 2004
SPRINGFIELD, ILLINOIS

May 3, 2004

RECEIVED
MAY 04 2004
Department of Insurance
Springfield

John Gatlin, Director of 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: 04-IL-60
COMPANY FEIN NO: 35-0506406
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Increase	*+15.0%*
Revise Class Plan	*+ 0.0%*

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revise Section IV- State Rate Pages, Dentists

PROPOSED EFFECTIVE DATE: June 1, 2004

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests **June 01, 2004**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of +15.0 %. In addition, we have enclosed revised manual pages for *Section IV – Dentists* for the Company's Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Dentists Program, and therefore are being included in this submission.

Please find enclosed the required filing forms, actuary certification 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

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Enclosure(s)

The Medical Protective Company

Illinois

Dentists

Actuarial Memorandum

Enclosed please find rate pages reflecting a 15% premium level increase effective 06/01/04. The premium increase will be accomplished through a 15% base rate increase. The increase reflects updated ultimate loss projections, embedded yields, projected expenses and current level earned premiums.

CERTIFICATION

I certify that the Company's rates are based on sound actuarial principles and are not inconsistent with the Company's experience.

Keith M. Barnes, FCAS, MAAA
Vice President - Pricing

GE Commercial Insurance
Medical Protective

The Medical Protective Company
5200 Metcalf, P.O. Box 2991
Overland Park, KS 66201-1391
913 789-6600, 800 344-1899, Fax: 913 789-6605
www.gemedicalprotective.com

RECEIVED
MAR 04 2004
MPC
Department of Insurance
Springfield

March 2, 2004

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
APR 15 2004
SPRINGFIELD, ILLINOIS

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

NAIC # 350-11843
FEIN 35-0506406

Re: The Medical Protective Company
Healthcare Organization Liability Program
Rate and Rule Filing
Proposed Effective Date: April 15, 2004
Our Filing Numbers: RFF-04-00029

Dear Commissioner:

The Medical Protective Company (MPCO) wishes to propose the following rate revisions for the Healthcare Facilities program with a requested effective date of April 15, 2004. These rate changes are based on a competitive analysis. The proposed changes and their rate impact are described in the enclosed Explanatory Memorandum, and are further illustrated in the attached exhibits.

Enclosed are 2 copies of the transmittal documents, the revised rate pages and the Exhibits. Enclosed also is a self-addressed stamped envelope for the return of a file marked copy of the filing.

If you have any questions or concerns, please contact me at the numbers listed below. I appreciate your consideration of this submission.

Sincerely,

Theresa Cox
Product & Regulatory Services Specialist
800-255-6931 Ext. 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ercgroup.com

GE Commercial Insurance
Medical Protective

The Medical Protective Company
5200 Metcalf, P.O. Box 2991
Overland Park, KS 66201-1391
913 789-6600, 800 344-1899, Fax: 913 789-6605
www.gemedicalprotective.com

RECEIVED
MAR 15 2003
Department of Insurance
SPRINGFIELD

March 12, 2004

Ms. Gail Neuman
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

NAIC # 350-11843
FEIN 35-0506406

Re: The Medical Protective Company
Healthcare Organization Liability Program
Rate and Rule Filing
Proposed Effective Date: April 15, 2004
Our Filing Numbers: RFF-04-00029

Dear Ms. Neuman:

Enclosed, please find all of the rating and manual pages for Illinois. The schedule rating plan is outlined on page SR-IL-VI-6 for the Health Care Organization Liability, on page SR-IL-VII-4 for the General Liability and pages SR-IL-VIII- 3 & 4 for the Managed Care Entity Liability and SR-IL-IX 3 & 4 for the Pollution Rate Filing.

We report to ISO for the gathering of statistics for reporting.

Finally, enclosed, please find the certification that you had requested. Please let me know if you need any additional information.

Sincerely,

Theresa Cox
Product & Regulatory Services Specialist
800-255-6931 Ext. 6181
FAX: 913-676-6226
E-Mail: Theresa.Cox@ercgroup.com

Enclosures

Illinois - Certification of Rates

The company's Hospital Facility rates are based on sound actuarial principles and are not inconsistent with the company's or industry's experience.

Certified Actuary:

Jason Martin, FCAS, MAAA
Healthcare Actuary

Signature

Company Officer:

William E. Daley
Senior Vice President

The Medical Protective Company

OCT 09 2003

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

October 7, 2003

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: **THE MEDICAL PROTECTIVE COMPANY- NAIC #11843**
LINE 11 – M EDICAL MALPRACTICE
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Increase		*+ 28.7 %*
Territory Relativity Changes		*+19.7 %*
Revised Increased Limit Factors	*(2m/4m)*	*+ 1.6 %*
Revised Excess Limit Factors		*+ 0.0 %*
Revised Class Plan		*- 2.9 %*
Revised Partnership or Corporation Rating Rule (Caps Only)		

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revised Rule Manual - Section II Corporations, Partnerships & Associations State Rate Pages
Revised Rule Manual – Section III Physicians & Surgeons State Rate Pages

PROPOSED EFFECTIVE DATE: January 1, 2004

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate and rule filing applicable to its Illinois Physicians & Surgeons and its Illinois Comprehensive Liability Coverage for Health Care Providers program. The company requests **January 1, 2004,** as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Physicians & Surgeons programs through a base rate increase, Territory Relativity Change, Revised Increased Limit Factors, Revised Excess Limit Factors, Class Plan Changes and rule revisions. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of 52.1%.

In addition, the Company has enclosed revised *Section II - Corporations, Partnerships & Associations* and *Section III - Physicians & Surgeons* state rate pages for the Comprehensive Liability Coverage for Health Care Providers. The rates used for this program mirror those used for the Company's individual Physician & Surgeon Program, and therefore are being included in this submission.

Along with the Explanatory Memorandum, please find enclosed revised manual rule pages, the required forms, 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 contact me. Thank you.

Sincerely,

Melissa Coker

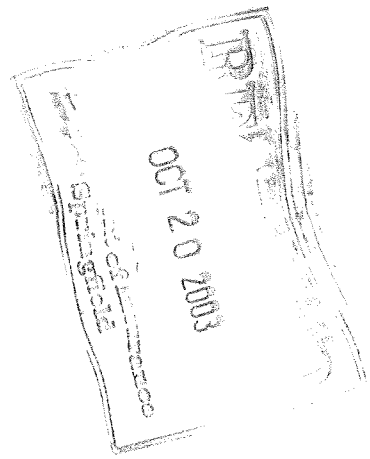
Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Hudy Paul Boutcher
CASUALTY ACTUARY
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED
10/31/2003

Enclosure(s)

The Medical Protective Company

October 17, 2003



John Gatlin, Supervisor, Property & Casualty Compliance Unit:
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY - NAIC #11843
LINE 11 – MEDICAL MALPRACTICE

PHYSICIANS & SURGEONS
DENTISTS
ALLIED HEALTH CARE PROVIDERS

Add Military Leave of Absence Credit Rule

PROPOSED EFFECTIVE DATE: November 1, 2003

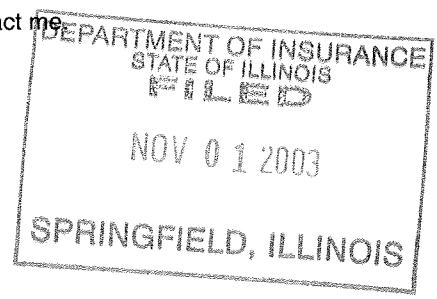
Dear Mr. Gatlin:

The Medical Protective Company hereby submits for your review and consideration the enclosed rule filing applicable to our Physicians & Surgeons, Dentists, and Allied Health Care Providers Programs. We request November 1, 2003 as the effective date for this submission.

The new rule specifies that an insured may be eligible for a premium discount if on a military leave of absence. The language contained within the proposed rule is the countrywide format, and the introduction of this rule has no significant rate effect.

Along with the manual rule, please find enclosed required forms and a self-addressed stamped envelope. Upon completion of your review, 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.



Sincerely,

Melissa Coker

Melissa Coker, Regulatory Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Enclosure(s)

GE Medical Protective

The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
260 485-9622
www.GEMedicalProtective.com

September 2, 2003

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
RECEIVED
SEP 04 2003
SPRINGFIELD, ILLINOIS

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS ALLIED HEALTH CARE PROVIDERS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Revised % Page
Withdraw Rating Territory Page

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revised Rule Manual - Section V Allied Health Care Providers

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
SEP 01 2003
SPRINGFIELD, ILLINOIS

PROPOSED EFFECTIVE DATE: September 1, 2003

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to its Illinois Allied Health Care Providers and its Illinois Comprehensive Liability Coverage for Health Care Providers program. The company requests **September 1, 2003,** as the effective date for this submission.

The accompanying Actuarial Memorandum provides support for the proposed rule revisions, which do not consist of a rate impact. In addition, the Company has enclosed revised Section V – Allied Health Care Providers state rate pages for the Comprehensive Liability Coverage for Health Care Providers. These pages reflect and include the above modifications and present no substantive rate impact.

Along with the Explanatory Memorandum, please find enclosed revised manual rule pages, the required forms, 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 contact me. Thank you.

Sincerely,

Melissa Coker

Melissa Coker, Compliance Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6838
(260)-486-0733 (fax)
melissa.coker@gemedicalprotective.com

Judy Pool Boutcher
CASUALTY ACTUARY
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED

Enclosure(s)

The Medical Protective Company

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
RECEIVED
MAY 06 2003
SPRINGFIELD, ILLINOIS

May 2, 2003

Illinois Department of Insurance
Attn: John Gatlin, Supervisor, Property & Casualty Compliance Unit
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JUN 05 2003
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
Comprehensive Liability Coverage for Health Care Providers
Revised Rule Manual, Section II and IV only

PROPOSED EFFECTIVE DATE: June 1, 2003

Dear Supervisor Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable for our Comprehensive Liability Coverage for Health Care Providers Program. The Company requests the effective date for this submission, effective **June 1, 2003.**

The Company wishes to update its Comprehensive Liability Coverage manual, *Section II* - Corporations, Partnerships & Associations and *Section IV* - Dentists. This revision contains modifications to the rates and rules for the Comprehensive Manual State Rate Pages for Dentists (Section IV) and Corporations, Partnerships & Associations (Section II). These modifications reflect and mirror the current rates and rules for the Company's Dental program. Updated Comprehensive Liability Coverage Manual State Exception Pages are enclosed for your review and approval.

In addition to the Actuarial Memorandum and rules, I have attached the required state filing forms and a self-addressed, stamped envelope. Upon completion of your review, I would appreciate it if you would return a file-stamped copy.

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

Sincerely,

Phillip J. Troyer/mdc

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

The Medical Protective Company
ILLINOIS
Comprehensive Liability Coverage For Health Care Providers

Explanatory Memorandum

The Medical Protective Company wishes to update its Comprehensive Liability Coverage manual, Section II – Corporations, Partnerships & Associations and Section IV – Dentists. This filing is to be effective June 1, 2003.

This revision contains modifications to the rates & rules for the Comprehensive Manual State Rate Pages for Dentists (Section IV) & Corporations, Partnerships & Associations (Section II). These modifications reflect & mirror the filing that has recently been approved, effective 6-1-03 for the Company's stand alone Dental Program. Updated Comprehensive Liability Coverage Manual State Exception Pages are enclosed for your review and approval.

The Medical Protective Company
ILLINOIS
Modular Product

Exhibit 1 - Rules Explanatory Grid
Page 1

Dentists

Rule Name	Current/Pending	Compared To:
Claim Free Credit	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Convertible Coverage Rating Rule	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Deferred Payment Plan	New	Dental Occurrence & Claims Made Products
Dental Board Exam Rule	Current - eff 6/1/03	Dental Occurrence Product
Full Time Equivalency	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Leave of Absence Credit	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Locum Tenens	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Membership Association Credit	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Minimum Premium	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
New to Practice	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Out-Patient Visit Rating	Current	Comprehensive Liability for Health Care Providers
Part Time Dentists	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Risk Management	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Partnership / Corp Rating	Current - eff 6/1/03	Dental Occurrence & Claims Made Products
Slot Rating Rule	Current - eff 6/1/03	Dental Standard Claims Made Product
Schedule Rating Plan	Current - eff 6/1/03	Dental Occurrence & Claims Made Products

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JUN 0 7 2003
SPRINGFIELD, ILLINOIS

The Medical Protective Company

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 1 1 2003
SPRINGFIELD, ILLINOIS

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
MAY 0 6 2003
SPRINGFIELD, ILLINOIS

May 2, 2003

Illinois Department of Insurance
Attn: John Gatlin, Supervisor, Property & Casualty Compliance Unit
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
Comprehensive Liability Coverage for Health Care Providers
Revised Rule Manual, Section II and III only

PROPOSED EFFECTIVE DATE: May 11, 2003

Dear Supervisor Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable for our Comprehensive Liability Coverage for Health Care Providers Program. The Company requests the effective date for this submission, effective **May 11, 2003.**

The Company wishes to update its Comprehensive Liability Coverage manual, Section II - Corporations, Partnerships & Associations and Section III - Physicians & Surgeons. The filing is to be May 11, 2003. This revision contains modifications to the rates and rules for the Comprehensive Manual State Rate Pages. These modifications reflect and mirror the rates and rules currently approved for the Company's Physician & Surgeon's stand alone programs. Updated Comprehensive Liability Coverage Manual State Exception Pages are enclosed for your review and approval. There is no rate effect associated with this filing.

In addition to the Actuarial Memorandum and rules, I have attached the required state filing forms and a self-addressed, stamped envelope. Upon completion of your review, I would appreciate it if you would return a file-stamped copy.

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

Sincerely,

Phillip J. Troyer /mdc

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

The Medical Protective Company
ILLINOIS
Comprehensive Liability Coverage For Health Care Providers

Explanatory Memorandum

The Medical Protective Company wishes to update its Comprehensive Liability Coverage manual, Section II – Corporations, Partnerships & Associations, and Section III – Physicians & Surgeons. This filing is to be effective May 11, 2003.

This revision contains modifications to the rates & rules for the Comprehensive Manual State Rate Pages for Physicians & Surgeons (Section III) & Corporations, Partnerships & Associations (Section II). These modifications reflect & mirror the filing that is approved for the Company's Physician & Surgeon stand alone program. Updated Comprehensive Liability Coverage Manual State Exception Pages are enclosed for your review and approval.

The Medical Protective Company
ILLINOIS
Modular Product

Exhibit 1 - Rules Explanatory Grid
Page 1

Physicians & Surgeons

Rule Name	Current/Pending	Compared To:
Accelerated Extension Contract Rating	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Deferred Payment Plan	New	N/A
Full Time Equivalency	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Leave of Absence Credit	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Locum Tenens	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Loss Free Credit Plan	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Membership Association Credit	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Minimum Premium	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
New to Practice	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Out Patient Visit Rating	Current	Comprehensive Liability for Health Care Providers Program
Part Time Practice Rule	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Partnership / Corp Rating	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Risk Management	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Schedule Rating Plan	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Slot Rating	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product
Solo Corporation	Current - 5/11/03	Physician & Surgeon Occurrence & Claims Made Product

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 11 2003
SPRINGFIELD, ILLINOIS

The Medical Protective Company

RECEIVED
MAY 15 2003
Department of Insurance
Springfield

May 14, 2003

Illinois Department of Insurance
Attn: John Gatlin, Supervisor, Property & Casualty Compliance Unit
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 11 2003
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Revision to Physicians Rate Classes,May 1, 2003 Effective Date Filing

PROPOSED EFFECTIVE DATE CHANGE : From May 1, 2003 to May 11, 2003

Dear Mr. Gatlin:

On January 31, 2003, The Medical Protective Company submitted a rate filing in reference to our Physicians & Surgeons Occurrence and Standard Claims Made programs, which included revisions to the class plans, territories and rules, we had requested a proposed effective date of April 1, 2003. On February 20, 2003, in reference to the same filing, we requested to move back the proposed effective date from April 1, 2003 to May 1, 2003. After further consideration, we are requesting that the effective date be moved back, a final time from May 1, 2003 to **May 11, 2003**.

In addition, during a review of the recent Physicians & Surgeons filing approved by the Illinois Department of Insurance, it was discovered that there was a typo in the Physicians Rate Classes Standard Claims Made and Occurrence Program. The company wishes to provide updated manual pages reflecting the following modifications for clarification purposes.

- Class 2C has been modified to include "Physicians Not Otherwise Classified" instead of "Family Practice/General Practice"
- Class 3B has been modified to include "Family Practice/General Practice - Including Deliveries" instead of "Family Practice/General Practice with more than 125 deliveries"

Please find enclosed the modified manual pages 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,

Phillip J. Troyer/mdc

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

The Medical Protective Company

RECEIVED
MAY 15 2003
Department of Insurance
Springfield

May 14, 2003

Illinois Department of Insurance
Attn: John Gatlin, Supervisor, Property & Casualty Compliance Unit
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 1 2 2003
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
Comprehensive Liability Coverage for Health Care Providers
Revised Rule Manual, Section II and III only

PROPOSED EFFECTIVE DATE: May 11, 2003

Dear Supervisor Gatlin:

On May 2, 2003, The Medical Protective Company submitted for your review and consideration the above-captioned rule filing applicable for our Comprehensive Liability Coverage for Health Care Providers Program. The Company requested the effective date for this submission, effective **May 11, 2003.**

During a review of the recent Comprehensive Liability Coverage for Health Care Providers filing, pending with the Illinois Department of Insurance, it was discovered that there was a typo in the Physicians Rate Classes Standard Claims Made and Occurrence Program. The company wishes to provide updated manual pages reflecting the following modifications for clarification purposes.

- Class 2C has been modified to include "Physicians Not Otherwise Classified" instead of "Family Practice/General Practice"
- Class 3B has been modified to include "Family Practice/General Practice - Including Deliveries" instead of "Family Practice/General Practice with more than 125 deliveries"

In addition to the revised rule pages, I have attached a self-addressed, stamped envelope. Upon completion of your review, I would appreciate it if you would return a file-stamped copy.

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

Sincerely,

Phillip J. Troyer/mdc

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

The Medical Protective Company

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 11 2003
SPRINGFIELD, ILLINOIS

RECEIVED
MAY 06 2003
Department of Insurance
Springfield

May 2, 2003

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY - NAIC #11843
ILLINOIS ALLIED HEALTH CARE PROVIDERS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Add Deferred Payment Plan Rule
Add Slot Rule Rating (Standard Claims Made Only)
Revise Prior Acts (Standard Claims Made Only)
Revise Extension Contract Rating (Standard Claims Made Only)
Revise Minimum Premium Rule
Revise Partnerships or Corporations Coverage Rating Rule
Revise Part Time Practice
Revise Risk Management
Revise Solo Corp Rule
Revise Schedule Rating Plan
Revise Rating Territory Page
Withdraw Accelerated Extension Contract Rule (Standard Claims Made Only)
Withdraw Leave of Absence Credit Rule
Withdraw Locum Tenens

Cindy Poole Boutchee
CASUALTY ACTUARY
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED
5/9/03

ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

Revised Rule Manual - Section V Allied Health Care Providers

PROPOSED EFFECTIVE DATE : May 11, 2003

Dear Mr. Luke:

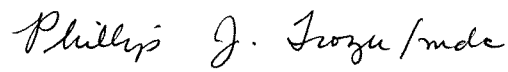
The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable to its Illinois Allied Health Care Providers and its Illinois Comprehensive Liability Coverage for Health Care Providers program. The company requests **May 11, 2003** as the effective date for this submission.

The accompanying Actuarial Memorandum provides support for the proposed rule revisions, which do not consist of a rate impact. In addition, the Company has enclosed revised Section V – Allied Health Care Providers state rate pages for the Comprehensive Liability Coverage for Health Care Providers. These pages reflect and include the above modifications and present no substantive rate impact.

Along with the Actuarial Memorandum, please find enclosed revised manual rule pages, the required forms, 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 contact me. Thank you.

Sincerely,



Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
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(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885
Professional Protection Exclusively since 1899

January 31, 2003

Hon. Nathaniel S. Shapo, Director of Insurance
Illinois Department of Insurance
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 07 2003
SPRINGFIELD, ILLINOIS

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
RECEIVED
FEB 03 2003
SPRINGFIELD, ILLINOIS

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Increase (+ 7.9 %)
Classification Changes (+ 19.6 %)
Revised Mature CM factor from .92 to .975 (+ 5.6 %)
Revised 1st Year CM Step Factor from .250 to .325
Territory Changes (5.1%)
- *Increased Area 1 factor from 1.820 to 2.100*
- *Area 2 county and factor revisions*
- *Area 3 county and factor revisions*
- *Area 4 county and factor revisions*
- *Area 5 county and factor revisions*

Revised Full Time Equivalency Rating Rule
Add Deferred Premium Payment Plan Rule
Add Membership Association Credit Rule
Revised Acc. Extension Contract Rating (Standard Claims Made Only)
Revised Extension Contract Rule (Standard Claims Made Only)
Revised Leave of Absence Credit Rule
Revised Locum Tenens
Revised Minimum Premium Rule ($250)
Revised Loss Free Credit
Revised New to Practice (50/30/0)
Revised P/C Rating Rule
Revised Part Time Practice (50/30/0)
Revised Prior Acts (Standard Claims Made Only)
Revised Risk Management
Revised Slot Rating Rule (Standard Claims Made Only)
Revised Solo Corp. Rule
Revised SRP (50%)
Withdraw Renewal Premium Increase Limitation Rule
Withdraw Retired Physicians Rating Rule (Occurrence Only)

ILLINOIS DI
RECEIVED
2/25/2003

PROPOSED EFFECTIVE DATE: April 1, 2003

Dear Director Shapo:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Physicians & Surgeons programs. The company requests **April 01, 2003**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Physicians & Surgeons programs through a base rate increase and class plan changes. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium increase of 43.2%.

Please find enclosed the required filing forms, filing fee 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,

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

April 7, 2003

Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
APR 2 0 2003
SPRINGFIELD, ILLINOIS

John Gatlin, Director of Property and Casualty Compliance Unit
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS DENTISTS
OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS

Base Rate Decrease (-14.2%)
Area 1 (–25.0%)
Area 2 (-10.0%)
Revised Dental Class Plan
Add Full Time Equivalency Rating Rule
Add Deferred Premium Payment Plan Rule
Revised Claim Free Credit Rule
Revised Convertible Claims Made Rating Rule
Revised Dental Board Association Rule (Occurrence Only)
Revised Membership Association Credit Rule
Revised Acc. Extension Contract Rating (Standard Claims Made Only)
Revised Extension Contract Rule (Standard Claims Made Only)
Revised Leave of Absence Credit Rule
Revised Locum Tenens
Revised Minimum Premium Rule ($100)
Revised New to Practice
Revised P/C Rating Rule
Revised Part Time Practice
Revised Prior Acts (Standard Claims Made Only)
Revised Risk Management
Add Slot Rating Rule (Standard Claims Made Only)
Revised Solo Corp. Rule
Revised SRP

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JUN 0 1 2003
SPRINGFIELD, ILLINOIS

PROPOSED EFFECTIVE DATE: June 1, 2003

Dear Director Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Illinois Dentists programs. The company requests **June 01, 2003**, as the effective date for this submission.

The Company proposes to modify our currently filed rates for the Dentists programs. The accompanying Actuarial Memorandum provides support for the various changes for an overall premium decrease of –14.2 %.

Judy Pool Boutchee
CASUALTY ACTUARY
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED
4/10/03

Please find enclosed the required filing forms, actuary certification 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,

Phillip J. Troyer/mac

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

March 17, 2003

Gayle Neuman
P&C Evaluation Section
Illinois Department of Insurance
320 West Washington
Springfield, IL 62767

RE: **THE MEDICAL PROTECTIVE COMPANY – NAIC #11843**
Response to Request for Complete Rate/Rule Manual

Ms. Neuman,

Pursuant to your request, I have enclosed a complete copy of the rate and rule manuals for each of our current programs (Physicians & Surgeons, Dentists, Allied Health Care Providers, and Comprehensive Liability Coverage for Health Care Providers).

If you should have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Phillip J. Troyer,
Associate General Counsel
5814 Reed Road
Fort Wayne, Indiana 46835
(800) 348-4669, ext. 6854
phillip.troyer@gemedicalprotective.com

enc.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46335
Professional Protection Exclusively since 1899

January 28, 2003

RECEIVED
JAN 28 2003
MPC
Department of Insurance
Springfield

Hon. Nathaniel S. Shapo, Director of Insurance
Illinois Department of Insurance
Property and Casualty Compliance Unit
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
ILLINOIS COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revise Section I – General Manual
Revise Section VI – Health Care Facilities (HPL)
Revise Section VII – General Liability
Revise Section VIII – Managed Care Entity Liability
Revise Section IX – Pollution Liability

PROPOSED EFFECTIVE DATE: JANUARY 31, 2003

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 31 2003
SPRINGFIELD, ILLINOIS

Dear Director Shapo:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable for our hospital programs. We request **January 31, 2003** as the effective date for this submission.

The Company proposes to implement changes in the manner in which hospital risks are rated, including changes to its:

- increased limits factors;
- deductible and self insured retention credits;
- claims made and reporting endorsement factors;
- class plan relativities;
- experience rating plan; and
- territory definitions.

73.1% increase

The Company further proposes to alter the method it uses to calculate rates for general liability and managed care liability coverage. These changes are described more fully in the attached Actuarial Memorandum, which will have a total overall rate effect of +60.6% without General Liability coverage and 73.1% with it.

In addition to the Actuarial Memorandum and the proposed manual pages, I have enclosed the necessary state filing forms and a self-addressed stamped envelope for you to return a file-stamped copy of this filing. Should you have any questions regarding this filing, please do not hesitate to contact me.

Sincerely,

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

The Medical Protective Company

RECEIVED
FEB 18 2003

February 13, 2003

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

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Add Section VI – Health Care Facilities (HPL)
Add Section VII – General Liability
Add Section VIII – Managed Care Entity Liability
Add Section IX – Pollution Liability

Dear Ms. Neuman,

Pursuant to your request, please find enclosed a revised RF-3 form. Currently, the company insures only one hospital in Illinois, and it has general liability coverage. As a result, I have just used the increase with general liability coverage.

If you have any questions regarding this filing or need additional information, please do not hesitate to contact me.

Sincerely,

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

Judy Rae Boutchee
CASUALTY ACTUARY
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED
2/19/2003

enc.

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2003
SPRINGFIELD, ILLINOIS

November 7, 2002

John Gatlin, Supervisor,
Property & Casualty Compliance Unit:
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: THE MEDICAL PROTECTIVE COMPANY- NAIC #11843 35-0506406
Comprehensive Liability Coverage for Health Care Providers
Revised Rule Manual

PROPOSED EFFECTIVE DATE: JANUARY 1, 2003

Dear Mr. Gatlin:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rule filing applicable for our Comprehensive Liability Coverage for Health Care Providers Program. The Company requests **January 1, 2003** as the effective date for this submission.

The company is revising Sections I-V of its rule manual for this program. Because the rate levels included in the filing match those already approved by the Department for the program, this filing has no rate effect.

In addition to the Actuarial Memorandum and rules, I have attached the required state filing forms and a self-addressed, stamped envelope. Upon completion of your review, I would appreciate it if you would return a file-stamped copy.

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

Sincerely,

Phillip J. Troyer, Associate General Counsel
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4669, ext. 6854
(260)-486-0733 (fax)
phillip.troyer@gemedicalprotective.com

enc.

The Medical Protective Company

PHILLIP J. TROYER, CONTRACT ATTORNEY
E-MAIL: PHILLIP.TROYER@GEMEDICALPROTECTIVE.COM

TEL: 800-348-4669, EXT. 6854
FAX: 260-486-0733

The Medical Protective Company
5814 Reed Road, Fort Wayne, IN 46835-356
219 485-9622, Fax: 219 486-0415
www.gemedicalprotective.com

July 19, 2002

RECEIVED
JUL 22 2002
MPC
Department of Insurance
Springfield

Donna Raffa
Insurance Analyst IV
Property & Casualty Division
Illinois Department of Insurance
320 W. Washington
Springfield, IL 62767

RE: THE MEDICAL PROTECTIVE COMPANY - NAIC #11843
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE
Revised Excess Limit Factors
EFFECTIVE DATE: October 1, 2002

Dear Ms. Raffa:

The Medical Protective Company hereby submits for your review and consideration the enclosed rate filing applicable for our filed Illinois Physicians & Surgeons program. We request October 1, 2002 as the effective date for this submission.

The accompanying Actuarial Memorandum provides support for the proposed change to its increased limits factors, which will result in an overall increase of 1.0%.

Along with the Memorandum, please find enclosed revised manual pages as well as a self-addressed stamped envelope. It is our understanding that we will be billed for the filing by the Insurance Department. Upon completion of your review, 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 contact me at **(800) 348-4669** or via e-mail at **phillip.troyer@GEMedicalProtective.com**. Thank you.

Sincerely,

Phillip J. Troyer
Associate General Counsel
enc.

Judy Rae Boutchee
CASUALTY ACTUARY
ILLINOIS DEPT. OF INSURANCE
RECEIVED/APPROVED
7/25/02

The Medical Protective Company

PHILLIP J. TROYER, ASSOCIATE GENERAL COUNSEL
E-MAIL: PHILLIP.TROYER@GEMEDICALPROTECTIVE.COM

TEL: 800-348-4669, EXT. 6854
FAX: 260-486-0733

The Medical Protective Company
5814 Reed Road, P.O. Box 15021
Fort Wayne, IN 46885-5021
219 485-9622, Fax: 219 486-0415

July 25, 2002

Donna J. Raffa
Insurance Analyst IV
Illinois Insurance Department
Property & Casualty Division
320 W. Washington
Springfield, Ill 62767

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JUL 1 - 2002
SPRINGFIELD, ILLINOIS

Via fax #217-524-6497

RE: THE MEDICAL PROTECTIVE COMPANY - NAIC #11843, FEIN 35-0506406
ILLINOIS PHYSICIANS & SURGEONS
OCCURRENCE AND STANDARD CLAIMS MADE
Revised Excess Limit Factors

PROPOSED EFFECTIVE DATE: October 1, 2002

Dear Ms. Raffa:

Thank you for your email regarding the above-referenced filing. Pursuant to your request, I am forwarding the RF-3 form. I apologize for the oversight in not including it with the filing.

If you have any questions or need any additional materials, please contact me at **(800) 348-4669, ext. 6854** or via e-mail at **phillip.troyer@GEMedicalProtective.com**. Thank you.

Sincerely,

Phillip J. Troyer
Associate General Counsel
enc.

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

INDIVIDUAL RISK RATING PLAN

TERRITORIAL / SPECIALTY NON-DISCRETIONARY DEBIT CALCULATION EXCEPTION

FOR INSUREDS WHOSE RATE CONTAINS UNIQUE AND UNUSUAL RISK CHARACTERISTICS AS A RESULT OF CLAIM EXPERIENCE AND/OR TERRITORIAL ANAMOLIES NOT CONTEMPLATED IN THE COMPANY'S FILED NON-DISCRETIONARY DEBIT RATING PLAN, INSURED'S PREMIUM WILL BE INDIVIDUALLY RISK RATED.

THE RATE WILL BE DERIVED BY APPLYING A 25% DEBIT FOR PRIOR CARRIER CLAIMS IN LIEU OF THE DEBITS OUTLINED IN THE NON-DISCRETIONARY DEBIT RATING PROGRAM.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUL 01 2008
SPRINGFIELD, ILLINOIS

The
Medical Protective Company
Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

ILLINOIS

INDIVIDUAL RISK RATING PLAN

CORPORATION VICARIOUS LIABILITY FOR PHYSICIANS NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A VICARIOUS LIABILITY EXPOSURE FOR PHYSICANS WHO ARE NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
MAR 0 1 2008
SPRINGFIELD, ILLINOIS

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS I A

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

CLASS I B

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

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS II B

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

CLASS III

ANY DENTAL SPECIALIST PERFORMING PROCEDURES NOT OTHERWISE CLASSIFIED.

SPECIALISTS IN PAIN MANAGEMENT.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR

TERRITORY 2: DUPAGE, KANE, WILL, LAKE, MCHENRY

TERRITORY 3: REMAINDER OF STATE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUN 0 1 2005
SPRINGFIELD, ILLINOIS

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS - AREA 1

DENTISTS

OCCURRENCE RATES

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
2A	6,993	7,972	8,531	9,091	9,790	10,490	11,189	11,888
2B	13,403	15,279	16,352	17,424	20,105	22,115	23,455	24,796
3	15,152	17,273	18,485	19,698	22,728	25,001	26,516	28,031

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS - AREA 2

DENTISTS

OCCURRENCE RATES

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
2A	5,829	6,645	7,111	7,578	8,161	8,744	9,326	9,909
2B	11,172	12,736	13,630	14,524	16,758	18,434	19,551	20,668
3	12,630	14,398	15,409	16,419	18,945	20,840	22,103	23,366

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS - AREA 3

DENTISTS

OCCURRENCE RATES

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
2A	4,662	5,315	5,688	6,061	6,527	6,993	7,459	7,925
2B	8,936	10,187	10,902	11,617	13,404	14,744	15,638	16,532
3	10,101	11,515	12,323	13,131	15,152	16,667	17,677	18,687

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

INCREASED LIMITS TABLE

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

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885

Professional Protection Exclusively since 1899

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, RISK MANAGEMENT, MEMBERSHIP ASSOCIATION OR DEDUCTIBLE CREDITS.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 01 2006
SPRINGFIELD, ILLINOIS

The

Medical Protective Company

Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
STATE OF ILLINOIS/DFPR
RECEIVED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

ILLINOIS

DENTISTS

OCCURRENCE 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.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

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.

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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 A PREMIUM OF $25, AND IS 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.

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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. 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.

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FULL TIME EQUIVALENCY RATING RULE (CONT.)

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

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
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 NEW TO PRACTICE, PART TIME PRACTICE, OR CLAIM FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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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 "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.

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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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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 INSUREDS.

A PREMIUM CREDIT OF 5% 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 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 $100. 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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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 25% OF FILED MANUAL RATES SHALL APPLY TO THE INSUREDS FIRST, SECOND AND THIRD CONSECUTIVE YEARS OF COVERAGE. 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 THREE YEAR 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 60% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 40% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 20% 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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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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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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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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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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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	10%

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

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 RISK MANAGEMENT AND/OR MEMBERSHIP ASSOCIATION.

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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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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 $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, LOSS/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 INSUREDS 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 -50% / +50%, 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 INSUREDS UNDERWRITING FILE.

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

CRITERIA	RANGE
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%

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CRITERIA	RANGE
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.	-5% TO +5%
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.	-15% TO +15%
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).	-10% TO +10%
MANAGEMENT CONTROL PROCEDURES: SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
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.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-5% TO +5%
OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES: ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
TRAINING, ACCREDITATION AND CREDENTIALING: THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

CRITERIA	RANGE
RECORD-KEEPING PRACTICES: DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
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, 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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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 LIABLILITY PER OCCURRENCE OR ANNUAL AGGREGATE BEYOND THE STATED LIMITS OF THE INDIVIDUAL POLICY.

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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.

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RATE CLASSES

CLASS I A

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

CLASS I B

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

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY

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RATE CLASSES

CLASS II B

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

CLASS III

ANY DENTAL SPECIALIST PERFORMING PROCEDURES NOT OTHERWISE CLASSIFIED.

SPECIALISTS IN PAIN MANAGEMENT.

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STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR

TERRITORY 2: DUPAGE, KANE, WILL, LAKE, MCHENRY

TERRITORY 3: REMAINDER OF STATE

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	1,511	1,723	1,843	1,964	2,115	2,267	2,418	2,569
2B	2,897	3,303	3,534	3,766	4,346	4,780	5,070	5,359
3	3,275	3,734	3,996	4,258	4,913	5,404	5,731	6,059

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	3,023	3,446	3,688	3,930	4,232	4,535	4,837	5,139
2B	5,793	6,604	7,067	7,531	8,690	9,558	10,138	10,717
3	6,549	7,466	7,990	8,514	9,824	10,806	11,461	12,116

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	4,912	5,600	5,993	6,386	6,877	7,368	7,859	8,350
2B	9,414	10,732	11,485	12,238	14,121	15,533	16,475	17,416
3	10,642	12,132	12,983	13,835	15,963	17,559	18,624	19,688

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DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	5,730	6,532	6,991	7,449	8,022	8,595	9,168	9,741
2B	10,983	12,521	13,399	14,278	16,475	18,122	19,220	20,319
3	12,416	14,154	15,148	16,141	18,624	20,486	21,728	22,970

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DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	6,297	7,179	7,682	8,186	8,816	9,446	10,075	10,705
2B	12,069	13,759	14,724	15,690	18,104	19,914	21,121	22,328
3	13,644	15,554	16,646	17,737	20,466	22,513	23,877	25,241

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DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	1,259	1,435	1,536	1,637	1,763	1,889	2,014	2,140
2B	2,414	2,752	2,945	3,138	3,621	3,983	4,225	4,466
3	2,729	3,111	3,329	3,548	4,094	4,503	4,776	5,049

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	2,519	2,872	3,073	3,275	3,527	3,779	4,030	4,282
2B	4,827	5,503	5,889	6,275	7,241	7,965	8,447	8,930
3	5,457	6,221	6,658	7,094	8,186	9,004	9,550	10,095

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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
2A	4,093	4,666	4,993	5,321	5,730	6,140	6,549	6,958
2B	7,844	8,942	9,570	10,197	11,766	12,943	13,727	14,511
3	8,868	10,110	10,819	11,528	13,302	14,632	15,519	16,406

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STANDARD CLAIMS MADE RATES

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
2A	4,775	5,444	5,826	6,208	6,685	7,163	7,640	8,118
2B	9,152	10,433	11,165	11,898	13,728	15,101	16,016	16,931
3	10,346	11,794	12,622	13,450	15,519	17,071	18,106	19,140

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DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	5,247	5,982	6,401	6,821	7,346	7,871	8,395	8,920
2B	10,057	11,465	12,270	13,074	15,086	16,594	17,600	18,605
3	11,369	12,961	13,870	14,780	17,054	18,759	19,896	21,033

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ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	1,007	1,148	1,229	1,309	1,410	1,511	1,611	1,712
2B	1,931	2,201	2,356	2,510	2,897	3,186	3,379	3,572
3	2,183	2,489	2,663	2,838	3,275	3,602	3,820	4,039

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ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	2,015	2,297	2,458	2,620	2,821	3,023	3,224	3,426
2B	3,861	4,402	4,710	5,019	5,792	6,371	6,757	7,143
3	4,365	4,976	5,325	5,675	6,548	7,202	7,639	8,075

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DENTISTS

STANDARD CLAIMS MADE RATES

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
2A	3,274	3,732	3,994	4,256	4,584	4,911	5,238	5,566
2B	6,274	7,152	7,654	8,156	9,411	10,352	10,980	11,607
3	7,093	8,086	8,653	9,221	10,640	11,703	12,413	13,122

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STANDARD CLAIMS MADE RATES

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
2A	3,819	4,354	4,659	4,965	5,347	5,729	6,110	6,492
2B	7,320	8,345	8,930	9,516	10,980	12,078	12,810	13,542
3	8,276	9,435	10,097	10,759	12,414	13,655	14,483	15,311

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STANDARD CLAIMS MADE RATES

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
2A	4,197	4,785	5,120	5,456	5,876	6,296	6,715	7,135
2B	8,044	9,170	9,814	10,457	12,066	13,273	14,077	14,881
3	9,094	10,367	11,095	11,822	13,641	15,005	15,915	16,824

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STANDARD CLAIMS MADE PROGRAM

INCREASED LIMITS TABLE

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

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STANDARD CLAIMS-MADE

CLAIMS-MADE FACTORS

YEARS SINCE RATROACTIVE DATE	FACTOR
0	0.240
1	0.480
2	0.780
3	0.910
4 OR MORE	1.000
CLAIMS-MADE TO OCCURRENCE FACTOR	0.900

EFFECTIVE DATE JUN 0 1 1998

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STANDARD CLAIMS-MADE

EXTENSION CONTRACT FACTORS

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
0	0.900
1	1.500
2	1.750
3 OR MORE	1.900

EFFECTIVE DATE JUN 01 1998

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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 FIVE YEARS.

3) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSURED HAD LIMITED PRIOR ACTS EXPOSURE.

4) AT THE TIME THE INSURED PERMANENTLY RETIRES, HE OR SHE HAS ATTAINED THE AGE OF 55 AND IS ASSOCIATED WITH THE GROUP INSURED BY THE COMPANY.

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

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.

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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.

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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.

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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 EXPIRING STANDARD MATURE CLAIMS MADE RATE, SUBJECT TO EXPIRING PART TIME, NON-DISCRETIONARY DEBIT, DEDUCTIBLE AND SCHEDULE RATING DEBITS.

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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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. 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.

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FULL TIME EQUIVALENCY RATING RULE (CONT.)

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

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
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 NEW TO PRACTICE, PART TIME PRACTICE, OR CLAIM FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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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 "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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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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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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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 INSUREDS.

A PREMIUM CREDIT OF 5% 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 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 $100. 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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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 25% OF FILED MANUAL RATES SHALL APPLY TO THE INSUREDS FIRST, SECOND AND THIRD CONSECUTIVE YEARS OF COVERAGE. 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 THREE YEAR 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 60% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 40% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 20% 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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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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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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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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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, RISK MANAGEMENT, MEMBERSHIP ASSOCIATION OR DEDUCTIBLE CREDITS.

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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	10%

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

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 RISK MANAGEMENT AND/OR MEMBERSHIP ASSOCIATION.

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PART TIME PRACTICE RULE (CONT.)

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.

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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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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 $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, LOSS/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 INSUREDS 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 -50% / +50%, 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 INSUREDS UNDERWRITING FILE.

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

CRITERIA	RANGE
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%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-15% TO +15%
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).	-10% TO +10%
MANAGEMENT CONTROL PROCEDURES: SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
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.	-5% TO +5%

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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-5% TO +5%
OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES: ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
TRAINING, ACCREDITATION AND CREDENTIALING: THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
RECORD-KEEPING PRACTICES: DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
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, 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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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.

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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 LIABLILITY PER CLAIM FILED OR ANNUAL AGGREGATE BEYOND THE STATED LIMITS OF THE INDIVIDUAL POLICY.

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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.

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, JACKSON, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: LAKE, AND VERMILLION COUNTIES.

TERRITORY 3: KANE, MCHENRY, AND WINNEBAGO COUNTIES.

TERRITORY 4: DUPAGE, KANKAKEE, AND MACON, COUNTIES.

TERRITORY 5: BUREAU, CHAMPAIGN, COLES, DEKALB, EFFINGHAM, LASALLE, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 6: GRUNDY AND SANGAMON COUNTIES

TERRITORY 7: PEORIA COUNTY

TERRITORY 8: REMAINDER OF STATE.

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,728	10,510	15,533	19,243	20,016
1B	10,304	14,013	20,711	25,657	26,687
1C	12,107	16,466	24,335	30,146	31,357
1D	13,189	17,937	26,510	32,841	34,160
2A	14,426	19,619	28,996	35,921	37,363
2B	17,002	23,123	34,174	42,335	44,035
2C	20,093	27,326	40,387	50,032	52,041
2D	22,669	30,830	45,565	56,446	58,713
3A	24,214	33,173	50,123	63,683	66,589
3B	26,790	36,702	55,455	70,458	73,673
4A	29,366	40,231	60,788	77,233	80,757
4B	31,942	43,761	66,120	84,007	87,841
5A	36,064	49,408	74,652	94,848	99,176
5B	40,186	55,055	83,185	105,689	110,512
6A	42,246	57,877	87,449	111,107	116,177
6B	47,398	64,935	98,114	124,657	130,345
7	54,611	74,817	113,045	143,627	150,180
8	78,310	107,285	162,102	205,955	215,353

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ILLINOIS - AREA 2

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,956	9,460	13,982	17,320	18,016
1B	9,274	12,613	18,641	23,092	24,020
1C	10,897	14,820	21,903	27,134	28,223
1D	11,871	16,145	23,861	29,559	30,746
2A	12,984	17,658	26,098	32,330	33,629
2B	15,302	20,811	30,757	38,102	39,632
2C	18,084	24,594	36,349	45,029	46,838
2D	20,403	27,748	41,010	50,803	52,844
3A	21,794	29,858	45,114	57,318	59,934
3B	24,112	33,033	49,912	63,415	66,308
4A	26,431	36,210	54,712	69,514	72,685
4B	28,749	39,386	59,510	75,610	79,060
5A	32,459	44,469	67,190	85,367	89,262
5B	36,169	49,552	74,870	95,124	99,465
6A	38,023	52,092	78,708	100,000	104,563
6B	42,660	58,444	88,306	112,196	117,315
7	49,152	67,338	101,745	129,270	135,168
8	70,482	96,560	145,898	185,368	193,826

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	6,734	9,158	13,535	16,768	17,441
1B	8,979	12,211	18,048	22,358	23,256
1C	10,550	14,348	21,206	26,270	27,325
2A	13,020	17,707	26,170	32,420	33,722
2B	14,815	20,148	29,778	36,889	38,371
2C	17,509	23,812	35,193	43,597	45,348
2D	18,856	25,644	37,901	46,951	48,837
3A	22,448	30,754	46,467	59,038	61,732
3B	24,243	33,213	50,183	63,759	66,668
4A	28,733	39,364	59,477	75,568	79,016
4B	32,773	44,899	67,840	86,193	90,126
5A	35,916	49,205	74,346	94,459	98,769
5B	42,201	57,815	87,356	110,989	116,053
6	49,385	67,657	102,227	129,883	135,809
7	52,976	72,577	109,660	139,327	145,684
8	69,587	95,334	144,045	183,014	191,364

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PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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ILLINOIS - AREA 5

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

INCREASED LIMITS TABLE

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

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EXCESS LIMITS FACTORS TABLE			
LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
1M/1M xs 1M/3M	1.270	1.300	1.300
2M/2M xs 1M/3M	1.430	1.480	1.480
3M/3M xs 1M/3M	1.560	1.620	1.620
4M/4M xs 1M/3M	1.670	1.740	1.740

Note: For aggregate limits not listed above, refer to company.

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PHYSICIANS AND SURGEONS

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, RISK MANAGEMENT OR DEDUCTIBLE CREDITS.

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PHYSICIANS AND SURGEONS

OCCURRENCE 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 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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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OCCURRENCE PROGRAM

CONVERTIBLE / NOSE RATING PLAN

AN INSURED MAY BE ELIGIBLE FOR NOSE COVERAGE. THE RATING FOR SUCH COVERAGE IS BASED UPON THE INSUREDS STANDARD MATURE CLAIMS MADE RATE TIMES THE FACTOR IDENTIFIED IN THE TABLE BELOW.

NUMBER OF YEARS BEFORE EXPIRATION DATE OF NOSE COVERAGE	FACTOR
0	0.750
1	1.190
2	1.400
3	1.550
4 OR MORE	1.550

THE APPLICABLE PREMIUM UNDER THIS PLAN SHALL BE IN ADDITION TO THE INSUREDS STANDARD OCCURRENCE PREMIUM AND SHALL BE PAID TO THE COMPANY OVER AN INSTALLMENT PERIOD.

THE ABOVE RATING IS SUBJECT TO APPLICABLE PART-TIME AND SCHEDULE RATING MODIFICATIONS.

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DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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%

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DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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 PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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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.

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FULL TIME EQUIVALENCY RATING RULE

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

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

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

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

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FULL TIME EQUIVALENCY RATING RULE (CONT.)

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

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
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 NEW TO PRACTICE, PART TIME PRACTICE, OR LOSS FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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GROUP RATING RULE

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE PHYSICIANS 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 "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.

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INDIVIDUAL RISK RATING PLAN

CORPORATION VICARIOUS LIABILITY FOR PHYSICIANS NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A VICARIOUS LIABILITY EXPOSURE FOR PHYSICANS WHO ARE NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

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INDIVIDUAL RISK RATING PLAN

CRNA TO ANESTHESIOLOGIST RATIO

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A CRNA TO ANESTHESIOLOGIST RATIO OF GREATER THAN 2 TO 1, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

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LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN 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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LOCUM TENENS

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

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

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LOSS FREE CREDIT

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IF NO LOSS HAS BEEN ATTRIBUTED TO AN INSURED, THE INSURED WILL BE ELIGIBLE FOR PREMIUM CREDITS ON THE FOLLOWING SCHEDULE:

1. IF INSURED BY THE COMPANY AND LOSS 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 LOSS FREE FOR 5 YEARS BUT LESS THAN 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND LOSS FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% SHALL BE APPLIED TO THE NEXT POLICY RENEWAL.

A LOSS 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS LOSS FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE LOSS FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH STANDARD GUIDELINES APPLICABLE TO THE COMPANY'S INSUREDS.

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MEMBERSHIP ASSOCIATION CREDIT RULE

THE UNIQUE CHARACTERISTICS OF A MEDICAL 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 5% 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 PHYSICIAN 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 $250. 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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NEW TO PRACTICE CREDIT

A "NEW" PHYSICIAN SHALL BE A PHYSICIAN WHO HAS RECENTLY COMPLETED ONE OF THE FOLLOWING PROGRAMS AND WILL BEGIN A FULL TIME PRACTICE FOR THE FIRST TIME:

A) RESIDENCY;
B) FELLOWSHIP PROGRAM IN THEIR MEDICAL SPECIALITY;
C) FULFILLMENT OF A MILITARY OBLIGATION IN REMUNERATION FOR MEDICAL SCHOOL TUITION;
D) MEDICAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

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

CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR AND CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR AND CREDITS IN THE AMOUNT OF 15% OF FILED MANUAL RATES SHALL APPLY TO INSUREDS FOR THEIR THIRD YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR MEDICAL TRAINING PROGRAM.

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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 MADE AGAINST THE INSURED DURING THE PAST 5 YEARS PURSUANT TO THE FOLLOWING SCHEDULE:

Closed 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 $100,00 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

HOWEVER, PROVIDERS WHO HAVE BEEN INSURED WITH THE COMPANY FOR LESS THAN FIVE COMPLETE YEARS WILL HAVE THEIR POINTS ADJUSTED PURSUANT TO THE FOLLOWING FORMULA:

Adjusted Points = (5 / # of Full Years of Experience) x Points

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE.

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NON-DISCRETIONARY DEBIT PLAN

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

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. 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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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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PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

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 PHYSICIANS.

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PART TIME PRACTICE RULE

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

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 RISK MANAGEMENT AND/OR MEMBERSHIP ASSOCIATION.

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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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RENEWAL PREMIUM INCREASE LIMITATION

THE RENEWAL PREMIUM SHALL BE BASED UPON THE RATES IN EFFECT ON THE RENEWAL OR ANNIVERSARY DATE PROVIDED. HOWEVER, WITH RESPECT TO ANY INDIVIDUAL POLICY OR RISK RECEIVING A PREMIUM INCREASE, THAT PORTION OF THE PREMIUM INCREASE SPECIFICALLY CAUSED BY FILED CHANGES IN THE BASE RATE, INCREASED LIMIT FACTORS, CLAIMS MADE STEP FACTORS, TERRITORY FACTORS AND CLASS RELATIVITIES SHALL BE LESS THAN 30%. AT EACH SUBSEQUENT RENEWAL, THE BASE RATE, INCREASED LIMIT FACTOR, CLAIMS MADE STEP FACTOR, TERRITORY FACTOR AND CLASS RELATIVITY FOR AN AFFECTED INSURED WILL CONTINUE TO INCREASE (SUBJECT AGAIN TO A MAXIMUM COMBINED INCREASE OF LESS THAN 30%) UNTIL HIS/HER RATE MATCHES THOSE CURRENTLY APPROVED FOR USE IN THE STATE.

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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 $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, LOSS/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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RETIRED PHYSICIANS RATING RULE

IF PERMANENTLY RETIRED FROM THE PRACTICE OF MEDICINE, A PHYSICIAN MAY QUALIFY FOR $100,000/$300,000 LIMITS OCCURRENCE COVERAGE AT AN ANNUAL RATE OF $200 FOR THE FOLLOWING ACTIVITIES:

1) PRESCRIPTION WRITING FOR SELF AND IMMEDIATE FAMILY MEMBERS ONLY.

2) SERVICE ON OR EXECUTING THE DIRECTIVES OF A FORMAL ACCREDITATION, PEER REVIEW OR CREDENTIALING COMMITTEE OR HEARING PANEL.

THE PERFORMANCE OF ANY CLINICAL ACTIVITIES WILL REQUIRE THE PHYSICIAN TO BE RE-RATED IN ACCORDANCE WITH THE APPROPRIATE SPECIALTY.

NO OTHER CREDITS MAY APPLY CONCURRENTLY WITH THIS RULE.

EFFECTIVE DATE JAN 0 1 1999

The

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Fort Wayne, Indiana 46835

Professional Protection Exclusively Since 1899

DIVISION OF INSURANCE
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ILLINOIS

PHYSICIANS & SURGEONS

OCCURRENCE 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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SCHEDULE RATING PLAN

THE MEDICAL PROTECTIVE COMPANY SHALL UTILIZE THE FOLLOWING SCHEDULE OF MODIFICATIONS TO DETERMINE APPROPRIATE PREMIUMS FOR INSUREDS 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 -50% / +50%, 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 INSUREDS UNDERWRITING FILE.

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

CRITERIA	RANGE
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%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-15% TO +15%
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).	-10% TO +10%
MANAGEMENT CONTROL PROCEDURES: SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
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.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-5% TO +5%
OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES: ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
TRAINING, ACCREDITATION AND CREDENTIALING: THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
RECORD-KEEPING PRACTICES: DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
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, 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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OCCURRENCE PROGRAM

SOLO CORPORATION COVERAGE

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 07 2003
SPRINGFIELD, ILLINOIS

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

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

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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ILLINOIS

STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

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PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, JACKSON, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: LAKE, AND VERMILLION COUNTIES.

TERRITORY 3: KANE, MCHENRY, AND WINNEBAGO COUNTIES.

TERRITORY 4: DUPAGE, KANKAKEE, AND MACON, COUNTIES.

TERRITORY 5: BUREAU, CHAMPAIGN, COLES, DEKALB, EFFINGHAM, LASALLE, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 6: GRUNDY AND SANGAMON COUNTIES

TERRITORY 7: PEORIA COUNTY

TERRITORY 8: REMAINDER OF STATE.

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,072	2,818	4,165	5,159	5,366
1B	2,763	3,758	5,554	6,880	7,156
1C	3,246	4,415	6,524	8,083	8,407
1D	3,536	4,809	7,107	8,805	9,158
2A	3,868	5,260	7,775	9,631	10,018
2B	4,558	6,199	9,162	11,349	11,805
2C	5,387	7,326	10,828	13,414	13,952
2D	6,078	8,266	12,217	15,134	15,742
3A	6,492	8,894	13,438	17,074	17,853
3B	7,183	9,841	14,869	18,891	19,753
4A	7,874	10,787	16,299	20,709	21,654
4B	8,564	11,733	17,727	22,523	23,551
5A	9,669	13,247	20,015	25,429	26,590
5B	10,774	14,760	22,302	28,336	29,629
6A	11,327	15,518	23,447	29,790	31,149
6B	12,708	17,410	26,306	33,422	34,947
7	14,642	20,060	30,309	38,508	40,266
8	20,996	28,765	43,462	55,219	57,739

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,793	20,266	30,622	38,906	40,681
5A	16,701	22,880	34,571	43,924	45,928
5B	18,610	25,496	38,523	48,944	51,178
6A	19,565	26,804	40,500	51,456	53,804
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,853	12,040	17,795	22,044	22,929
1D	9,644	13,116	19,384	24,014	24,978
2A	10,548	14,345	21,201	26,265	27,319
2B	12,432	16,908	24,988	30,956	32,199
2C	14,693	19,982	29,533	36,586	38,055
2D	16,576	22,543	33,318	41,274	42,932
3A	17,706	24,257	36,651	46,567	48,692
3B	19,590	26,838	40,551	51,522	53,873
4A	21,473	29,418	44,449	56,474	59,051
4B	23,357	31,999	48,349	61,429	64,232
5A	26,371	36,128	54,588	69,356	72,520
5B	29,384	40,256	60,825	77,280	80,806
6A	30,892	42,322	63,946	81,246	84,953
6B	34,659	47,483	71,744	91,153	95,312
7	39,933	54,708	82,661	105,024	109,816
8	57,263	78,450	118,534	150,602	157,473

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STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,782	9,224	13,632	16,887	17,565
1B	9,041	12,296	18,172	22,512	23,416
1C	10,624	14,449	21,354	26,454	27,516
1D	11,573	15,739	23,262	28,817	29,974
2A	12,658	17,215	25,443	31,518	32,784
2B	14,918	20,288	29,985	37,146	38,638
2C	17,631	23,978	35,438	43,901	45,664
2D	19,891	27,052	39,981	49,529	51,518
3A	21,247	29,108	43,981	55,880	58,429
3B	23,508	32,206	48,662	61,826	64,647
4A	25,768	35,302	53,340	67,770	70,862
4B	28,029	38,400	58,020	73,716	77,080
5A	31,645	43,354	65,505	83,226	87,024
5B	35,261	48,308	72,990	92,736	96,968
6A	37,070	50,786	76,735	97,494	101,943
6B	41,591	56,980	86,093	109,384	114,375
7	47,920	65,650	99,194	126,030	131,780
8	68,715	94,140	142,240	180,720	188,966

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,158	9,735	14,388	17,823	18,539
1B	9,544	12,980	19,183	23,765	24,719
1C	11,214	15,251	22,540	27,923	29,044
1D	12,216	16,614	24,554	30,418	31,639
2A	13,361	18,171	26,856	33,269	34,605
2B	15,747	21,416	31,651	39,210	40,785
2C	18,611	25,311	37,408	46,341	48,202
2D	20,996	28,555	42,202	52,280	54,380
3A	22,428	30,726	46,426	58,986	61,677
3B	24,814	33,995	51,365	65,261	68,239
4A	27,199	37,263	56,302	71,533	74,797
4B	29,586	40,533	61,243	77,811	81,362
5A	33,403	45,762	69,144	87,850	91,858
5B	37,220	50,991	77,045	97,889	102,355
6A	39,130	53,608	80,999	102,912	107,608
6B	43,901	60,144	90,875	115,460	120,728
7	50,582	69,297	104,705	133,031	139,101
8	72,533	99,370	150,143	190,762	199,466

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,535	10,248	15,145	18,762	19,516
1B	10,046	13,663	20,192	25,015	26,019
1C	11,804	16,053	23,726	29,392	30,572
1D	12,859	17,488	25,847	32,019	33,305
2A	14,064	19,127	28,269	35,019	36,426
2B	16,576	22,543	33,318	41,274	42,932
2C	19,590	26,642	39,376	48,779	50,738
2D	22,101	30,057	44,423	55,031	57,242
3A	23,608	32,343	48,869	62,089	64,922
3B	26,120	35,784	54,068	68,696	71,830
4A	28,631	39,224	59,266	75,300	78,735
4B	31,143	42,666	64,466	81,906	85,643
5A	35,161	48,171	72,783	92,473	96,693
5B	39,179	53,675	81,101	103,041	107,742
6A	41,189	56,429	85,261	108,327	113,270
6B	46,212	63,310	95,659	121,538	127,083
7	53,244	72,944	110,215	140,032	146,421
8	76,350	104,600	158,045	200,801	209,963

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ILLINOIS - AREA 2

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,865	2,536	3,749	4,644	4,830
1B	2,486	3,381	4,997	6,190	6,439
1C	2,921	3,973	5,871	7,273	7,565
1D	3,182	4,328	6,396	7,923	8,241
2A	3,481	4,734	6,997	8,668	9,016
2B	4,102	5,579	8,245	10,214	10,624
2C	4,848	6,593	9,744	12,072	12,556
2D	5,470	7,439	10,995	13,620	14,167
3A	5,843	8,005	12,095	15,367	16,068
3B	6,464	8,856	13,380	17,000	17,776
4A	7,086	9,708	14,668	18,636	19,487
4B	7,707	10,559	15,953	20,269	21,194
5A	8,702	11,922	18,013	22,886	23,931
5B	9,697	13,285	20,073	25,503	26,667
6A	10,194	13,966	21,102	26,810	28,034
6B	11,437	15,669	23,675	30,079	31,452
7	13,177	18,052	27,276	34,656	36,237
8	18,896	25,888	39,115	49,696	51,964

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ILLINOIS - AREA 2

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,294	5,840	8,631	10,692	11,121
1C	5,046	6,863	10,142	12,565	13,069
1D	5,497	7,476	11,049	13,688	14,237
2A	6,012	8,176	12,084	14,970	15,571
2B	7,086	9,637	14,243	17,644	18,353
2C	8,374	11,389	16,832	20,851	21,689
2D	9,448	12,849	18,990	23,526	24,470
3A	10,092	13,826	20,890	26,542	27,753
3B	11,166	15,297	23,114	29,367	30,707
4A	12,239	16,767	25,335	32,189	33,657
4B	13,313	18,239	27,558	35,013	36,611
5A	15,031	20,592	31,114	39,532	41,335
5B	16,749	22,946	34,670	44,050	46,060
6A	17,607	24,122	36,446	46,306	48,419
6B	19,755	27,064	40,893	51,956	54,326
7	22,761	31,183	47,115	59,861	62,593
8	32,638	44,714	67,561	85,838	89,755

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ILLINOIS - AREA 2

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,781	9,222	13,630	16,885	17,563
1C	7,967	10,835	16,014	19,838	20,635
1D	8,679	11,803	17,445	21,611	22,479
2A	9,493	12,910	19,081	23,638	24,587
2B	11,189	15,217	22,490	27,861	28,980
2C	13,223	17,983	26,578	32,925	34,248
2D	14,918	20,288	29,985	37,146	38,638
3A	15,935	21,831	32,985	41,909	43,821
3B	17,630	24,153	36,494	46,367	48,483
4A	19,325	26,475	40,003	50,825	53,144
4B	21,020	28,797	43,511	55,283	57,805
5A	23,733	32,514	49,127	62,418	65,266
5B	26,445	36,230	54,741	69,550	72,724
6A	27,801	38,087	57,548	73,117	76,453
6B	31,192	42,733	64,567	82,035	85,778
7	35,938	49,235	74,392	94,517	98,830
8	51,534	70,602	106,675	135,534	141,719

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,103	8,300	12,267	15,196	15,807
1B	8,137	11,066	16,355	20,261	21,075
1C	9,561	13,003	19,218	23,807	24,763
1D	10,415	14,164	20,934	25,933	26,975
2A	11,391	15,492	22,896	28,364	29,503
2B	13,426	18,259	26,986	33,431	34,773
2C	15,867	21,579	31,893	39,509	41,096
2D	17,901	24,345	35,981	44,573	46,364
3A	19,121	26,196	39,580	50,288	52,583
3B	21,156	28,984	43,793	55,640	58,179
4A	23,190	31,770	48,003	60,990	63,773
4B	25,224	34,557	52,214	66,339	69,366
5A	28,480	39,018	58,954	74,902	78,320
5B	31,734	43,476	65,689	83,460	87,269
6A	33,361	45,705	69,057	87,739	91,743
6B	37,430	51,279	77,480	98,441	102,933
7	43,125	59,081	89,269	113,419	118,594
8	61,841	84,722	128,011	162,642	170,063

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,442	8,761	12,948	16,041	16,685
1B	8,589	11,681	17,264	21,387	22,246
1C	10,092	13,725	20,285	25,129	26,138
1D	10,993	14,950	22,096	27,373	28,472
2A	12,024	16,353	24,168	29,940	31,142
2B	14,172	19,274	28,486	35,288	36,705
2C	16,749	22,779	33,665	41,705	43,380
2D	18,896	25,699	37,981	47,051	48,941
3A	20,184	27,652	41,781	53,084	55,506
3B	22,332	30,595	46,227	58,733	61,413
4A	24,479	33,536	50,672	64,380	67,317
4B	26,626	36,478	55,116	70,026	73,222
5A	30,062	41,185	62,228	79,063	82,671
5B	33,497	45,891	69,339	88,097	92,117
6A	35,215	48,245	72,895	92,615	96,841
6B	39,510	54,129	81,786	103,911	108,653
7	45,521	62,364	94,228	119,720	125,183
8	65,276	89,428	135,121	171,676	179,509

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,781	9,222	13,630	16,885	17,563
1B	9,041	12,296	18,172	22,512	23,416
1C	10,623	14,447	21,352	26,451	27,514
1D	11,572	15,738	23,260	28,814	29,971
2A	12,657	17,214	25,441	31,516	32,782
2B	14,918	20,288	29,985	37,146	38,638
2C	17,630	23,977	35,436	43,899	45,662
2D	19,890	27,050	39,979	49,526	51,515
3A	21,246	29,107	43,979	55,877	58,427
3B	23,507	32,205	48,659	61,823	64,644
4A	25,767	35,301	53,338	67,767	70,859
4B	28,027	38,397	58,016	73,711	77,074
5A	31,644	43,352	65,503	83,224	87,021
5B	35,260	48,306	72,988	92,734	96,965
6A	37,068	50,783	76,731	97,489	101,937
6B	41,589	56,977	86,089	109,379	114,370
7	47,917	65,646	99,188	126,022	131,772
8	68,712	94,135	142,234	180,713	188,958

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,569	8,934	13,204	16,357	17,014
1B	8,758	11,911	17,604	21,807	22,683
1C	10,291	13,996	20,685	25,625	26,654
1D	11,210	15,246	22,532	27,913	29,034
2A	12,261	16,675	24,645	30,530	31,756
2B	14,451	19,653	29,047	35,983	37,428
2C	17,078	23,226	34,327	42,524	44,232
2D	19,268	26,204	38,729	47,977	49,904
3A	20,581	28,196	42,603	54,128	56,598
3B	22,771	31,196	47,136	59,888	62,620
4A	24,960	34,195	51,667	65,645	68,640
4B	27,150	37,196	56,201	71,405	74,663
5A	30,653	41,995	63,452	80,617	84,296
5B	34,156	46,794	70,703	89,830	93,929
6A	35,908	49,194	74,330	94,438	98,747
6B	40,287	55,193	83,394	105,955	110,789
7	46,417	63,591	96,083	122,077	127,647
8	66,561	91,189	137,781	175,055	183,043

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,761	2,395	3,540	4,385	4,561
1B	2,348	3,193	4,719	5,847	6,081
1C	2,759	3,752	5,546	6,870	7,146
1D	3,006	4,088	6,042	7,485	7,786
2A	3,288	4,472	6,609	8,187	8,516
2B	3,874	5,269	7,787	9,646	10,034
2C	4,579	6,227	9,204	11,402	11,860
2D	5,166	7,026	10,384	12,863	13,380
3A	5,518	7,560	11,422	14,512	15,175
3B	6,105	8,364	12,637	16,056	16,789
4A	6,692	9,168	13,852	17,600	18,403
4B	7,280	9,974	15,070	19,146	20,020
5A	8,219	11,260	17,013	21,616	22,602
5B	9,158	12,546	18,957	24,086	25,185
6A	9,628	13,190	19,930	25,322	26,477
6B	10,802	14,799	22,360	28,409	29,706
7	12,446	17,051	25,763	32,733	34,227
8	17,846	24,449	36,941	46,935	49,077

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,042	4,137	6,114	7,575	7,879
1B	4,056	5,516	8,153	10,099	10,505
1C	4,766	6,482	9,580	11,867	12,344
1D	5,192	7,061	10,436	12,928	13,447
2A	5,679	7,723	11,415	14,141	14,709
2B	6,692	9,101	13,451	16,663	17,332
2C	7,909	10,756	15,897	19,693	20,484
2D	8,923	12,135	17,935	22,218	23,111
3A	9,532	13,059	19,731	25,069	26,213
3B	10,545	14,447	21,828	27,733	28,999
4A	11,560	15,837	23,929	30,403	31,790
4B	12,574	17,226	26,028	33,070	34,579
5A	14,196	19,449	29,386	37,335	39,039
5B	15,818	21,671	32,743	41,601	43,500
6A	16,630	22,783	34,424	43,737	45,733
6B	18,658	25,561	38,622	49,071	51,310
7	21,497	29,451	44,499	56,537	59,117
8	30,826	42,232	63,810	81,072	84,772

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,803	6,532	9,654	11,959	12,440
1B	6,404	8,709	12,872	15,946	16,586
1C	7,525	10,234	15,125	18,737	19,490
1D	8,198	11,149	16,478	20,413	21,233
2A	8,966	12,194	18,022	22,325	23,222
2B	10,567	14,371	21,240	26,312	27,369
2C	12,488	16,984	25,101	31,095	32,344
2D	14,090	19,162	28,321	35,084	36,493
3A	15,050	20,619	31,154	39,582	41,388
3B	16,651	22,812	34,468	43,792	45,790
4A	18,252	25,005	37,782	48,003	50,193
4B	19,853	27,199	41,096	52,213	54,596
5A	22,415	30,709	46,399	58,951	61,641
5B	24,977	34,218	51,702	65,690	68,687
6A	26,258	35,973	54,354	69,059	72,210
6B	29,459	40,359	60,980	77,477	81,012
7	33,943	46,502	70,262	89,270	93,343
8	48,672	66,681	100,751	128,007	133,848

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,764	7,839	11,586	14,352	14,929
1B	7,685	10,452	15,447	19,136	19,904
1C	9,030	12,281	18,150	22,485	23,388
1D	9,837	13,378	19,772	24,494	25,478
2A	10,760	14,634	21,628	26,792	27,868
2B	12,680	17,245	25,487	31,573	32,841
2C	14,986	20,381	30,122	37,315	38,814
2D	16,907	22,994	33,983	42,098	43,789
3A	18,060	24,742	37,384	47,498	49,665
3B	19,981	27,374	41,361	52,550	54,948
4A	21,902	30,006	45,337	57,602	60,231
4B	23,824	32,639	49,316	62,657	65,516
5A	26,898	36,850	55,679	70,742	73,970
5B	29,972	41,062	62,042	78,826	82,423
6A	31,509	43,167	65,224	82,869	86,650
6B	35,351	48,431	73,177	92,973	97,215
7	40,731	55,801	84,313	107,123	112,010
8	58,406	80,016	120,900	153,608	160,617

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,084	8,274	12,229	15,149	15,758
1B	8,112	11,032	16,305	20,199	21,010
1C	9,531	12,962	19,157	23,732	24,685
1D	10,384	14,122	20,872	25,856	26,895
2A	11,357	15,446	22,828	28,279	29,415
2B	13,385	18,204	26,904	33,329	34,667
2C	15,818	21,512	31,794	39,387	40,969
2D	17,847	24,272	35,872	44,439	46,224
3A	19,064	26,118	39,462	50,138	52,426
3B	21,091	28,895	43,658	55,469	58,000
4A	23,119	31,673	47,856	60,803	63,577
4B	25,147	34,451	52,054	66,137	69,154
5A	28,393	38,898	58,774	74,674	78,081
5B	31,637	43,343	65,489	83,205	87,002
6A	33,260	45,566	68,848	87,474	91,465
6B	37,315	51,122	77,242	98,138	102,616
7	42,994	58,902	88,998	113,074	118,234
8	61,651	84,462	127,618	162,142	169,540

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,404	8,709	12,872	15,946	16,586
1B	8,539	11,613	17,163	21,262	22,116
1C	10,033	13,645	20,166	24,982	25,985
1D	10,930	14,865	21,969	27,216	28,309
2A	11,955	16,259	24,030	29,768	30,963
2B	14,089	19,161	28,319	35,082	36,491
2C	16,651	22,645	33,469	41,461	43,126
2D	18,786	25,549	37,760	46,777	48,656
3A	20,067	27,492	41,539	52,776	55,184
3B	22,201	30,415	45,956	58,389	61,053
4A	24,336	33,340	50,376	64,004	66,924
4B	26,471	36,265	54,795	69,619	72,795
5A	29,887	40,945	61,866	78,603	82,189
5B	33,302	45,624	68,935	87,584	91,581
6A	35,010	47,964	72,471	92,076	96,278
6B	39,279	53,812	81,308	103,304	108,017
7	45,257	62,002	93,682	119,026	124,457
8	64,896	88,908	134,335	170,676	178,464

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ILLINOIS - AREA 4

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,796	7,883	11,650	14,432	15,012
1B	7,728	10,510	15,533	19,243	20,016
1C	9,080	12,349	18,251	22,609	23,517
1D	9,892	13,453	19,883	24,631	25,620
2A	10,819	14,714	21,746	26,939	28,021
2B	12,751	17,341	25,630	31,750	33,025
2C	15,070	20,495	30,291	37,524	39,031
2D	17,002	23,123	34,174	42,335	44,035
3A	18,161	24,881	37,593	47,763	49,943
3B	20,093	27,527	41,593	52,845	55,256
4A	22,025	30,174	45,592	57,926	60,569
4B	23,957	32,821	49,591	63,007	65,882
5A	27,048	37,056	55,989	71,136	74,382
5B	30,139	41,290	62,388	79,266	82,882
6A	31,685	43,408	65,588	83,332	87,134
6B	35,549	48,702	73,586	93,494	97,760
7	40,958	56,112	84,783	107,720	112,635
8	58,733	80,464	121,577	154,468	161,516

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,554	2,113	3,124	3,869	4,025
1B	2,072	2,818	4,165	5,159	5,366
1C	2,435	3,312	4,894	6,063	6,307
1D	2,652	3,607	5,331	6,603	6,869
2A	2,901	3,945	5,831	7,223	7,514
2B	3,419	4,650	6,872	8,513	8,855
2C	4,041	5,496	8,122	10,062	10,466
2D	4,559	6,200	9,164	11,352	11,808
3A	4,869	6,671	10,079	12,805	13,390
3B	5,388	7,382	11,153	14,170	14,817
4A	5,906	8,091	12,225	15,533	16,242
4B	6,424	8,801	13,298	16,895	17,666
5A	7,253	9,937	15,014	19,075	19,946
5B	8,081	11,071	16,728	21,253	22,223
6A	8,496	11,640	17,587	22,344	23,364
6B	9,532	13,059	19,731	25,069	26,213
7	10,982	15,045	22,733	28,883	30,201
8	15,748	21,575	32,598	41,417	43,307

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ILLINOIS - AREA 4

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,684	3,650	5,395	6,683	6,952
1B	3,579	4,867	7,194	8,912	9,270
1C	4,206	5,720	8,454	10,473	10,894
1D	4,581	6,230	9,208	11,407	11,865
2A	5,011	6,815	10,072	12,477	12,978
2B	5,906	8,032	11,871	14,706	15,297
2C	6,979	9,491	14,028	17,378	18,076
2D	7,874	10,709	15,827	19,606	20,394
3A	8,411	11,523	17,411	22,121	23,130
3B	9,306	12,749	19,263	24,475	25,592
4A	10,201	13,975	21,116	26,829	28,053
4B	11,096	15,202	22,969	29,182	30,514
5A	12,527	17,162	25,931	32,946	34,449
5B	13,959	19,124	28,895	36,712	38,387
6A	14,675	20,105	30,377	38,595	40,356
6B	16,464	22,556	34,080	43,300	45,276
7	18,970	25,989	39,268	49,891	52,168
8	27,201	37,265	56,306	71,539	74,803

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ILLINOIS - AREA 4

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,238	5,764	8,518	10,553	10,976
1B	5,651	7,685	11,359	14,071	14,636
1C	6,641	9,032	13,348	16,536	17,200
1D	7,234	9,838	14,540	18,013	18,736
2A	7,912	10,760	15,903	19,701	20,492
2B	9,325	12,682	18,743	23,219	24,152
2C	11,020	14,987	22,150	27,440	28,542
2D	12,433	16,909	24,990	30,958	32,201
3A	13,280	18,194	27,490	34,926	36,520
3B	14,693	20,129	30,415	38,643	40,406
4A	16,106	22,065	33,339	42,359	44,292
4B	17,519	24,001	36,264	46,075	48,177
5A	19,780	27,099	40,945	52,021	54,395
5B	22,040	30,195	45,623	57,965	60,610
6A	23,171	31,744	47,964	60,940	63,720
6B	25,996	35,615	53,812	68,369	71,489
7	29,952	41,034	62,001	78,774	82,368
8	42,950	58,842	88,907	112,959	118,113

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,782	9,224	13,632	16,887	17,565
1C	7,969	10,838	16,018	19,843	20,640
1D	8,681	11,806	17,449	21,616	22,484
2A	9,494	12,912	19,083	23,640	24,589
2B	11,190	15,218	22,492	27,863	28,982
2C	13,224	17,985	26,580	32,928	34,250
2D	14,919	20,290	29,987	37,148	38,640
3A	15,936	21,832	32,988	41,912	43,824
3B	17,632	24,156	36,498	46,372	48,488
4A	19,328	26,479	40,009	50,833	53,152
4B	21,023	28,802	43,518	55,290	57,813
5A	23,736	32,518	49,134	62,426	65,274
5B	26,448	36,234	54,747	69,558	72,732
6A	27,805	38,093	57,556	73,127	76,464
6B	31,195	42,737	64,574	82,043	85,786
7	35,942	49,241	74,400	94,527	98,841
8	51,539	70,608	106,686	135,548	141,732

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,368	7,300	10,790	13,366	13,903
1B	7,158	9,735	14,388	17,823	18,539
1C	8,411	11,439	16,906	20,943	21,784
1D	9,163	12,462	18,418	22,816	23,732
2A	10,022	13,630	20,144	24,955	25,957
2B	11,811	16,063	23,740	29,409	30,590
2C	13,958	18,983	28,056	34,755	36,151
2D	15,748	21,417	31,653	39,213	40,787
3A	16,822	23,046	34,822	44,242	46,261
3B	18,611	25,497	38,525	48,947	51,180
4A	20,401	27,949	42,230	53,655	56,103
4B	22,191	30,402	45,935	58,362	61,025
5A	25,054	34,324	51,862	65,892	68,899
5B	27,918	38,248	57,790	73,424	76,775
6A	29,349	40,208	60,752	77,188	80,710
6B	32,928	45,111	68,161	86,601	90,552
7	37,939	51,976	78,534	99,780	104,332
8	54,403	74,532	112,614	143,080	149,608

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,854	12,041	17,797	22,046	22,932
1D	9,645	13,117	19,386	24,016	24,981
2A	10,549	14,347	21,203	26,267	27,322
2B	12,433	16,909	24,990	30,958	32,201
2C	14,693	19,982	29,533	36,586	38,055
2D	16,577	22,545	33,320	41,277	42,934
3A	17,707	24,259	36,653	46,569	48,694
3B	19,591	26,840	40,553	51,524	53,875
4A	21,475	29,421	44,453	56,479	59,056
4B	23,359	32,002	48,353	61,434	64,237
5A	26,373	36,131	54,592	69,361	72,526
5B	29,387	40,260	60,831	77,288	80,814
6A	30,894	42,325	63,951	81,251	84,959
6B	34,661	47,486	71,748	91,158	95,318
7	39,936	54,712	82,668	105,032	109,824
8	57,266	78,454	118,541	150,610	157,482

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PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,410	7,358	10,874	13,471	14,012
1B	7,213	9,810	14,498	17,960	18,682
1C	8,475	11,526	17,035	21,103	21,950
1D	9,233	12,557	18,558	22,990	23,913
2A	10,098	13,733	20,297	25,144	26,154
2B	11,901	16,185	23,921	29,633	30,824
2C	14,065	19,128	28,271	35,022	36,428
2D	15,869	21,582	31,897	39,514	41,101
3A	16,951	23,223	35,089	44,581	46,615
3B	18,754	25,693	38,821	49,323	51,574
4A	20,557	28,163	42,553	54,065	56,532
4B	22,360	30,633	46,285	58,807	61,490
5A	25,246	34,587	52,259	66,397	69,427
5B	28,131	38,539	58,231	73,985	77,360
6A	29,573	40,515	61,216	77,777	81,326
6B	33,180	45,457	68,683	87,263	91,245
7	38,229	52,374	79,134	100,542	105,130
8	54,819	75,102	113,475	144,174	150,752

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,450	1,972	2,915	3,611	3,756
1B	1,934	2,630	3,887	4,816	5,009
1C	2,272	3,090	4,567	5,657	5,884
1D	2,475	3,366	4,975	6,163	6,410
2A	2,707	3,682	5,441	6,740	7,011
2B	3,191	4,340	6,414	7,946	8,265
2C	3,771	5,129	7,580	9,390	9,767
2D	4,254	5,785	8,551	10,592	11,018
3A	4,544	6,225	9,406	11,951	12,496
3B	5,028	6,888	10,408	13,224	13,827
4A	5,511	7,550	11,408	14,494	15,155
4B	5,995	8,213	12,410	15,767	16,486
5A	6,768	9,272	14,010	17,800	18,612
5B	7,542	10,333	15,612	19,835	20,741
6A	7,929	10,863	16,413	20,853	21,805
6B	8,895	12,186	18,413	23,394	24,461
7	10,249	14,041	21,215	26,955	28,185
8	14,697	20,135	30,423	38,653	40,417

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,505	3,407	5,035	6,237	6,488
1B	3,340	4,542	6,713	8,317	8,651
1C	3,925	5,338	7,889	9,773	10,166
1D	4,275	5,814	8,593	10,645	11,072
2A	4,676	6,359	9,399	11,643	12,111
2B	5,511	7,495	11,077	13,722	14,273
2C	6,513	8,858	13,091	16,217	16,869
2D	7,348	9,993	14,769	18,297	19,031
3A	7,849	10,753	16,247	20,643	21,585
3B	8,684	11,897	17,976	22,839	23,881
4A	9,519	13,041	19,704	25,035	26,177
4B	10,355	14,186	21,435	27,234	28,476
5A	11,691	16,017	24,200	30,747	32,150
5B	13,027	17,847	26,966	34,261	35,824
6A	13,695	18,762	28,349	36,018	37,661
6B	15,365	21,050	31,806	40,410	42,254
7	17,703	24,253	36,645	46,559	48,683
8	25,385	34,777	52,547	66,763	69,809

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,956	5,380	7,952	9,850	10,246
1B	5,274	7,173	10,601	13,132	13,660
1C	6,197	8,428	12,456	15,431	16,050
1D	6,751	9,181	13,570	16,810	17,485
2A	7,384	10,042	14,842	18,386	19,125
2B	8,702	11,835	17,491	21,668	22,538
2C	10,284	13,986	20,671	25,607	26,636
2D	11,603	15,780	23,322	28,891	30,052
3A	12,394	16,980	25,656	32,596	34,084
3B	13,712	18,785	28,384	36,063	37,708
4A	15,031	20,592	31,114	39,532	41,335
4B	16,349	22,398	33,842	42,998	44,960
5A	18,459	25,289	38,210	48,547	50,762
5B	20,569	28,180	42,578	54,096	56,565
6A	21,623	29,624	44,760	56,868	59,463
6B	24,260	33,236	50,218	63,804	66,715
7	27,953	38,296	57,863	73,516	76,871
8	40,082	54,912	82,970	105,416	110,226

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,747	6,456	9,541	11,820	12,295
1B	6,329	8,607	12,721	15,759	16,392
1C	7,437	10,114	14,948	18,518	19,262
1D	8,101	11,017	16,283	20,171	20,982
2A	8,861	12,051	17,811	22,064	22,950
2B	10,443	14,202	20,990	26,003	27,047
2C	12,341	16,784	24,805	30,729	31,963
2D	13,923	18,935	27,985	34,668	36,061
3A	14,873	20,376	30,787	39,116	40,901
3B	16,455	22,543	34,062	43,277	45,251
4A	18,037	24,711	37,337	47,437	49,602
4B	19,619	26,878	40,611	51,598	53,952
5A	22,151	30,347	45,853	58,257	60,915
5B	24,683	33,816	51,094	64,916	67,878
6A	25,948	35,549	53,712	68,243	71,357
6B	29,112	39,883	60,262	76,565	80,058
7	33,543	45,954	69,434	88,218	92,243
8	48,099	65,896	99,565	126,500	132,272

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,010	6,814	10,070	12,475	12,976
1B	6,680	9,085	13,427	16,633	17,301
1C	7,850	10,676	15,779	19,547	20,332
1D	8,551	11,629	17,188	21,292	22,147
2A	9,353	12,720	18,800	23,289	24,224
2B	11,023	14,991	22,156	27,447	28,550
2C	13,026	17,715	26,182	32,435	33,737
2D	14,697	19,988	29,541	36,596	38,065
3A	15,699	21,508	32,497	41,288	43,172
3B	17,369	23,796	35,954	45,680	47,765
4A	19,039	26,083	39,411	50,073	52,357
4B	20,709	28,371	42,868	54,465	56,950
5A	23,381	32,032	48,399	61,492	64,298
5B	26,054	35,694	53,932	68,522	71,649
6A	27,389	37,523	56,695	72,033	75,320
6B	30,730	42,100	63,611	80,820	84,508
7	35,407	48,508	73,292	93,120	97,369
8	50,771	69,556	105,096	133,528	139,620

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ILLINOIS - AREA 5

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,274	7,173	10,601	13,132	13,660
1B	7,032	9,564	14,134	17,510	18,213
1C	8,263	11,238	16,609	20,575	21,401
1D	9,001	12,241	18,092	22,412	23,313
2A	9,845	13,389	19,788	24,514	25,499
2B	11,603	15,780	23,322	28,891	30,052
2C	13,712	18,648	27,561	34,143	35,514
2D	15,470	21,039	31,095	38,520	40,067
3A	16,525	22,639	34,207	43,461	45,444
3B	18,283	25,048	37,846	48,084	50,278
4A	20,041	27,456	41,485	52,708	55,113
4B	21,799	29,865	45,124	57,331	59,947
5A	24,612	33,718	50,947	64,730	67,683
5B	27,425	37,572	56,770	72,128	75,419
6A	28,831	39,498	59,680	75,826	79,285
6B	32,347	44,315	66,958	85,073	88,954
7	37,270	51,060	77,149	98,020	102,493
8	53,443	73,217	110,627	140,555	146,968

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ILLINOIS - AREA 6

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,637	6,306	9,320	11,546	12,010
1B	6,182	8,408	12,426	15,393	16,011
1C	7,264	9,879	14,601	18,087	18,814
1D	7,913	10,762	15,905	19,703	20,495
2A	8,655	11,771	17,397	21,551	22,416
2B	10,200	13,872	20,502	25,398	26,418
2C	12,055	16,395	24,231	30,017	31,222
2D	13,600	18,496	27,336	33,864	35,224
3A	14,528	19,903	30,073	38,209	39,952
3B	16,073	22,020	33,271	42,272	44,201
4A	17,619	24,138	36,471	46,338	48,452
4B	19,164	26,255	39,669	50,401	52,701
5A	21,637	29,643	44,789	56,905	59,502
5B	24,110	33,031	49,908	63,409	66,303
6A	25,346	34,724	52,466	66,660	69,702
6B	28,437	38,959	58,865	74,789	78,202
7	32,765	44,888	67,824	86,172	90,104
8	46,983	64,367	97,255	123,565	129,203

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ILLINOIS - AREA 6

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,243	1,690	2,498	3,095	3,219
1B	1,658	2,255	3,333	4,128	4,294
1C	1,948	2,649	3,915	4,851	5,045
1D	2,122	2,886	4,265	5,284	5,496
2A	2,321	3,157	4,665	5,779	6,011
2B	2,735	3,720	5,497	6,810	7,084
2C	3,233	4,397	6,498	8,050	8,373
2D	3,647	4,960	7,330	9,081	9,446
3A	3,896	5,338	8,065	10,246	10,714
3B	4,310	5,905	8,922	11,335	11,853
4A	4,725	6,473	9,781	12,427	12,994
4B	5,139	7,040	10,638	13,516	14,132
5A	5,802	7,949	12,010	15,259	15,956
5B	6,465	8,857	13,383	17,003	17,779
6A	6,797	9,312	14,070	17,876	18,692
6B	7,625	10,446	15,784	20,054	20,969
7	8,786	12,037	18,187	23,107	24,162
8	12,599	17,261	26,080	33,135	34,647

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ILLINOIS - AREA 6

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,147	2,920	4,315	5,346	5,561
1B	2,863	3,894	5,755	7,129	7,415
1C	3,364	4,575	6,762	8,376	8,713
1D	3,665	4,984	7,367	9,126	9,492
2A	4,009	5,452	8,058	9,982	10,383
2B	4,724	6,425	9,495	11,763	12,235
2C	5,584	7,594	11,224	13,904	14,463
2D	6,299	8,567	12,661	15,685	16,314
3A	6,729	9,219	13,929	17,697	18,505
3B	7,445	10,200	15,411	19,580	20,474
4A	8,161	11,181	16,893	21,463	22,443
4B	8,876	12,160	18,373	23,344	24,409
5A	10,022	13,730	20,746	26,358	27,561
5B	11,167	15,299	23,116	29,369	30,709
6A	11,740	16,084	24,302	30,876	32,285
6B	13,171	18,044	27,264	34,640	36,220
7	15,175	20,790	31,412	39,910	41,731
8	21,761	29,813	45,045	57,231	59,843

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ILLINOIS - AREA 6

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,947	13,528	19,993	24,768	25,763
3A	10,625	14,556	21,994	27,944	29,219
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,069	5,534	8,179	10,132	10,539
1B	5,425	7,378	10,904	13,508	14,051
1C	6,375	8,670	12,814	15,874	16,511
1D	6,944	9,444	13,957	17,291	17,985
2A	7,595	10,329	15,266	18,912	19,671
2B	8,951	12,173	17,992	22,288	23,183
2C	10,580	14,389	21,266	26,344	27,402
2D	11,936	16,233	23,991	29,721	30,914
3A	12,749	17,466	26,390	33,530	35,060
3B	14,106	19,325	29,199	37,099	38,792
4A	15,462	21,183	32,006	40,665	42,521
4B	16,818	23,041	34,813	44,231	46,250
5A	18,988	26,014	39,305	49,938	52,217
5B	21,158	28,986	43,797	55,646	58,185
6A	22,244	30,474	46,045	58,502	61,171
6B	24,956	34,190	51,659	65,634	68,629
7	28,753	39,392	59,519	75,620	79,071
8	41,232	56,488	85,350	108,440	113,388

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,295	5,841	8,633	10,695	11,124
1B	5,727	7,789	11,511	14,260	14,833
1C	6,729	9,151	13,525	16,755	17,428
1D	7,330	9,969	14,733	18,252	18,985
2A	8,017	10,903	16,114	19,962	20,764
2B	9,449	12,851	18,992	23,528	24,473
2C	11,167	15,187	22,446	27,806	28,923
2D	12,599	17,135	25,324	31,372	32,631
3A	13,458	18,437	27,858	35,395	37,010
3B	14,889	20,398	30,820	39,158	40,945
4A	16,321	22,360	33,784	42,924	44,883
4B	17,753	24,322	36,749	46,690	48,821
5A	20,043	27,459	41,489	52,713	55,118
5B	22,334	30,598	46,231	58,738	61,419
6A	23,479	32,166	48,602	61,750	64,567
6B	26,343	36,090	54,530	69,282	72,443
7	30,351	41,581	62,827	79,823	83,465
8	43,522	59,625	90,091	114,463	119,686

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,521	6,149	9,087	11,257	11,709
1B	6,028	8,198	12,116	15,010	15,613
1C	7,083	9,633	14,237	17,637	18,345
1D	7,716	10,494	15,509	19,213	19,984
2A	8,439	11,477	16,962	21,013	21,857
2B	9,946	13,527	19,991	24,766	25,760
2C	11,755	15,987	23,628	29,270	30,445
2D	13,262	18,036	26,657	33,022	34,349
3A	14,166	19,407	29,324	37,257	38,957
3B	15,673	21,472	32,443	41,220	43,101
4A	17,180	23,537	35,563	45,183	47,245
4B	18,687	25,601	38,682	49,147	51,389
5A	21,098	28,904	43,673	55,488	58,020
5B	23,509	32,207	48,664	61,829	64,650
6A	24,715	33,860	51,160	65,000	67,966
6B	27,729	37,989	57,399	72,927	76,255
7	31,948	43,769	66,132	84,023	87,857
8	45,813	62,764	94,833	120,488	125,986

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PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,478	4,730	6,991	8,660	9,008
1B	4,637	6,306	9,320	11,546	12,010
1C	5,448	7,409	10,950	13,566	14,110
1D	5,935	8,072	11,929	14,778	15,372
2A	6,492	8,829	13,049	16,165	16,814
2B	7,651	10,405	15,379	19,051	19,816
2C	9,042	12,297	18,174	22,515	23,419
2D	10,201	13,873	20,504	25,400	26,421
3A	10,897	14,929	22,557	28,659	29,967
3B	12,056	16,517	24,956	31,707	33,154
4A	13,215	18,105	27,355	34,755	36,341
4B	14,375	19,694	29,756	37,806	39,531
5A	16,230	22,235	33,596	42,685	44,633
5B	18,084	24,775	37,434	47,561	49,731
6A	19,012	26,046	39,355	50,002	52,283
6B	21,330	29,222	44,153	56,098	58,658
7	24,576	33,669	50,872	64,635	67,584
8	35,241	48,280	72,949	92,684	96,913

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	933	1,269	1,875	2,323	2,416
1B	1,243	1,690	2,498	3,095	3,219
1C	1,461	1,987	2,937	3,638	3,784
1D	1,591	2,164	3,198	3,962	4,121
2A	1,740	2,366	3,497	4,333	4,507
2B	2,052	2,791	4,125	5,109	5,315
2C	2,424	3,297	4,872	6,036	6,278
2D	2,735	3,720	5,497	6,810	7,084
3A	2,922	4,003	6,049	7,685	8,036
3B	3,233	4,429	6,692	8,503	8,891
4A	3,543	4,854	7,334	9,318	9,743
4B	3,854	5,280	7,978	10,136	10,599
5A	4,352	5,962	9,009	11,446	11,968
5B	4,849	6,643	10,037	12,753	13,335
6A	5,097	6,983	10,551	13,405	14,017
6B	5,719	7,835	11,838	15,041	15,727
7	6,589	9,027	13,639	17,329	18,120
8	9,449	12,945	19,559	24,851	25,985

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,611	2,191	3,238	4,011	4,172
1B	2,147	2,920	4,315	5,346	5,561
1C	2,523	3,431	5,071	6,282	6,535
1D	2,749	3,739	5,525	6,845	7,120
2A	3,006	4,088	6,042	7,485	7,786
2B	3,544	4,820	7,123	8,825	9,179
2C	4,188	5,696	8,418	10,428	10,847
2D	4,724	6,425	9,495	11,763	12,235
3A	5,046	6,913	10,445	13,271	13,877
3B	5,584	7,650	11,559	14,686	15,356
4A	6,120	8,384	12,668	16,096	16,830
4B	6,657	9,120	13,780	17,508	18,307
5A	7,516	10,297	15,558	19,767	20,669
5B	8,375	11,474	17,336	22,026	23,031
6A	8,805	12,063	18,226	23,157	24,214
6B	9,879	13,534	20,450	25,982	27,167
7	11,381	15,592	23,559	29,932	31,298
8	16,321	22,360	33,784	42,924	44,883

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,543	3,458	5,111	6,332	6,586
1B	3,391	4,612	6,816	8,444	8,783
1C	3,984	5,418	8,008	9,920	10,319
1D	4,340	5,902	8,723	10,807	11,241
2A	4,747	6,456	9,541	11,820	12,295
2B	5,595	7,609	11,246	13,932	14,491
2C	6,612	8,992	13,290	16,464	17,125
2D	7,460	10,146	14,995	18,575	19,321
3A	7,968	10,916	16,494	20,956	21,912
3B	8,816	12,078	18,249	23,186	24,244
4A	9,664	13,240	20,004	25,416	26,576
4B	10,511	14,400	21,758	27,644	28,905
5A	11,868	16,259	24,567	31,213	32,637
5B	13,224	18,117	27,374	34,779	36,366
6A	13,902	19,046	28,777	36,562	38,231
6B	15,598	21,369	32,288	41,023	42,895
7	17,971	24,620	37,200	47,264	49,420
8	25,770	35,305	53,344	67,775	70,868

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,052	4,151	6,135	7,599	7,905
1B	4,069	5,534	8,179	10,132	10,539
1C	4,781	6,502	9,610	11,905	12,383
1D	5,208	7,083	10,468	12,968	13,489
2A	5,696	7,747	11,449	14,183	14,753
2B	6,714	9,131	13,495	16,718	17,389
2C	7,934	10,790	15,947	19,756	20,549
2D	8,951	12,173	17,992	22,288	23,183
3A	9,562	13,100	19,793	25,148	26,296
3B	10,580	14,495	21,901	27,825	29,095
4A	11,597	15,888	24,006	30,500	31,892
4B	12,614	17,281	26,111	33,175	34,689
5A	14,242	19,512	29,481	37,456	39,166
5B	15,869	21,741	32,849	41,735	43,640
6A	16,682	22,854	34,532	43,874	45,876
6B	18,717	25,642	38,744	49,226	51,472
7	21,565	29,544	44,640	56,716	59,304
8	30,924	42,366	64,013	81,330	85,041

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,295	5,841	8,633	10,695	11,124
1C	5,046	6,863	10,142	12,565	13,069
1D	5,498	7,477	11,051	13,690	14,240
2A	6,013	8,178	12,086	14,972	15,574
2B	7,087	9,638	14,245	17,647	18,355
2C	8,375	11,390	16,834	20,854	21,691
2D	9,449	12,851	18,992	23,528	24,473
3A	10,093	13,827	20,893	26,545	27,756
3B	11,167	15,299	23,116	29,369	30,709
4A	12,241	16,770	25,339	32,194	33,663
4B	13,314	18,240	27,560	35,016	36,614
5A	15,033	20,595	31,118	39,537	41,341
5B	16,750	22,948	34,673	44,053	46,063
6A	17,609	24,124	36,451	46,312	48,425
6B	19,757	27,067	40,897	51,961	54,332
7	22,763	31,185	47,119	59,867	62,598
8	32,642	44,720	67,569	85,848	89,766

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ILLINOIS - AREA 7

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

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ILLINOIS - AREA 8

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,864	5,255	7,767	9,621	10,008
1B	5,152	7,007	10,356	12,828	13,344
1C	6,054	8,233	12,169	15,074	15,680
1D	6,595	8,969	13,256	16,422	17,081
2A	7,213	9,810	14,498	17,960	18,682
2B	8,501	11,561	17,087	21,167	22,018
2C	10,046	13,663	20,192	25,015	26,019
2D	11,334	15,414	22,781	28,222	29,355
3A	12,107	16,587	25,061	31,841	33,294
3B	13,395	18,351	27,728	35,229	36,836
4A	14,683	20,116	30,394	38,616	40,378
4B	15,971	21,880	33,060	42,004	43,920
5A	18,032	24,704	37,326	47,424	49,588
5B	20,093	27,527	41,593	52,845	55,256
6A	21,123	28,939	43,725	55,553	58,088
6B	23,699	32,468	49,057	62,328	65,172
7	27,306	37,409	56,523	71,815	75,092
8	39,155	53,642	81,051	102,978	107,676

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,036	1,409	2,082	2,580	2,683
1B	1,381	1,878	2,776	3,439	3,577
1C	1,623	2,207	3,262	4,041	4,204
1D	1,768	2,404	3,554	4,402	4,579
2A	1,934	2,630	3,887	4,816	5,009
2B	2,279	3,099	4,581	5,675	5,903
2C	2,694	3,664	5,415	6,708	6,977
2D	3,039	4,133	6,108	7,567	7,871
3A	3,246	4,447	6,719	8,537	8,927
3B	3,592	4,921	7,435	9,447	9,878
4A	3,937	5,394	8,150	10,354	10,827
4B	4,282	5,866	8,864	11,262	11,776
5A	4,835	6,624	10,008	12,716	13,296
5B	5,387	7,380	11,151	14,168	14,814
6A	5,663	7,758	11,722	14,894	15,573
6B	6,354	8,705	13,153	16,711	17,474
7	7,321	10,030	15,154	19,254	20,133
8	10,498	14,382	21,731	27,610	28,870

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ILLINOIS - AREA 8

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,789	2,433	3,596	4,455	4,634
1B	2,386	3,245	4,796	5,941	6,180
1C	2,803	3,812	5,634	6,979	7,260
1D	3,054	4,153	6,139	7,604	7,910
2A	3,340	4,542	6,713	8,317	8,651
2B	3,937	5,354	7,913	9,803	10,197
2C	4,653	6,328	9,353	11,586	12,051
2D	5,249	7,139	10,550	13,070	13,595
3A	5,607	7,682	11,606	14,746	15,419
3B	6,204	8,499	12,842	16,317	17,061
4A	6,800	9,316	14,076	17,884	18,700
4B	7,396	10,133	15,310	19,451	20,339
5A	8,351	11,441	17,287	21,963	22,965
5B	9,305	12,748	19,261	24,472	25,589
6A	9,782	13,401	20,249	25,727	26,901
6B	10,975	15,036	22,718	28,864	30,181
7	12,645	17,324	26,175	33,256	34,774
8	18,133	24,842	37,535	47,690	49,866

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2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,825	3,842	5,678	7,034	7,317
1B	3,767	5,123	7,572	9,380	9,757
1C	4,427	6,021	8,898	11,023	11,466
1D	4,822	6,558	9,692	12,007	12,489
2A	5,274	7,173	10,601	13,132	13,660
2B	6,216	8,454	12,494	15,478	16,099
2C	7,346	9,991	14,765	18,292	19,026
2D	8,288	11,272	16,659	20,637	21,466
3A	8,853	12,129	18,326	23,283	24,346
3B	9,795	13,419	20,276	25,761	26,936
4A	10,737	14,710	22,226	28,238	29,527
4B	11,678	15,999	24,173	30,713	32,115
5A	13,186	18,065	27,295	34,679	36,262
5B	14,693	20,129	30,415	38,643	40,406
6A	15,446	21,161	31,973	40,623	42,477
6B	17,330	23,742	35,873	45,578	47,658
7	19,967	27,355	41,332	52,513	54,909
8	28,631	39,224	59,266	75,300	78,735

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3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,390	4,610	6,814	8,441	8,780
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,786	7,869	11,630	14,407	14,986
2A	6,329	8,607	12,721	15,759	16,392
2B	7,459	10,144	14,993	18,573	19,319
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,754	16,103	24,331	30,913	32,324
4A	12,884	17,651	26,670	33,885	35,431
4B	14,014	19,199	29,009	36,857	38,539
5A	15,823	21,678	32,754	41,614	43,513
5B	17,631	24,154	36,496	46,370	48,485
6A	18,535	25,393	38,367	48,747	50,971
6B	20,795	28,489	43,046	54,691	57,186
7	23,960	32,825	49,597	63,015	65,890
8	34,358	47,070	71,121	90,362	94,485

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4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,792	20,265	30,619	38,903	40,678
5A	16,702	22,882	34,573	43,926	45,931
5B	18,611	25,497	38,525	48,947	51,180
6A	19,564	26,803	40,497	51,453	53,801
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

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MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,767	5,123	7,572	9,380	9,757
1B	5,023	6,831	10,096	12,507	13,010
1C	5,902	8,027	11,863	14,696	15,286
1D	6,429	8,743	12,922	16,008	16,651
2A	7,032	9,564	14,134	17,510	18,213
2B	8,288	11,272	16,659	20,637	21,466
2C	9,795	13,321	19,688	24,390	25,369
2D	11,051	15,029	22,213	27,517	28,622
3A	11,804	16,171	24,434	31,045	32,461
3B	13,060	17,892	27,034	34,348	35,915
4A	14,316	19,613	29,634	37,651	39,369
4B	15,571	21,332	32,232	40,952	42,820
5A	17,581	24,086	36,393	46,238	48,348
5B	19,590	26,838	40,551	51,522	53,873
6A	20,594	28,214	42,630	54,162	56,634
6B	23,106	31,655	47,829	60,769	63,542
7	26,622	36,472	55,108	70,016	73,211
8	38,175	52,300	79,022	100,400	104,981

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STANDARD CLAIMS MADE PROGRAM

INCREASED LIMITS TABLE

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

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EXCESS LIMITS FACTORS TABLE			
LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
1M/1M xs 1M/3M	1.270	1.300	1.300
2M/2M xs 1M/3M	1.430	1.480	1.480
3M/3M xs 1M/3M	1.560	1.620	1.620
4M/4M xs 1M/3M	1.670	1.740	1.740

Note: For aggregate limits not listed above, refer to company.

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CLAIMS MADE FACTORS

YEARS SINCE RETROACTIVE DATE	FACTOR
0	0.275
1	0.475
2	0.750
3	0.900
4	0.950
5 OR MORE	1.000
MATURE CLAIMS MADE TO OCCURRENCE FACTOR	0.975

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STANDARD CLAIMS-MADE

EXTENSION CONTRACT FACTORS

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

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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 MEDICINE IN LESS THAN FIVE YEARS.

3) THE COMPANY APPROVED THE GROUP'S REQUEST FOR THE WAIVER AFTER DETERMINING THE INSURED HAD LIMITED PRIOR ACTS EXPOSURE.

4) AT THE TIME THE INSURED PERMANENTLY RETIRES, HE OR SHE HAS ATTAINED THE AGE OF 55 AND IS ASSOCIATED WITH THE GROUP INSURED BY THE COMPANY.

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, RISK MANAGEMENT OR DEDUCTIBLE CREDITS.

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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 YEARS, 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 10 YEARS, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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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DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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%

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DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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 PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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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 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.

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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 DEBITS.

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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FULL TIME EQUIVALENCY RATING RULE

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

2,500	-GROUP PRACTICE
2,100	-RESIDENCY PROGRAMS

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

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

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FULL TIME EQUIVALENCY RATING RULE (CONT.)

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

FTE* PER POLICY	PREMIUM MODIFICATION	FTE* PER POLICY	PREMIUM MODIFICATION
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 NEW TO PRACTICE, PART TIME PRACTICE, OR LOSS FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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GROUP RATING RULE

ANY GROUP PRACTICE CONSISTING OF TWO OR MORE PHYSICIANS 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 "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 CONRACT RATING RULE.

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INDIVIDUAL RISK RATING PLAN

CORPORATION VICARIOUS LIABILITY FOR PHYSICIANS NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A VICARIOUS LIABILITY EXPOSURE FOR PHYSICANS WHO ARE NOT INDIVIDUALLY INSURED BY MEDICAL PROTECTIVE, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

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INDIVIDUAL RISK RATING PLAN

CRNA TO ANESTHESIOLOGIST RATIO

WHEN A RISK OF CORPORATION COVERAGE INCLUDES A CRNA TO ANESTHESIOLOGIST RATIO OF GREATER THAN 2 TO 1, THE RISK MAY FALL OUTSIDE OF THE COMPANY'S STANDARD CORPORATION POLICY PRICING AND REQUIRE THE INSURED'S PREMIUM BE INDIVIDUALLY RISK RATED.

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LEAVE OF ABSENCE CREDIT RULE

A PHYSICIAN 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.

THE
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LOCUM TENENS

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

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

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LOSS FREE CREDIT

IF NO LOSS HAS BEEN ATTRIBUTED TO AN INSURED, THE INSURED WILL BE ELIGIBLE FOR PREMIUM CREDITS ON THE FOLLOWING SCHEDULE:

1. IF INSURED BY THE COMPANY AND LOSS 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 LOSS FREE FOR 5 YEARS BUT LESS THAN 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND LOSS FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% SHALL BE APPLIED TO THE NEXT POLICY RENEWAL.

A LOSS 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS LOSS FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE LOSS FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH STANDARD GUIDELINES APPLICABLE TO THE COMPANY'S INSUREDS.

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MEMBERSHIP ASSOCIATION CREDIT RULE

THE UNIQUE CHARACTERISTICS OF A MEDICAL 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 5% 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 PHYSICIAN 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 $250. 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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NEW TO PRACTICE CREDIT

A "NEW" PHYSICIAN SHALL BE A PHYSICIAN WHO HAS RECENTLY COMPLETED ONE OF THE FOLLOWING PROGRAMS AND WILL BEGIN A FULL TIME PRACTICE FOR THE FIRST TIME:

A) RESIDENCY;
B) FELLOWSHIP PROGRAM IN THEIR MEDICAL SPECIALITY;
C) FULFILLMENT OF A MILITARY OBLIGATION IN REMUNERATION FOR MEDICAL SCHOOL TUITION;
D) MEDICAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

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

CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR AND CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR AND CREDITS IN THE AMOUNT OF 15% OF FILED MANUAL RATES SHALL APPLY TO INSUREDS FOR THEIR THIRD YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR MEDICAL TRAINING PROGRAM.

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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 MADE AGAINST THE INSURED DURING THE PAST 5 YEARS PURSUANT TO THE FOLLOWING SCHEDULE:

Closed 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 $100,00 to $249,999	4
Loss payment of $250,000 to $499,999	6
Loss payment of $500,000 or more	8

HOWEVER, PROVIDERS WHO HAVE BEEN INSURED WITH THE COMPANY FOR LESS THAN FIVE COMPLETE YEARS WILL HAVE THEIR POINTS ADJUSTED PURSUANT TO THE FOLLOWING FORMULA:

Adjusted Points = (5 / # of Full Years of Experience) x Points

INSUREDS WITH LESS THAN ONE YEAR OF EXPERIENCE SHALL BE ASSUMED TO HAVE ONE YEAR OF EXPERIENCE.

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NON-DISCRETIONARY DEBIT PLAN

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

Total Points	Table A	Table B
0	0%	0%
1	0%	0%
2	0%	0%
3	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

(FOR THE PURPOSES OF THIS SCHEDULE, TABLE B SHALL APPLY TO ALL INSUREDS PRACTICING UNDER THE FOLLOWING ISO CODES: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. 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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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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PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

Limit	Territory 1 Cap	Territory 2 Cap	Territory 3 Cap	Territory 4 Cap	Territory 5 Cap	Territory 6 Cap	Territory 7 Cap	Territory 8 Cap
1000/3000 and below	$40,600	$36,500	$34,500	$30,400	$28,400	$24,300	$18,200	$20,300
2000/4000	$51,500	$46,300	$43,800	$38,600	$36,000	$30,900	$23,200	$25,700
3000/5000	$58,000	$52,200	$49,300	$43,500	$40,600	$34,800	$26,100	$29,000
4000/6000	$63,300	$56,900	$53,800	$47,400	$44,300	$38,000	$28,500	$31,600
5000/7000	$67,700	$60,900	$57,600	$50,800	$47,400	$40,600	$30,500	$33,900

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 PHYSICIANS.

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

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 RISK MANAGEMENT AND/OR MEMBERSHIP ASSOCIATION.

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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 THE APPROVAL OF THE COMPANY.

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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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RENEWAL PREMIUM INCREASE LIMITATION

THE RENEWAL PREMIUM SHALL BE BASED UPON THE RATES IN EFFECT ON THE RENEWAL OR ANNIVERSARY DATE PROVIDED. HOWEVER, WITH RESPECT TO ANY INDIVIDUAL POLICY OR RISK RECEIVING A PREMIUM INCREASE, THAT PORTION OF THE PREMIUM INCREASE SPECIFICALLY CAUSED BY FILED CHANGES IN THE BASE RATE, INCREASED LIMIT FACTORS, CLAIMS MADE STEP FACTORS, TERRITORY FACTORS AND CLASS RELATIVITIES SHALL BE LESS THAN 30%. AT EACH SUBSEQUENT RENEWAL, THE BASE RATE, INCREASED LIMIT FACTOR, CLAIMS MADE STEP FACTOR, TERRITORY FACTOR AND CLASS RELATIVITY FOR AN AFFECTED INSURED WILL CONTINUE TO INCREASE (SUBJECT AGAIN TO A MAXIMUM COMBINED INCREASE OF LESS THAN 30%) UNTIL HIS/HER RATE MATCHES THOSE CURRENTLY APPROVED FOR USE IN THE STATE.

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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 $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, LOSS/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 INSUREDS 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 -50% / +50%, 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 INSUREDS UNDERWRITING FILE.

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

CRITERIA	RANGE
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%

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CRITERIA	RANGE
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.	-5% TO +5%
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.	-15% TO +15%
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).	-10% TO +10%
MANAGEMENT CONTROL PROCEDURES: SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
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.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-5% TO +5%
OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES: ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
TRAINING, ACCREDITATION AND CREDENTIALING: THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
RECORD-KEEPING PRACTICES: DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
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, 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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SLOT RATING RULE

COVERAGE FOR MULTI-PHYSICIAN GROUPS IS AVAILABLE, AT THE COMPANY'S OPTION, ON A SLOT BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. THE SLOT ENDORSEMENT WILL IDENTIFY THE INDIVIDUALS AND PRACTICE SETTINGS THAT ARE COVERED. COVERAGE WILL BE PROVIDED ON A SHARED LIMIT BASIS FOR THOSE INSUREDS MOVING THROUGH THE SLOT OR POSITION.

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 LOSS FREE CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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SOLO CORPORATION COVERAGE

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

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

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WITHDRAWN FORMS
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30 (#430)
39
49 (#145)
61 (#145)
66 (#508/645/646)
67 (#508/645/646)
70 (#172)
108 (#508)
129 (#229)
526 (#757)
533 (#985)
613 (#985)
660
661
662
Medical Professional Liability Insurance Application
Plastic Surgery Supplemental Application
Supplemental Application
State Statutory Requirement

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OCCURRENCE PROGRAM

ALLIED HEALTHCARE PROVIDERS RATE CLASSES

CLASS I-A

DENTAL ASSISTANT, DENTAL HYGIENIST.

CLASS I-B

CARDIOLOGY TECHNOLOGIST, CLINICAL LABORATORY TECHNOLOGIST, COUNSELOR, DIETICIAN, ELECTROCARDIOGRAPH TECHNICIAN, ELECTRONEURODIAGNOSTIC TECHNOLOGIST, LICENSED PRACTICING NURSE, MEDICAL LABORATORY TECHNICIAN, MEDICAL (OFFICE) ASSISTANT, MEDICAL RECORDS TECHNICIAN, NUCLEAR MEDICINE TECHNOLOGIST, OPHTHALMOLOGY TECHNICIAN, RESPIRATORY THERAPY ASSISTANT, REGISTERED NURSE.

CLASS II

AUDIOLOGIST/SPEECH PATHOLOGIST, NURSE MIDWIFE ASSISTANT, OCCUPATIONAL THERAPIST ASSISTANT, OPTICIAN, PHYSICAL THERAPY ASSISTANT, RADIATION THERAPY TECHNOLOGIST, SOCIAL WORKER, SURGICAL TECHNICIAN, X-RAY TECHNICIAN.

CLASS III

OPTOMETRIST, PARAMEDIC/EMT, PHARMACIST, PHYSICAL THERAPIST (NON-OWNER).

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CLASS IV

CASE MANAGER, OCCUPATIONAL THERAPIST, PERFUSIONIST, PHYSICAL THERAPIST (OWNER), PSYCHOLOGIST, RESPIRATORY THERAPIST.

CLASS V

NURSE PRACTITIONER (NON-PRESCRIBING), PHYSICIAN'S ASSISTANT (NON-PRESCRIBING).

CLASS VI

NURSE SURGICAL ASSISTANT, PHYSICIAN SURGICAL ASSISTANT.

NURSE PRACTITIONER (PRESCRIBING), PHYSICIAN'S ASSISTANT (PRESCRIBING).

CLASS VII-A

CERTIFIED REGISTERED NURSE ANESTHETIST, REGISTERED NURSE ANESTHETIST.

CLASS VII-B

NURSE MIDWIFE.

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ALLIED HEALTHCARE PROVIDERS RATE CLASSES (CONT.)

CLASS VIII-A

PODIATRIST (NO SURGERY).

CLASS VIII-B

PODIATRIST (SURGERY).

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OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: DUPAGE, JACKSON, KANE, LAKE, MCHENRY, AND VERMILION COUNTIES

TERRITORY 3: CHAMPAIGN, KANKAKEE, MACON, SANGAMON, AND WINNEBAGO COUNTIES

TERRITORY 4: BUREAU, COLES, DEKALB, LA SALLE, OGLE, AND RANDOLPH COUNTIES

TERRITORY 5: REMAINDER OF STATE

- TERRITORIES ABOVE APPLY TO ALLIED HEALTH CARE PROVIDERS CLASSES 4-8B.
- RATES FOR ALLIED HEALTH CARE PROVIDERS CLASSES 1A-3B UTILIZE THE APPLICABLE BASE TERRITORY RATE.

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OCCURRENCE RATES

Class	Rate
1A	5% of 80211
1B	3% of 80420
2	5% of 80420
3	7% of 80420
4	14% of 80420
5	18% of 80420
6	22% of 80420
7A	25% of 80151
7B	40% of 80153
8A	25% of 80176
8B	50% of 80176

Class 1A base rates are calculated as a percentage of the Dentists Territory 2 (Rest of State) 100/300 Limits Occurrence rate.
Classes 1B-4 base rates are calculated as a percentage of the Physicians & Surgeons Territory 5 (Rest of State) 100/300 Limits Occurrence rate.
Classes 5-8B base rates are calculated as a percentage of the Physicians & Surgeons 100/300 Limits Occurrence rate for the appropriate territory.
Rates for limits higher than 100/300 limits are calculated by applying Allied Healthcare Provider increased limit factors to the base rate.

80211 General Dentist
80420 Family/General Practice (No Surgery)
80151 Anesthesiology
80153 Obstetrics/Gynecology
80176 Surgery - Orthopedic (Excluding Back Surgery)

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INCREASED LIMITS TABLE

LIMITS	CLASSES 1A-5	CLASSES 6-8B
100/300	1.00	1.00
200/600	1.22	1.26
500/1000	1.46	1.63
1000/1000	1.75	1.94
1000/3000	1.80	2.00
2000/2000	2.05	2.41
2000/4000	2.12	2.48
3000/3000	2.22	2.68
3000/5000	2.29	2.75

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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 OR RISK MANAGEMENT CREDITS.

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OCCURRENCE PROGRAM

DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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%

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DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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%

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OCCURRENCE PROGRAM

DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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 PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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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.

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OCCURRENCE PROGRAM

FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR AN ALLIED HEALTHCARE PROVIDER 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 ALLIED HEALTHCARE PROVIDER'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 ALLIED HEALTHCARE PROVIDER 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 ALLIED HEALTHCARE RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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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:

FTE* PER POLICY	PREMIUM MODIFICATION
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 PART TIME PRACTICE 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 ALLIED HEALTHCARE PROVIDERS 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 "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.

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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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LOCUM TENENS

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

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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 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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PARTNERSHIP OR CORPORATION COVERAGE

REGARDLESS OF THE NUMBER OF PARTNERS OR SHAREHOLDERS OR THE RATE CLASSES OF THE INDIVIDUAL PARTNERS OR SHAREHOLDERS, THE PREMIUM FOR A PARTNERSHIP OR CORPORATION POLICY SHALL BE AS FOLLOWS:

POLICY LIMITS	PREMIUM
$100,000/$300,000	$500

FOR HIGHER LIMITS, APPLY THE ALLIED HEALTHCARE PROVIDERS INCREASED LIMITS FACTORS (CLASSES 1A-5) FOUND IN THE RATES SECTION OF THIS MANUAL.

LIMITS FOR COVERAGE FOR THE PARTNERSHIP OR CORPORATION MAY NOT EXCEED THE LOWEST LIMITS OF COVERAGE OF ANY OF THE INSUREDS PARTNERS, SHAREHOLDERS OR EMPLOYED/CONTRACTED ALLIED HEALTHCARE PROVIDERS.

A SEPARATE POLICY IS ISSUED.

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT.

DUE TO MINIMUM PREMIUM REQUIREMENTS, PART TIME CREDITS ARE AVAILABLE FOR CLASS 4-8B ONLY.

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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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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 $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, LOSS/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 INSUREDS 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 -50% / +50%, 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 INSUREDS UNDERWRITING FILE.

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

CRITERIA	RANGE
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%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-15% TO +15%
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).	-10% TO +10%
MANAGEMENT CONTROL PROCEDURES: SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
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.	-5% TO +5%

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OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

CRITERIA	RANGE
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.	-5% TO +5%
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.	-5% TO +5%
OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES: ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
TRAINING, ACCREDITATION AND CREDENTIALING: THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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SCHEDULE RATING PLAN

CRITERIA	RANGE
RECORD-KEEPING PRACTICES: DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
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, 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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SOLO CORPORATION COVERAGE

SOLO INDIVIDUAL PROFESSIONAL CORPORATION OR ASSOCIATIONS MAY BE MADE AN ADDITIONAL INSURED ON AN ALLIED HEALTHCARE PROVIDER'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.

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STANDARD CLAIMS MADE PROGRAM

ALLIED HEALTHCARE PROVIDERS RATE CLASSES

CLASS I-A

DENTAL ASSISTANT, DENTAL HYGIENIST.

CLASS I-B

CARDIOLOGY TECHNOLOGIST, CLINICAL LABORATORY TECHNOLOGIST, COUNSELOR, DIETICIAN, ELECTROCARDIOGRAPH TECHNICIAN, ELECTRONEURODIAGNOSTIC TECHNOLOGIST, LICENSED PRACTICING NURSE, MEDICAL LABORATORY TECHNICIAN, MEDICAL (OFFICE) ASSISTANT, MEDICAL RECORDS TECHNICIAN, NUCLEAR MEDICINE TECHNOLOGIST, OPHTHALMOLOGY TECHNICIAN, RESPIRATORY THERAPY ASSISTANT, REGISTERED NURSE.

CLASS II

AUDIOLOGIST/SPEECH PATHOLOGIST, NURSE MIDWIFE ASSISTANT, OCCUPATIONAL THERAPIST ASSISTANT, OPTICIAN, PHYSICAL THERAPY ASSISTANT, RADIATION THERAPY TECHNOLOGIST, SOCIAL WORKER, SURGICAL TECHNICIAN, X-RAY TECHNICIAN.

CLASS III

OPTOMETRIST, PARAMEDIC/EMT, PHARMACIST, PHYSICAL THERAPIST (NON-OWNER).

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ALLIED HEALTHCARE PROVIDERS RATE CLASSES (CONT.)

CLASS IV

CASE MANAGER, OCCUPATIONAL THERAPIST, PERFUSIONIST, PHYSICAL THERAPIST (OWNER), PSYCHOLOGIST, RESPIRATORY THERAPIST.

CLASS V

NURSE PRACTITIONER (NON-PRESCRIBING), PHYSICIAN'S ASSISTANT (NON-PRESCRIBING).

CLASS VI

NURSE SURGICAL ASSISTANT, PHYSICIAN SURGICAL ASSISTANT.

NURSE PRACTITIONER (PRESCRIBING), PHYSICIAN'S ASSISTANT (PRESCRIBING).

CLASS VII-A

CERTIFIED REGISTERED NURSE ANESTHETIST, REGISTERED NURSE ANESTHETIST.

CLASS VII-B

NURSE MIDWIFE.

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ALLIED HEALTHCARE PROVIDERS RATE CLASSES (CONT.)

CLASS VIII-A

PODIATRIST (NO SURGERY).

CLASS VIII-B

PODIATRIST (SURGERY).

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STANDARD CLAIMS MADE PROGRAM

RATING TERRITORIES

TERRITORY 1:	COOK, MADISON, ST. CLAIR, AND WILL COUNTIES
TERRITORY 2:	DUPAGE, JACKSON, KANE, LAKE, MCHENRY, AND VERMILION COUNTIES
TERRITORY 3:	CHAMPAIGN, KANKAKEE, MACON, SANGAMON, AND WINNEBAGO COUNTIES
TERRITORY 4:	BUREAU, COLES, DEKALB, LA SALLE, OGLE, AND RANDOLPH COUNTIES
TERRITORY 5:	REMAINDER OF STATE

- TERRITORIES ABOVE APPLY TO ALLIED HEALTH CARE PROVIDERS CLASSES 4-8B.
- RATES FOR ALLIED HEALTH CARE PROVIDERS CLASSES 1A-3B UTILIZE THE APPLICABLE BASE TERRITORY RATE.

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STANDARD CLAIMS MADE RATES

Class	Rate
1A	5% of 80211
1B	3% of 80420
2	5% of 80420
3	7% of 80420
4	14% of 80420
5	18% of 80420
6	22% of 80420
7A	25% of 80151
7B	40% of 80153
8A	25% of 80176
8B	50% of 80176

The Mature Standard Claims Made rate is 0.920 of the corresponding Allied Healthcare Provider Occurrence rate.

Allied Healthcre Provider Claims Made Factors may be applied to the Mature Standard Claims Made base rate for the applicable year of claims made coverage.

Class 1A base rates are calculated as a percentage of the Dentists Territory 2 (Rest of State) 100/300 Limits Occurrence rate.

Classes 1B-4 base rates are calculated as a percentage of the Physicians & Surgeons Territory 5 (Rest of State) 100/300 Limits Occurrence rate.

Classes 5-8B base rates are calculated as a percentage of the Physicians & Surgeons 100/300 Limits Occurrence rate for the appropriate territory.

Rates for limits higher than 100/300 limits are calculated by applying Allied Healthcare Provider increased limit factors to the base rate.

80211 General Dentist
80420 Family/General Practice (No Surgery)
80151 Anesthesiology
80153 Obstetrics/Gynecology
80176 Surgery - Orthopedic (Excluding Back Surgery)

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CLAIMS MADE FACTORS

YEARS SINCE RETROACTIVE DATE	CLASSES 1A-4	CLASSES 5-8B
0	0.60	0.45
1	0.80	0.70
2	0.90	0.85
3	0.95	0.90
4 OR MORE	1.00	1.00
CLAIMS MADE TO OCCURRENCE FACTOR	0.92	0.92

FACTOR APPLIES TO MATURE CLAIMS MADE ALLIED HEALTHCARE PROVIDERS RATE

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EXTENSION CONTRACT FACTORS

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	CLASSES 1A-4	CLASSES 5-8B
1	0.750	0.700
2	1.000	1.000
3	1.100	1.150
4	1.150	1.200
5 OR MORE	1.200	1.250

FACTOR APPLIES TO MATURE CLAIMS MADE ALLIED HEALTHCARE PROVIDERS RATE

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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.

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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 AND SCHEDULE RATING MODIFICATIONS.

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FULL TIME EQUIVALENCY RATING RULE

COVERAGE FOR AN ALLIED HEALTHCARE PROVIDER 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 ALLIED HEALTHCARE PROVIDER'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 ALLIED HEALTHCARE PROVIDER 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 ALLIED HEALTHCARE RATE TO THE CORRESPONDING FTE WILL BE ADJUSTED TO REFLECT LOSS COST CONSIDERATIONS NOT RECOGNIZED IN THE STANDARD RATES.

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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:

FTE* PER POLICY	PREMIUM MODIFICATION
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 PART TIME PRACTICE 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 ALLIED HEALTHCARE PROVIDERS 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 "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 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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ACCELERATED EXTENSION CONTRACT RULE

AN INSURED SHALL QUALIFY FOR AN ACCELERATED EXTENSION CONTRACT, FOR NO ADDITIONAL PREMIUM, IF THE FOLLOWING UNDERWRITING REQUIREMENTS HAVE BEEN MET:

1) THE INSURED ANTICIPATES RETIREMENT FROM HIS OR HER PROFESSION IN LESS THAN FIVE YEARS.

2) THE INSURED HAS ATTAINED AGE 55.

3) THE INSURED HAS CLAIMS-MADE COVERAGE WITH THE COMPANY IN A GROUP PRACTICE.

4) THE INSURED HAS LIMITED PRIOR ACTS EXPOSURE BASED UPON UNDERWRITING REVIEW.

THE TOTAL NUMBER OF INSUREDS, WITHIN A GROUP PRACTICE, THAT MAY QUALIFY FOR THE ACCELERATED EXTENSION CONTRACT SHOULD NOT EXCEED A RATIO OF 1 IN 3.

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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 OR RISK MANAGEMENT CREDITS.

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DEDUCTIBLE CREDIT RULE

THE FOLLOWING CREDITS SHALL BE AVAILABLE, SUBJECT TO UNDERWRITING GUIDELINES:

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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%

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DEDUCTIBLE CREDIT RULE

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	INCIDENT POLICY LIMIT (000S)				
DEDUCTIBLE (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 PRIMARY LIMIT PREMIUM, NET OF ALL OTHER APPLICABLE CREDITS, SUBJECT TO A MAXIMUM DOLLAR CREDIT OF 85% OF THE AGGREGATE LIMIT.

FOR DEDUCTIBLES AND LIMIT COMBINATIONS NOT LISTED, CREDITS WILL BE INTERPOLATED OR EXTRAPOLATED FROM THE ABOVE RANGES.

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LOCUM TENENS

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

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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 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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PARTNERSHIP OR CORPORATION COVERAGE

REGARDLESS OF THE NUMBER OF PARTNERS OR SHAREHOLDERS OR THE RATE CLASSES OF THE INDIVIDUAL PARTNERS OR SHAREHOLDERS, THE PREMIUM FOR A PARTNERSHIP OR CORPORATION POLICY SHALL BE AS FOLLOWS:

POLICY LIMITS	PREMIUM
$100,000/$300,000	$500

FOR HIGHER LIMITS, APPLY THE ALLIED HEALTHCARE PROVIDERS INCREASED LIMITS FACTORS (CLASSES 1A-5) FOUND IN THE RATES SECTION OF THIS MANUAL.

LIMITS FOR COVERAGE FOR THE PARTNERSHIP OR CORPORATION MAY NOT EXCEED THE LOWEST LIMITS OF COVERAGE OF ANY OF THE INSUREDS PARTNERS, SHAREHOLDERS OR EMPLOYED/CONTRACTED ALLIED HEALTHCARE PROVIDERS.

A SEPARATE POLICY IS ISSUED.

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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.

AVERAGE NUMBER HOURS PRACTICED PER WEEK	MAX. AGGREGATE HOURS PER YR	CREDIT
0-10 HOURS	515	50%
11-20 HOURS	1,050	30%

NO OTHER CREDITS OR DISCOUNTS ARE TO APPLY CONCURRENT WITH THIS RULE EXCEPT RISK MANAGEMENT CREDIT.

DUE TO MINIMUM PREMIUM REQUIREMENTS, PART TIME CREDITS ARE AVAILABLE FOR CLASS 4-8B ONLY.

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 THE APPROVAL BY THE COMPANY.

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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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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 $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, LOSS/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 INSUREDS 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 -50% / +50%, 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 INSUREDS UNDERWRITING FILE.

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

CRITERIA	RANGE
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%

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CRITERIA	RANGE
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.	-5% TO +5%
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.	-15% TO +15%
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).	-10% TO +10%
MANAGEMENT CONTROL PROCEDURES: SPECIFIC OPERATIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN BY THE INSURED TO REDUCE THE FREQUENCY AND/OR SEVERITY OF CLAIMS.	-5% TO +5%
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.	-5% TO +5%

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CRITERIA	RANGE
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.	-5% TO +5%
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.	-5% TO +5%
OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES: ADDITIONAL ACTIVITIES (OR LACK OF) UNDERTAKEN WITH THE SPECIFIC INTENTION OF REDUCING THE FREQUENCY OR SEVERITY OF CLAIMS.	-5% TO +5%
TRAINING, ACCREDITATION AND CREDENTIALING: THE INSURED(S) EXHIBITS GREATER/LESS THAN NORMAL PARTICIPATION AND SUPPORT OF SUCH ACTIVITIES.	-5% TO +5%

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CRITERIA	RANGE
RECORD-KEEPING PRACTICES: DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.	-5% TO +5%
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, 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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SLOT RATING RULE

COVERAGE FOR MULTI-PHYSICIAN GROUPS IS AVAILABLE, AT THE COMPANY'S OPTION, ON A SLOT BASIS RATHER THAN ON AN INDIVIDUAL PHYSICIAN BASIS. THE SLOT ENDORSEMENT WILL IDENTIFY THE INDIVIDUALS AND PRACTICE SETTINGS THAT ARE COVERED. COVERAGE WILL BE PROVIDED ON A SHARED LIMIT BASIS FOR THOSE INSUREDS MOVING THROUGH THE SLOT OR POSITION.

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 PART TIME PRACTICE AND RISK MANAGEMENT CANNOT BE USED IN CONJUNCTION WITH THIS RATING RULE.

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SOLO CORPORATION COVERAGE

SOLO INDIVIDUAL PROFESSIONAL CORPORATION OR ASSOCIATIONS MAY BE MADE AN ADDITIONAL INSURED ON AN ALLIED HEALTHCARE PROVIDER'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.

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I. APPLICATION OF MANUAL

A. This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the following health care providers:

Section

II. Corporations, Partnerships and Associations
III. Physicians and Surgeons
IV. Dentists
V. Allied Health Care Providers
VI. Health Care Facilities

B. This manual also specifies rules, rates, premiums, classifications and territories for the purpose of providing the following optional associated coverages to health care providers:

Section

VII. General Liability
VIII. Managed Care Entity Liability
IX. Pollution Liability

II. APPLICATION OF GENERAL RULES

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the respective Section or State Rate Pages.

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

III. POLICY TERM

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

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IV. LOCATION OF PRACTICE

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

V. PREMIUM COMPUTATION

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

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

VI. FACTORS OR MULTIPLIERS

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

VII. WHOLE DOLLAR RULE

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

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

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

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

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

C. The Company may waive an additional premium of $100 or less for coverages related to Healthcare facilities. This waiver only applies to cash exchange due on an endorsement effective date.

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IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. a policy is canceled at the Company's request;

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider and is shown on the appropriate State Rate Pages.

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

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate State Rate Pages.

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XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the State Rate Pages.

XIII. COVERAGE

Coverage may be provided on either an Occurrence or Claims-Made basis, unless noted otherwise in the respective section or State Rate Pages. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Occurrence or Standard Claims-Made, subject to availability and identified on the State Rate Pages.

XIV. BASIC LIMITS OF LIABILITY

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

XV. INCREASED LIMITS OF LIABILITY

A. Individual Limits of Liability

1. Increased Limits factors shall be those shown as applicable for the respective insureds and be used to develop the applicable premium.

B. Shared Limits of Liability

1. Limits of Liability may be increased on a shared limits basis excess of an individual limit per insured.

2. The rate for the shared excess limits shall be computed in the following manner:

   a. The rate for the individual limit of liability and the total limit of liability shall be calculated in accordance with the State Rate Pages. The total limit of liability is the sum of the individual per occurrence limit and the shared per occurrence limit.

   b. The initial shared limits rate is the difference between the total limits rate and the individual limits rate .

   c. The initial shared limits rate may be modified subject to the restrictions identified on the State Rate Pages, based on the following objective considerations:

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i. The number and distribution by classification of insureds.

ii. The amount of the shared limit and its relationship to the size and distribution of the group.

iii. The amount of the individual limit (attachment point) underlying the shared limit.

3. The minimum individual limit over which a shared excess limit may be provided is identified on the State Rate Pages.

4. Requests for total limits of liability (the sum of the individual per health care occurrence limit and the shared excess per health care occurrence limit) that exceed the maximum limit of liability identified on the State Rate Pages shall be referred to the Company and (a) rated.

XVI. PRIOR ACTS COVERAGE

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

XVII. EXTENDED REPORTING PERIOD COVERAGE (Claims-Made Coverage only)

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

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Experience, Part Time, Non -Discretionary Debit and Schedule Rating Debits. Deductible Credits may or may not apply to a groups Extension Contract, at the Insureds option.

D. Premium must be paid, in accordance with state statutes, promptly when due.

E. 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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XVIII. LARGE GROUP PRACTICE

A. Physicians organized in a Large Group practice may be collectively rated.

B. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

C. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, Risk Management, or Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

D. Locum Tenens Group Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

E. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

F. Refer to the State Rate Pages for availability.

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XIX. SMALL GROUP PRACTICE

Any group practice consisting of two or more healthcare providers 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 preformed 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 equally 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 insured's 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.

XX. MEMBERSHIP IN QUALIFIED ASSOCIATIONS

A. The unique characteristics of medical/dental practices and their membership in qualified professional associations shall make them eligible for premium modifications in addition to those available to all other groups.

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B. Members of a qualified medical/dental group professional association shall be eligible for additional premium modifications.

1. Membership Credit

a. A premium credit, identified on the State Rate Pages, shall be given to those insureds whose group is a member of a qualified association.

b. A Qualified Association may include State Medical or Dental Societies.

2. Renewal Rate Rule

a. If the group practice generates a manual premium in excess of $250,000 (or as identified in the State Rate Pages, by Section), 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 and loss/claim free credit and non-discretionary credits will be applied in the usual manner.

b. Only one consecutive renewal may receive application of this rule. The group practice may again qualify for this rule after the payment of one renewal premium based upon currently filed rates.

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XVII. Extended Reporting Period Coverage

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 Expiring standard mature claims made rate, subject to expiring part time, Non-Discretionary Debit, Deductible and schedule rating modifications debits.

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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MANUAL PAGES
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I. APPLICATION OF MANUAL

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

1. Professional Corporations, Partnerships and Associations

2. Miscellaneous Entities

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

1. are organized as a legal entity;

2. maintain common facilities (including multiple locations) and support personnel; and

3. maintain medical/dental records of patients of the group as a historical record of patient care.

C. 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

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III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates (or premium per FTE/OPV rated policy) of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated on the State Rate Pages.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any modifications presented on the State Rate Pages.

3. 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 physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.

4. The premium for professional corporations, partnerships and associations may be subject to premium caps or flat rates as indicated on the State Rate Pages and may be reduced or eliminated as part of credits provided to multi-physician practices.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy or FTE/OPV rated policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

C. The premium for other entities shall be referred to the Home Office for the determination of premium and filing with the state insurance department.

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IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

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

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

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

2. Including the following types of entities:

   a. Urgicare Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center
   f. Home Health Agency
   g. Nursing Home
   h. Physical Fitness Center

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 risk 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.

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B. 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 SIR limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

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3. Large Group & Temporary Staffing Agency Rating - Corporations

A. Corporation Coverage for Temporary Staffing Agencies or Large Group practices may be collectively rated.

B. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

C. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence, or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

D. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

E. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

F. Refer to the State Rate Pages for availability.

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4. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers 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.)

A. 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 preformed 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.)

B. The "Group's net premium" will equal the sum of the "individual net premiums" for each individual or entity receiving separate limits of liability.

C. The "Individual net premiums" will equally 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 insured's based upon applicable underwriting criteria.

D. For Individual insured's within the group, the extension contract premium will be calculated per the filed Extension Contract Rating Rule.

E. Refer to the applicable state rate page for availability.

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A. **Classification**

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

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists – All Other Dental Specialties	10%	Available
Dentists – Oral Surgeons	1%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

2. **Miscellaneous Entities**

NOT AVAILABLE

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3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.750	1.150	1.200
5 or more	1.820	1.750	1.200	1.250

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

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$25
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 50%
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

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2. Deductible Credits
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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.

3. Self-Insured Retention Credits

NOT AVAILABLE

4. **Group, Large Group & Temporary Staffing Agency Rating – Corporations**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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5. **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.

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 Physicians/Surgeons.

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 physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical 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.

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B. Part Time Physicians

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 and membership association credits.

C. Physicians in Training

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

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

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

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

   Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

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

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   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.

D. Locum Tenens Physician –Physicians Substituting for MPCo Insured Physicians

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

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

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E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agency Coverage is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. New Physician

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

   a. Residency;

   b. Fellowship program in their medical specialty;

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

   d. Medical school or specialty training program.

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

3. A reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

G. Physician Teaching Specialists

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

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

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

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

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

   c. No other credits are to apply concurrent with this rule except risk management and membership credits.

   d. The applicable percentages are presented on the State Rate Pages.

H. Physician's Leave of Absence

1. A physician 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.

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I. Physicians Military Leave of Absence

A physician 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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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 therequired 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 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.

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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.

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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 claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

   a. Premiums paid
   b. Number of claims
   c. Incurred losses
   d. 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 eight complete years from their initial medical-school graduation date, the total assigned claim points (as calculated from the Schedule A) will be multiplied by the applicable factor set forth in the following schedule:

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Years Between Effective Date of Coverage and Graduation Date	Factor
Less than 5 years	5.00
At least 5 years but less than 6 years	2.50
At least 6 years but less than 7 years	1.666
At least 7 years but less than 8 years	1.25
8 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 the insured's rate 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.

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G. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

6. Refer to the State Rate Pages for availability.

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H. Small Group Rating Rule

Any group practice consisting of two or more physicians providers 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 preformed 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 equally 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 insured's based upon applicable underwriting criteria.

4. For Individual insured's within the group, the extension contract premium will be per the filed Extension Contract Rating Rule.

5. Refer to the applicable state rate page 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:

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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 losses attributed to the insured. (A loss 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 coverage.

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 and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

3. The Enhanced Claims-Made base rate is subject to Claim Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

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

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be provided on a shared limit basis for those insureds moving through the slot or position.

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

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit cannot be used in conjunction with this rating rule.

D. 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 physician basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each physician's number of hours of medical practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
2,100 - Residency Programs

2. For group practices, the minimum average FTE assigned to individual physicians is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

4. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

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FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

5. Premium modifications for new physician, part time, moonlighting, teaching, loss free credit or other similar credit cannot be used in conjunction with this rating rule.

E. 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 physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician 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 medical 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 physician, part time, moonlighting, teaching, claim free credit, or other similar credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and an Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability or permanent 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 five years.

   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. At the time the insured permanently retires, he or she has attained the age of 55 and is associated with the group insured by the Company.

   f. Refer to the State Rate Pages for availability.

G. Deferred Premium Payment Plan.

The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the state rate pages.

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H. 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 or Deductible Credits.

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PHYSICIANS & SURGEONS

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 IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

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CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

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CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: COSMETIC SURGERY, PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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B. Manual Rates

1. Territory Definitions

Area 1	Cook, Jackson, Madison, St. Clair, and Will Counties
Area 2	Lake, and Vermillion Counties
Area 3	Kane, McHenry, and Winnebago Counties.
Area 4	Dupage, Kankakee, and Macon, Counties
Area 5	Bureau, Champaign, Coles, Dekalb, Effingham, Lasalle, Ogle, and Randolph Counties
Area 6	Grundy and Sangamon Counties
Area 7	Peoria County
Area 8	Remainder of State

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2. Occurrence Program

a. Area 1

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,728	10,510	15,533	19,243	20,016
1B	10,304	14,013	20,711	25,657	26,687
1C	12,107	16,466	24,335	30,146	31,357
1D	13,189	17,937	26,510	32,841	34,160
2A	14,426	19,619	28,996	35,921	37,363
2B	17,002	23,123	34,174	42,335	44,035
2C	20,093	27,326	40,387	50,032	52,041
2D	22,669	30,830	45,565	56,446	58,713
3A	24,214	33,173	50,123	63,683	66,589
3B	26,790	36,702	55,455	70,458	73,673
4A	29,366	40,231	60,788	77,233	80,757
4B	31,942	43,761	66,120	84,007	87,841
5A	36,064	49,408	74,652	94,848	99,176
5B	40,186	55,055	83,185	105,689	110,512
6A	42,246	57,877	87,449	111,107	116,177
6B	47,398	64,935	98,114	124,657	130,345
7	54,611	74,817	113,045	143,627	150,180
8	78,310	107,285	162,102	205,955	215,353

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b. Area 2

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,956	9,460	13,982	17,320	18,016
1B	9,274	12,613	18,641	23,092	24,020
1C	10,897	14,820	21,903	27,134	28,223
1D	11,871	16,145	23,861	29,559	30,746
2A	12,984	17,658	26,098	32,330	33,629
2B	15,302	20,811	30,757	38,102	39,632
2C	18,084	24,594	36,349	45,029	46,838
2D	20,403	27,748	41,010	50,803	52,844
3A	21,794	29,858	45,114	57,318	59,934
3B	24,112	33,033	49,912	63,415	66,308
4A	26,431	36,210	54,712	69,514	72,685
4B	28,749	39,386	59,510	75,610	79,060
5A	32,459	44,469	67,190	85,367	89,262
5B	36,169	49,552	74,870	95,124	99,465
6A	38,023	52,092	78,708	100,000	104,563
6B	42,660	58,444	88,306	112,196	117,315
7	49,152	67,338	101,745	129,270	135,168
8	70,482	96,560	145,898	185,368	193,826

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c. Area 3

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,569	8,934	13,204	16,357	17,014
1B	8,758	11,911	17,604	21,807	22,683
1C	10,291	13,996	20,685	25,625	26,654
1D	11,210	15,246	22,532	27,913	29,034
2A	12,261	16,675	24,645	30,530	31,756
2B	14,451	19,653	29,047	35,983	37,428
2C	17,078	23,226	34,327	42,524	44,232
2D	19,268	26,204	38,729	47,977	49,904
3A	20,581	28,196	42,603	54,128	56,598
3B	22,771	31,196	47,136	59,888	62,620
4A	24,960	34,195	51,667	65,645	68,640
4B	27,150	37,196	56,201	71,405	74,663
5A	30,653	41,995	63,452	80,617	84,296
5B	34,156	46,794	70,703	89,830	93,929
6A	35,908	49,194	74,330	94,438	98,747
6B	40,287	55,193	83,394	105,955	110,789
7	46,417	63,591	96,083	122,077	127,647
8	66,561	91,189	137,781	175,055	183,043

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d. Area 4

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,796	7,883	11,650	14,432	15,012
1B	7,728	10,510	15,533	19,243	20,016
1C	9,080	12,349	18,251	22,609	23,517
1D	9,892	13,453	19,883	24,631	25,620
2A	10,819	14,714	21,746	26,939	28,021
2B	12,751	17,341	25,630	31,750	33,025
2C	15,070	20,495	30,291	37,524	39,031
2D	17,002	23,123	34,174	42,335	44,035
3A	18,161	24,881	37,593	47,763	49,943
3B	20,093	27,527	41,593	52,845	55,256
4A	22,025	30,174	45,592	57,926	60,569
4B	23,957	32,821	49,591	63,007	65,882
5A	27,048	37,056	55,989	71,136	74,382
5B	30,139	41,290	62,388	79,266	82,882
6A	31,685	43,408	65,588	83,332	87,134
6B	35,549	48,702	73,586	93,494	97,760
7	40,958	56,112	84,783	107,720	112,635
8	58,733	80,464	121,577	154,468	161,516

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e. Area 5

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,410	7,358	10,874	13,471	14,012
1B	7,213	9,810	14,498	17,960	18,682
1C	8,475	11,526	17,035	21,103	21,950
1D	9,233	12,557	18,558	22,990	23,913
2A	10,098	13,733	20,297	25,144	26,154
2B	11,901	16,185	23,921	29,633	30,824
2C	14,065	19,128	28,271	35,022	36,428
2D	15,869	21,582	31,897	39,514	41,101
3A	16,951	23,223	35,089	44,581	46,615
3B	18,754	25,693	38,821	49,323	51,574
4A	20,557	28,163	42,553	54,065	56,532
4B	22,360	30,633	46,285	58,807	61,490
5A	25,246	34,587	52,259	66,397	69,427
5B	28,131	38,539	58,231	73,985	77,360
6A	29,573	40,515	61,216	77,777	81,326
6B	33,180	45,457	68,683	87,263	91,245
7	38,229	52,374	79,134	100,542	105,130
8	54,819	75,102	113,475	144,174	150,752

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f. Area 6

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,637	6,306	9,320	11,546	12,010
1B	6,182	8,408	12,426	15,393	16,011
1C	7,264	9,879	14,601	18,087	18,814
1D	7,913	10,762	15,905	19,703	20,495
2A	8,655	11,771	17,397	21,551	22,416
2B	10,200	13,872	20,502	25,398	26,418
2C	12,055	16,395	24,231	30,017	31,222
2D	13,600	18,496	27,336	33,864	35,224
3A	14,528	19,903	30,073	38,209	39,952
3B	16,073	22,020	33,271	42,272	44,201
4A	17,619	24,138	36,471	46,338	48,452
4B	19,164	26,255	39,669	50,401	52,701
5A	21,637	29,643	44,789	56,905	59,502
5B	24,110	33,031	49,908	63,409	66,303
6A	25,346	34,724	52,466	66,660	69,702
6B	28,437	38,959	58,865	74,789	78,202
7	32,765	44,888	67,824	86,172	90,104
8	46,983	64,367	97,255	123,565	129,203

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g. Area 7

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,478	4,730	6,991	8,660	9,008
1B	4,637	6,306	9,320	11,546	12,010
1C	5,448	7,409	10,950	13,566	14,110
1D	5,935	8,072	11,929	14,778	15,372
2A	6,492	8,829	13,049	16,165	16,814
2B	7,651	10,405	15,379	19,051	19,816
2C	9,042	12,297	18,174	22,515	23,419
2D	10,201	13,873	20,504	25,400	26,421
3A	10,897	14,929	22,557	28,659	29,967
3B	12,056	16,517	24,956	31,707	33,154
4A	13,215	18,105	27,355	34,755	36,341
4B	14,375	19,694	29,756	37,806	39,531
5A	16,230	22,235	33,596	42,685	44,633
5B	18,084	24,775	37,434	47,561	49,731
6A	19,012	26,046	39,355	50,002	52,283
6B	21,330	29,222	44,153	56,098	58,658
7	24,576	33,669	50,872	64,635	67,584
8	35,241	48,280	72,949	92,684	96,913

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h. Area 8

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,864	5,255	7,767	9,621	10,008
1B	5,152	7,007	10,356	12,828	13,344
1C	6,054	8,233	12,169	15,074	15,680
1D	6,595	8,969	13,256	16,422	17,081
2A	7,213	9,810	14,498	17,960	18,682
2B	8,501	11,561	17,087	21,167	22,018
2C	10,046	13,663	20,192	25,015	26,019
2D	11,334	15,414	22,781	28,222	29,355
3A	12,107	16,587	25,061	31,841	33,294
3B	13,395	18,351	27,728	35,229	36,836
4A	14,683	20,116	30,394	38,616	40,378
4B	15,971	21,880	33,060	42,004	43,920
5A	18,032	24,704	37,326	47,424	49,588
5B	20,093	27,527	41,593	52,845	55,256
6A	21,123	28,939	43,725	55,553	58,088
6B	23,699	32,468	49,057	62,328	65,172
7	27,306	37,409	56,523	71,815	75,092
8	39,155	53,642	81,051	102,978	107,676

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3. Standard Claims Made Program

a. Area 1

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,072	2,818	4,165	5,159	5,366
1B	2,763	3,758	5,554	6,880	7,156
1C	3,246	4,415	6,524	8,083	8,407
1D	3,536	4,809	7,107	8,805	9,158
2A	3,868	5,260	7,775	9,631	10,018
2B	4,558	6,199	9,162	11,349	11,805
2C	5,387	7,326	10,828	13,414	13,952
2D	6,078	8,266	12,217	15,134	15,742
3A	6,492	8,894	13,438	17,074	17,853
3B	7,183	9,841	14,869	18,891	19,753
4A	7,874	10,787	16,299	20,709	21,654
4B	8,564	11,733	17,727	22,523	23,551
5A	9,669	13,247	20,015	25,429	26,590
5B	10,774	14,760	22,302	28,336	29,629
6A	11,327	15,518	23,447	29,790	31,149
6B	12,708	17,410	26,306	33,422	34,947
7	14,642	20,060	30,309	38,508	40,266
8	20,996	28,765	43,462	55,219	57,739

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1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,793	20,266	30,622	38,906	40,681
5A	16,701	22,880	34,571	43,924	45,928
5B	18,610	25,496	38,523	48,944	51,178
6A	19,565	26,804	40,500	51,456	53,804
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

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2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,853	12,040	17,795	22,044	22,929
1D	9,644	13,116	19,384	24,014	24,978
2A	10,548	14,345	21,201	26,265	27,319
2B	12,432	16,908	24,988	30,956	32,199
2C	14,693	19,982	29,533	36,586	38,055
2D	16,576	22,543	33,318	41,274	42,932
3A	17,706	24,257	36,651	46,567	48,692
3B	19,590	26,838	40,551	51,522	53,873
4A	21,473	29,418	44,449	56,474	59,051
4B	23,357	31,999	48,349	61,429	64,232
5A	26,371	36,128	54,588	69,356	72,520
5B	29,384	40,256	60,825	77,280	80,806
6A	30,892	42,322	63,946	81,246	84,953
6B	34,659	47,483	71,744	91,153	95,312
7	39,933	54,708	82,661	105,024	109,816
8	57,263	78,450	118,534	150,602	157,473

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,782	9,224	13,632	16,887	17,565
1B	9,041	12,296	18,172	22,512	23,416
1C	10,624	14,449	21,354	26,454	27,516
1D	11,573	15,739	23,262	28,817	29,974
2A	12,658	17,215	25,443	31,518	32,784
2B	14,918	20,288	29,985	37,146	38,638
2C	17,631	23,978	35,438	43,901	45,664
2D	19,891	27,052	39,981	49,529	51,518
3A	21,247	29,108	43,981	55,880	58,429
3B	23,508	32,206	48,662	61,826	64,647
4A	25,768	35,302	53,340	67,770	70,862
4B	28,029	38,400	58,020	73,716	77,080
5A	31,645	43,354	65,505	83,226	87,024
5B	35,261	48,308	72,990	92,736	96,968
6A	37,070	50,786	76,735	97,494	101,943
6B	41,591	56,980	86,093	109,384	114,375
7	47,920	65,650	99,194	126,030	131,780
8	68,715	94,140	142,240	180,720	188,966

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,158	9,735	14,388	17,823	18,539
1B	9,544	12,980	19,183	23,765	24,719
1C	11,214	15,251	22,540	27,923	29,044
1D	12,216	16,614	24,554	30,418	31,639
2A	13,361	18,171	26,856	33,269	34,605
2B	15,747	21,416	31,651	39,210	40,785
2C	18,611	25,311	37,408	46,341	48,202
2D	20,996	28,555	42,202	52,280	54,380
3A	22,428	30,726	46,426	58,986	61,677
3B	24,814	33,995	51,365	65,261	68,239
4A	27,199	37,263	56,302	71,533	74,797
4B	29,586	40,533	61,243	77,811	81,362
5A	33,403	45,762	69,144	87,850	91,858
5B	37,220	50,991	77,045	97,889	102,355
6A	39,130	53,608	80,999	102,912	107,608
6B	43,901	60,144	90,875	115,460	120,728
7	50,582	69,297	104,705	133,031	139,101
8	72,533	99,370	150,143	190,762	199,466

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,535	10,248	15,145	18,762	19,516
1B	10,046	13,663	20,192	25,015	26,019
1C	11,804	16,053	23,726	29,392	30,572
1D	12,859	17,488	25,847	32,019	33,305
2A	14,064	19,127	28,269	35,019	36,426
2B	16,576	22,543	33,318	41,274	42,932
2C	19,590	26,642	39,376	48,779	50,738
2D	22,101	30,057	44,423	55,031	57,242
3A	23,608	32,343	48,869	62,089	64,922
3B	26,120	35,784	54,068	68,696	71,830
4A	28,631	39,224	59,266	75,300	78,735
4B	31,143	42,666	64,466	81,906	85,643
5A	35,161	48,171	72,783	92,473	96,693
5B	39,179	53,675	81,101	103,041	107,742
6A	41,189	56,429	85,261	108,327	113,270
6B	46,212	63,310	95,659	121,538	127,083
7	53,244	72,944	110,215	140,032	146,421
8	76,350	104,600	158,045	200,801	209,963

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

b. Area 2

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,865	2,536	3,749	4,644	4,830
1B	2,486	3,381	4,997	6,190	6,439
1C	2,921	3,973	5,871	7,273	7,565
1D	3,182	4,328	6,396	7,923	8,241
2A	3,481	4,734	6,997	8,668	9,016
2B	4,102	5,579	8,245	10,214	10,624
2C	4,848	6,593	9,744	12,072	12,556
2D	5,470	7,439	10,995	13,620	14,167
3A	5,843	8,005	12,095	15,367	16,068
3B	6,464	8,856	13,380	17,000	17,776
4A	7,086	9,708	14,668	18,636	19,487
4B	7,707	10,559	15,953	20,269	21,194
5A	8,702	11,922	18,013	22,886	23,931
5B	9,697	13,285	20,073	25,503	26,667
6A	10,194	13,966	21,102	26,810	28,034
6B	11,437	15,669	23,675	30,079	31,452
7	13,177	18,052	27,276	34,656	36,237
8	18,896	25,888	39,115	49,696	51,964

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,294	5,840	8,631	10,692	11,121
1C	5,046	6,863	10,142	12,565	13,069
1D	5,497	7,476	11,049	13,688	14,237
2A	6,012	8,176	12,084	14,970	15,571
2B	7,086	9,637	14,243	17,644	18,353
2C	8,374	11,389	16,832	20,851	21,689
2D	9,448	12,849	18,990	23,526	24,470
3A	10,092	13,826	20,890	26,542	27,753
3B	11,166	15,297	23,114	29,367	30,707
4A	12,239	16,767	25,335	32,189	33,657
4B	13,313	18,239	27,558	35,013	36,611
5A	15,031	20,592	31,114	39,532	41,335
5B	16,749	22,946	34,670	44,050	46,060
6A	17,607	24,122	36,446	46,306	48,419
6B	19,755	27,064	40,893	51,956	54,326
7	22,761	31,183	47,115	59,861	62,593
8	32,638	44,714	67,561	85,838	89,755

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,781	9,222	13,630	16,885	17,563
1C	7,967	10,835	16,014	19,838	20,635
1D	8,679	11,803	17,445	21,611	22,479
2A	9,493	12,910	19,081	23,638	24,587
2B	11,189	15,217	22,490	27,861	28,980
2C	13,223	17,983	26,578	32,925	34,248
2D	14,918	20,288	29,985	37,146	38,638
3A	15,935	21,831	32,985	41,909	43,821
3B	17,630	24,153	36,494	46,367	48,483
4A	19,325	26,475	40,003	50,825	53,144
4B	21,020	28,797	43,511	55,283	57,805
5A	23,733	32,514	49,127	62,418	65,266
5B	26,445	36,230	54,741	69,550	72,724
6A	27,801	38,087	57,548	73,117	76,453
6B	31,192	42,733	64,567	82,035	85,778
7	35,938	49,235	74,392	94,517	98,830
8	51,534	70,602	106,675	135,534	141,719

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,103	8,300	12,267	15,196	15,807
1B	8,137	11,066	16,355	20,261	21,075
1C	9,561	13,003	19,218	23,807	24,763
1D	10,415	14,164	20,934	25,933	26,975
2A	11,391	15,492	22,896	28,364	29,503
2B	13,426	18,259	26,986	33,431	34,773
2C	15,867	21,579	31,893	39,509	41,096
2D	17,901	24,345	35,981	44,573	46,364
3A	19,121	26,196	39,580	50,288	52,583
3B	21,156	28,984	43,793	55,640	58,179
4A	23,190	31,770	48,003	60,990	63,773
4B	25,224	34,557	52,214	66,339	69,366
5A	28,480	39,018	58,954	74,902	78,320
5B	31,734	43,476	65,689	83,460	87,269
6A	33,361	45,705	69,057	87,739	91,743
6B	37,430	51,279	77,480	98,441	102,933
7	43,125	59,081	89,269	113,419	118,594
8	61,841	84,722	128,011	162,642	170,063

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,442	8,761	12,948	16,041	16,685
1B	8,589	11,681	17,264	21,387	22,246
1C	10,092	13,725	20,285	25,129	26,138
1D	10,993	14,950	22,096	27,373	28,472
2A	12,024	16,353	24,168	29,940	31,142
2B	14,172	19,274	28,486	35,288	36,705
2C	16,749	22,779	33,665	41,705	43,380
2D	18,896	25,699	37,981	47,051	48,941
3A	20,184	27,652	41,781	53,084	55,506
3B	22,332	30,595	46,227	58,733	61,413
4A	24,479	33,536	50,672	64,380	67,317
4B	26,626	36,478	55,116	70,026	73,222
5A	30,062	41,185	62,228	79,063	82,671
5B	33,497	45,891	69,339	88,097	92,117
6A	35,215	48,245	72,895	92,615	96,841
6B	39,510	54,129	81,786	103,911	108,653
7	45,521	62,364	94,228	119,720	125,183
8	65,276	89,428	135,121	171,676	179,509

DIVISION OF INSURANCE
STATE OF ILLINOIS/DFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,781	9,222	13,630	16,885	17,563
1B	9,041	12,296	18,172	22,512	23,416
1C	10,623	14,447	21,352	26,451	27,514
1D	11,572	15,738	23,260	28,814	29,971
2A	12,657	17,214	25,441	31,516	32,782
2B	14,918	20,288	29,985	37,146	38,638
2C	17,630	23,977	35,436	43,899	45,662
2D	19,890	27,050	39,979	49,526	51,515
3A	21,246	29,107	43,979	55,877	58,427
3B	23,507	32,205	48,659	61,823	64,644
4A	25,767	35,301	53,338	67,767	70,859
4B	28,027	38,397	58,016	73,711	77,074
5A	31,644	43,352	65,503	83,224	87,021
5B	35,260	48,306	72,988	92,734	96,965
6A	37,068	50,783	76,731	97,489	101,937
6B	41,589	56,977	86,089	109,379	114,370
7	47,917	65,646	99,188	126,022	131,772
8	68,712	94,135	142,234	180,713	188,958

c. Area 3

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,761	2,395	3,540	4,385	4,561
1B	2,348	3,193	4,719	5,847	6,081
1C	2,759	3,752	5,546	6,870	7,146
1D	3,006	4,088	6,042	7,485	7,786
2A	3,288	4,472	6,609	8,187	8,516
2B	3,874	5,269	7,787	9,646	10,034
2C	4,579	6,227	9,204	11,402	11,860
2D	5,166	7,026	10,384	12,863	13,380
3A	5,518	7,560	11,422	14,512	15,175
3B	6,105	8,364	12,637	16,056	16,789
4A	6,692	9,168	13,852	17,600	18,403
4B	7,280	9,974	15,070	19,146	20,020
5A	8,219	11,260	17,013	21,616	22,602
5B	9,158	12,546	18,957	24,086	25,185
6A	9,628	13,190	19,930	25,322	26,477
6B	10,802	14,799	22,360	28,409	29,706
7	12,446	17,051	25,763	32,733	34,227
8	17,846	24,449	36,941	46,935	49,077

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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JAN 01 2007
SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,042	4,137	6,114	7,575	7,879
1B	4,056	5,516	8,153	10,099	10,505
1C	4,766	6,482	9,580	11,867	12,344
1D	5,192	7,061	10,436	12,928	13,447
2A	5,679	7,723	11,415	14,141	14,709
2B	6,692	9,101	13,451	16,663	17,332
2C	7,909	10,756	15,897	19,693	20,484
2D	8,923	12,135	17,935	22,218	23,111
3A	9,532	13,059	19,731	25,069	26,213
3B	10,545	14,447	21,828	27,733	28,999
4A	11,560	15,837	23,929	30,403	31,790
4B	12,574	17,226	26,028	33,070	34,579
5A	14,196	19,449	29,386	37,335	39,039
5B	15,818	21,671	32,743	41,601	43,500
6A	16,630	22,783	34,424	43,737	45,733
6B	18,658	25,561	38,622	49,071	51,310
7	21,497	29,451	44,499	56,537	59,117
8	30,826	42,232	63,810	81,072	84,772

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD ILLINOIS

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,803	6,532	9,654	11,959	12,440
1B	6,404	8,709	12,872	15,946	16,586
1C	7,525	10,234	15,125	18,737	19,490
1D	8,198	11,149	16,478	20,413	21,233
2A	8,966	12,194	18,022	22,325	23,222
2B	10,567	14,371	21,240	26,312	27,369
2C	12,488	16,984	25,101	31,095	32,344
2D	14,090	19,162	28,321	35,084	36,493
3A	15,050	20,619	31,154	39,582	41,388
3B	16,651	22,812	34,468	43,792	45,790
4A	18,252	25,005	37,782	48,003	50,193
4B	19,853	27,199	41,096	52,213	54,596
5A	22,415	30,709	46,399	58,951	61,641
5B	24,977	34,218	51,702	65,690	68,687
6A	26,258	35,973	54,354	69,059	72,210
6B	29,459	40,359	60,980	77,477	81,012
7	33,943	46,502	70,262	89,270	93,343
8	48,672	66,681	100,751	128,007	133,848

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,764	7,839	11,586	14,352	14,929
1B	7,685	10,452	15,447	19,136	19,904
1C	9,030	12,281	18,150	22,485	23,388
1D	9,837	13,378	19,772	24,494	25,478
2A	10,760	14,634	21,628	26,792	27,868
2B	12,680	17,245	25,487	31,573	32,841
2C	14,986	20,381	30,122	37,315	38,814
2D	16,907	22,994	33,983	42,098	43,789
3A	18,060	24,742	37,384	47,498	49,665
3B	19,981	27,374	41,361	52,550	54,948
4A	21,902	30,006	45,337	57,602	60,231
4B	23,824	32,639	49,316	62,657	65,516
5A	26,898	36,850	55,679	70,742	73,970
5B	29,972	41,062	62,042	78,826	82,423
6A	31,509	43,167	65,224	82,869	86,650
6B	35,351	48,431	73,177	92,973	97,215
7	40,731	55,801	84,313	107,123	112,010
8	58,406	80,016	120,900	153,608	160,617

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,084	8,274	12,229	15,149	15,758
1B	8,112	11,032	16,305	20,199	21,010
1C	9,531	12,962	19,157	23,732	24,685
1D	10,384	14,122	20,872	25,856	26,895
2A	11,357	15,446	22,828	28,279	29,415
2B	13,385	18,204	26,904	33,329	34,667
2C	15,818	21,512	31,794	39,387	40,969
2D	17,847	24,272	35,872	44,439	46,224
3A	19,064	26,118	39,462	50,138	52,426
3B	21,091	28,895	43,658	55,469	58,000
4A	23,119	31,673	47,856	60,803	63,577
4B	25,147	34,451	52,054	66,137	69,154
5A	28,393	38,898	58,774	74,674	78,081
5B	31,637	43,343	65,489	83,205	87,002
6A	33,260	45,566	68,848	87,474	91,465
6B	37,315	51,122	77,242	98,138	102,616
7	42,994	58,902	88,998	113,074	118,234
8	61,651	84,462	127,618	162,142	169,540

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,404	8,709	12,872	15,946	16,586
1B	8,539	11,613	17,163	21,262	22,116
1C	10,033	13,645	20,166	24,982	25,985
1D	10,930	14,865	21,969	27,216	28,309
2A	11,955	16,259	24,030	29,768	30,963
2B	14,089	19,161	28,319	35,082	36,491
2C	16,651	22,645	33,469	41,461	43,126
2D	18,786	25,549	37,760	46,777	48,656
3A	20,067	27,492	41,539	52,776	55,184
3B	22,201	30,415	45,956	58,389	61,053
4A	24,336	33,340	50,376	64,004	66,924
4B	26,471	36,265	54,795	69,619	72,795
5A	29,887	40,945	61,866	78,603	82,189
5B	33,302	45,624	68,935	87,584	91,581
6A	35,010	47,964	72,471	92,076	96,278
6B	39,279	53,812	81,308	103,304	108,017
7	45,257	62,002	93,682	119,026	124,457
8	64,896	88,908	134,335	170,676	178,464

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

d. Area 4

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,554	2,113	3,124	3,869	4,025
1B	2,072	2,818	4,165	5,159	5,366
1C	2,435	3,312	4,894	6,063	6,307
1D	2,652	3,607	5,331	6,603	6,869
2A	2,901	3,945	5,831	7,223	7,514
2B	3,419	4,650	6,872	8,513	8,855
2C	4,041	5,496	8,122	10,062	10,466
2D	4,559	6,200	9,164	11,352	11,808
3A	4,869	6,671	10,079	12,805	13,390
3B	5,388	7,382	11,153	14,170	14,817
4A	5,906	8,091	12,225	15,533	16,242
4B	6,424	8,801	13,298	16,895	17,666
5A	7,253	9,937	15,014	19,075	19,946
5B	8,081	11,071	16,728	21,253	22,223
6A	8,496	11,640	17,587	22,344	23,364
6B	9,532	13,059	19,731	25,069	26,213
7	10,982	15,045	22,733	28,883	30,201
8	15,748	21,575	32,598	41,417	43,307

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,684	3,650	5,395	6,683	6,952
1B	3,579	4,867	7,194	8,912	9,270
1C	4,206	5,720	8,454	10,473	10,894
1D	4,581	6,230	9,208	11,407	11,865
2A	5,011	6,815	10,072	12,477	12,978
2B	5,906	8,032	11,871	14,706	15,297
2C	6,979	9,491	14,028	17,378	18,076
2D	7,874	10,709	15,827	19,606	20,394
3A	8,411	11,523	17,411	22,121	23,130
3B	9,306	12,749	19,263	24,475	25,592
4A	10,201	13,975	21,116	26,829	28,053
4B	11,096	15,202	22,969	29,182	30,514
5A	12,527	17,162	25,931	32,946	34,449
5B	13,959	19,124	28,895	36,712	38,387
6A	14,675	20,105	30,377	38,595	40,356
6B	16,464	22,556	34,080	43,300	45,276
7	18,970	25,989	39,268	49,891	52,168
8	27,201	37,265	56,306	71,539	74,803

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,238	5,764	8,518	10,553	10,976
1B	5,651	7,685	11,359	14,071	14,636
1C	6,641	9,032	13,348	16,536	17,200
1D	7,234	9,838	14,540	18,013	18,736
2A	7,912	10,760	15,903	19,701	20,492
2B	9,325	12,682	18,743	23,219	24,152
2C	11,020	14,987	22,150	27,440	28,542
2D	12,433	16,909	24,990	30,958	32,201
3A	13,280	18,194	27,490	34,926	36,520
3B	14,693	20,129	30,415	38,643	40,406
4A	16,106	22,065	33,339	42,359	44,292
4B	17,519	24,001	36,264	46,075	48,177
5A	19,780	27,099	40,945	52,021	54,395
5B	22,040	30,195	45,623	57,965	60,610
6A	23,171	31,744	47,964	60,940	63,720
6B	25,996	35,615	53,812	68,369	71,489
7	29,952	41,034	62,001	78,774	82,368
8	42,950	58,842	88,907	112,959	118,113

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,086	6,917	10,223	12,664	13,173
1B	6,782	9,224	13,632	16,887	17,565
1C	7,969	10,838	16,018	19,843	20,640
1D	8,681	11,806	17,449	21,616	22,484
2A	9,494	12,912	19,083	23,640	24,589
2B	11,190	15,218	22,492	27,863	28,982
2C	13,224	17,985	26,580	32,928	34,250
2D	14,919	20,290	29,987	37,148	38,640
3A	15,936	21,832	32,988	41,912	43,824
3B	17,632	24,156	36,498	46,372	48,488
4A	19,328	26,479	40,009	50,833	53,152
4B	21,023	28,802	43,518	55,290	57,813
5A	23,736	32,518	49,134	62,426	65,274
5B	26,448	36,234	54,747	69,558	72,732
6A	27,805	38,093	57,556	73,127	76,464
6B	31,195	42,737	64,574	82,043	85,786
7	35,942	49,241	74,400	94,527	98,841
8	51,539	70,608	106,686	135,548	141,732

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,368	7,300	10,790	13,366	13,903
1B	7,158	9,735	14,388	17,823	18,539
1C	8,411	11,439	16,906	20,943	21,784
1D	9,163	12,462	18,418	22,816	23,732
2A	10,022	13,630	20,144	24,955	25,957
2B	11,811	16,063	23,740	29,409	30,590
2C	13,958	18,983	28,056	34,755	36,151
2D	15,748	21,417	31,653	39,213	40,787
3A	16,822	23,046	34,822	44,242	46,261
3B	18,611	25,497	38,525	48,947	51,180
4A	20,401	27,949	42,230	53,655	56,103
4B	22,191	30,402	45,935	58,362	61,025
5A	25,054	34,324	51,862	65,892	68,899
5B	27,918	38,248	57,790	73,424	76,775
6A	29,349	40,208	60,752	77,188	80,710
6B	32,928	45,111	68,161	86,601	90,552
7	37,939	51,976	78,534	99,780	104,332
8	54,403	74,532	112,614	143,080	149,608

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,651	7,685	11,359	14,071	14,636
1B	7,535	10,248	15,145	18,762	19,516
1C	8,854	12,041	17,797	22,046	22,932
1D	9,645	13,117	19,386	24,016	24,981
2A	10,549	14,347	21,203	26,267	27,322
2B	12,433	16,909	24,990	30,958	32,201
2C	14,693	19,982	29,533	36,586	38,055
2D	16,577	22,545	33,320	41,277	42,934
3A	17,707	24,259	36,653	46,569	48,694
3B	19,591	26,840	40,553	51,524	53,875
4A	21,475	29,421	44,453	56,479	59,056
4B	23,359	32,002	48,353	61,434	64,237
5A	26,373	36,131	54,592	69,361	72,526
5B	29,387	40,260	60,831	77,288	80,814
6A	30,894	42,325	63,951	81,251	84,959
6B	34,661	47,486	71,748	91,158	95,318
7	39,936	54,712	82,668	105,032	109,824
8	57,266	78,454	118,541	150,610	157,482

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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JAN 0 1 2007
SPRINGFIELD, ILLINOIS

e. Area 5

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,450	1,972	2,915	3,611	3,756
1B	1,934	2,630	3,887	4,816	5,009
1C	2,272	3,090	4,567	5,657	5,884
1D	2,475	3,366	4,975	6,163	6,410
2A	2,707	3,682	5,441	6,740	7,011
2B	3,191	4,340	6,414	7,946	8,265
2C	3,771	5,129	7,580	9,390	9,767
2D	4,254	5,785	8,551	10,592	11,018
3A	4,544	6,225	9,406	11,951	12,496
3B	5,028	6,888	10,408	13,224	13,827
4A	5,511	7,550	11,408	14,494	15,155
4B	5,995	8,213	12,410	15,767	16,486
5A	6,768	9,272	14,010	17,800	18,612
5B	7,542	10,333	15,612	19,835	20,741
6A	7,929	10,863	16,413	20,853	21,805
6B	8,895	12,186	18,413	23,394	24,461
7	10,249	14,041	21,215	26,955	28,185
8	14,697	20,135	30,423	38,653	40,417

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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JAN 0 1 2007
SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,505	3,407	5,035	6,237	6,488
1B	3,340	4,542	6,713	8,317	8,651
1C	3,925	5,338	7,889	9,773	10,166
1D	4,275	5,814	8,593	10,645	11,072
2A	4,676	6,359	9,399	11,643	12,111
2B	5,511	7,495	11,077	13,722	14,273
2C	6,513	8,858	13,091	16,217	16,869
2D	7,348	9,993	14,769	18,297	19,031
3A	7,849	10,753	16,247	20,643	21,585
3B	8,684	11,897	17,976	22,839	23,881
4A	9,519	13,041	19,704	25,035	26,177
4B	10,355	14,186	21,435	27,234	28,476
5A	11,691	16,017	24,200	30,747	32,150
5B	13,027	17,847	26,966	34,261	35,824
6A	13,695	18,762	28,349	36,018	37,661
6B	15,365	21,050	31,806	40,410	42,254
7	17,703	24,253	36,645	46,559	48,683
8	25,385	34,777	52,547	66,763	69,809

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,956	5,380	7,952	9,850	10,246
1B	5,274	7,173	10,601	13,132	13,660
1C	6,197	8,428	12,456	15,431	16,050
1D	6,751	9,181	13,570	16,810	17,485
2A	7,384	10,042	14,842	18,386	19,125
2B	8,702	11,835	17,491	21,668	22,538
2C	10,284	13,986	20,671	25,607	26,636
2D	11,603	15,780	23,322	28,891	30,052
3A	12,394	16,980	25,656	32,596	34,084
3B	13,712	18,785	28,384	36,063	37,708
4A	15,031	20,592	31,114	39,532	41,335
4B	16,349	22,398	33,842	42,998	44,960
5A	18,459	25,289	38,210	48,547	50,762
5B	20,569	28,180	42,578	54,096	56,565
6A	21,623	29,624	44,760	56,868	59,463
6B	24,260	33,236	50,218	63,804	66,715
7	27,953	38,296	57,863	73,516	76,871
8	40,082	54,912	82,970	105,416	110,226

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,747	6,456	9,541	11,820	12,295
1B	6,329	8,607	12,721	15,759	16,392
1C	7,437	10,114	14,948	18,518	19,262
1D	8,101	11,017	16,283	20,171	20,982
2A	8,861	12,051	17,811	22,064	22,950
2B	10,443	14,202	20,990	26,003	27,047
2C	12,341	16,784	24,805	30,729	31,963
2D	13,923	18,935	27,985	34,668	36,061
3A	14,873	20,376	30,787	39,116	40,901
3B	16,455	22,543	34,062	43,277	45,251
4A	18,037	24,711	37,337	47,437	49,602
4B	19,619	26,878	40,611	51,598	53,952
5A	22,151	30,347	45,853	58,257	60,915
5B	24,683	33,816	51,094	64,916	67,878
6A	25,948	35,549	53,712	68,243	71,357
6B	29,112	39,883	60,262	76,565	80,058
7	33,543	45,954	69,434	88,218	92,243
8	48,099	65,896	99,565	126,500	132,272

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,010	6,814	10,070	12,475	12,976
1B	6,680	9,085	13,427	16,633	17,301
1C	7,850	10,676	15,779	19,547	20,332
1D	8,551	11,629	17,188	21,292	22,147
2A	9,353	12,720	18,800	23,289	24,224
2B	11,023	14,991	22,156	27,447	28,550
2C	13,026	17,715	26,182	32,435	33,737
2D	14,697	19,988	29,541	36,596	38,065
3A	15,699	21,508	32,497	41,288	43,172
3B	17,369	23,796	35,954	45,680	47,765
4A	19,039	26,083	39,411	50,073	52,357
4B	20,709	28,371	42,868	54,465	56,950
5A	23,381	32,032	48,399	61,492	64,298
5B	26,054	35,694	53,932	68,522	71,649
6A	27,389	37,523	56,695	72,033	75,320
6B	30,730	42,100	63,611	80,820	84,508
7	35,407	48,508	73,292	93,120	97,369
8	50,771	69,556	105,096	133,528	139,620

DIVISION OF INSURANC
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,274	7,173	10,601	13,132	13,660
1B	7,032	9,564	14,134	17,510	18,213
1C	8,263	11,238	16,609	20,575	21,401
1D	9,001	12,241	18,092	22,412	23,313
2A	9,845	13,389	19,788	24,514	25,499
2B	11,603	15,780	23,322	28,891	30,052
2C	13,712	18,648	27,561	34,143	35,514
2D	15,470	21,039	31,095	38,520	40,067
3A	16,525	22,639	34,207	43,461	45,444
3B	18,283	25,048	37,846	48,084	50,278
4A	20,041	27,456	41,485	52,708	55,113
4B	21,799	29,865	45,124	57,331	59,947
5A	24,612	33,718	50,947	64,730	67,683
5B	27,425	37,572	56,770	72,128	75,419
6A	28,831	39,498	59,680	75,826	79,285
6B	32,347	44,315	66,958	85,073	88,954
7	37,270	51,060	77,149	98,020	102,493
8	53,443	73,217	110,627	140,555	146,968

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DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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JAN 0 1 2007
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0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,243	1,690	2,498	3,095	3,219
1B	1,658	2,255	3,333	4,128	4,294
1C	1,948	2,649	3,915	4,851	5,045
1D	2,122	2,886	4,265	5,284	5,496
2A	2,321	3,157	4,665	5,779	6,011
2B	2,735	3,720	5,497	6,810	7,084
2C	3,233	4,397	6,498	8,050	8,373
2D	3,647	4,960	7,330	9,081	9,446
3A	3,896	5,338	8,065	10,246	10,714
3B	4,310	5,905	8,922	11,335	11,853
4A	4,725	6,473	9,781	12,427	12,994
4B	5,139	7,040	10,638	13,516	14,132
5A	5,802	7,949	12,010	15,259	15,956
5B	6,465	8,857	13,383	17,003	17,779
6A	6,797	9,312	14,070	17,876	18,692
6B	7,625	10,446	15,784	20,054	20,969
7	8,786	12,037	18,187	23,107	24,162
8	12,599	17,261	26,080	33,135	34,647

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,147	2,920	4,315	5,346	5,561
1B	2,863	3,894	5,755	7,129	7,415
1C	3,364	4,575	6,762	8,376	8,713
1D	3,665	4,984	7,367	9,126	9,492
2A	4,009	5,452	8,058	9,982	10,383
2B	4,724	6,425	9,495	11,763	12,235
2C	5,584	7,594	11,224	13,904	14,463
2D	6,299	8,567	12,661	15,685	16,314
3A	6,729	9,219	13,929	17,697	18,505
3B	7,445	10,200	15,411	19,580	20,474
4A	8,161	11,181	16,893	21,463	22,443
4B	8,876	12,160	18,373	23,344	24,409
5A	10,022	13,730	20,746	26,358	27,561
5B	11,167	15,299	23,116	29,369	30,709
6A	11,740	16,084	24,302	30,876	32,285
6B	13,171	18,044	27,264	34,640	36,220
7	15,175	20,790	31,412	39,910	41,731
8	21,761	29,813	45,045	57,231	59,843

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,947	13,528	19,993	24,768	25,763
3A	10,625	14,556	21,994	27,944	29,219
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,069	5,534	8,179	10,132	10,539
1B	5,425	7,378	10,904	13,508	14,051
1C	6,375	8,670	12,814	15,874	16,511
1D	6,944	9,444	13,957	17,291	17,985
2A	7,595	10,329	15,266	18,912	19,671
2B	8,951	12,173	17,992	22,288	23,183
2C	10,580	14,389	21,266	26,344	27,402
2D	11,936	16,233	23,991	29,721	30,914
3A	12,749	17,466	26,390	33,530	35,060
3B	14,106	19,325	29,199	37,099	38,792
4A	15,462	21,183	32,006	40,665	42,521
4B	16,818	23,041	34,813	44,231	46,250
5A	18,988	26,014	39,305	49,938	52,217
5B	21,158	28,986	43,797	55,646	58,185
6A	22,244	30,474	46,045	58,502	61,171
6B	24,956	34,190	51,659	65,634	68,629
7	28,753	39,392	59,519	75,620	79,071
8	41,232	56,488	85,350	108,440	113,388

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,295	5,841	8,633	10,695	11,124
1B	5,727	7,789	11,511	14,260	14,833
1C	6,729	9,151	13,525	16,755	17,428
1D	7,330	9,969	14,733	18,252	18,985
2A	8,017	10,903	16,114	19,962	20,764
2B	9,449	12,851	18,992	23,528	24,473
2C	11,167	15,187	22,446	27,806	28,923
2D	12,599	17,135	25,324	31,372	32,631
3A	13,458	18,437	27,858	35,395	37,010
3B	14,889	20,398	30,820	39,158	40,945
4A	16,321	22,360	33,784	42,924	44,883
4B	17,753	24,322	36,749	46,690	48,821
5A	20,043	27,459	41,489	52,713	55,118
5B	22,334	30,598	46,231	58,738	61,419
6A	23,479	32,166	48,602	61,750	64,567
6B	26,343	36,090	54,530	69,282	72,443
7	30,351	41,581	62,827	79,823	83,465
8	43,522	59,625	90,091	114,463	119,686

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,521	6,149	9,087	11,257	11,709
1B	6,028	8,198	12,116	15,010	15,613
1C	7,083	9,633	14,237	17,637	18,345
1D	7,716	10,494	15,509	19,213	19,984
2A	8,439	11,477	16,962	21,013	21,857
2B	9,946	13,527	19,991	24,766	25,760
2C	11,755	15,987	23,628	29,270	30,445
2D	13,262	18,036	26,657	33,022	34,349
3A	14,166	19,407	29,324	37,257	38,957
3B	15,673	21,472	32,443	41,220	43,101
4A	17,180	23,537	35,563	45,183	47,245
4B	18,687	25,601	38,682	49,147	51,389
5A	21,098	28,904	43,673	55,488	58,020
5B	23,509	32,207	48,664	61,829	64,650
6A	24,715	33,860	51,160	65,000	67,966
6B	27,729	37,989	57,399	72,927	76,255
7	31,948	43,769	66,132	84,023	87,857
8	45,813	62,764	94,833	120,488	125,986

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

g. Area 7

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	933	1,269	1,875	2,323	2,416
1B	1,243	1,690	2,498	3,095	3,219
1C	1,461	1,987	2,937	3,638	3,784
1D	1,591	2,164	3,198	3,962	4,121
2A	1,740	2,366	3,497	4,333	4,507
2B	2,052	2,791	4,125	5,109	5,315
2C	2,424	3,297	4,872	6,036	6,278
2D	2,735	3,720	5,497	6,810	7,084
3A	2,922	4,003	6,049	7,685	8,036
3B	3,233	4,429	6,692	8,503	8,891
4A	3,543	4,854	7,334	9,318	9,743
4B	3,854	5,280	7,978	10,136	10,599
5A	4,352	5,962	9,009	11,446	11,968
5B	4,849	6,643	10,037	12,753	13,335
6A	5,097	6,983	10,551	13,405	14,017
6B	5,719	7,835	11,838	15,041	15,727
7	6,589	9,027	13,639	17,329	18,120
8	9,449	12,945	19,559	24,851	25,985

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 0 1 2007
SPRINGFIELD, ILLINOIS

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,611	2,191	3,238	4,011	4,172
1B	2,147	2,920	4,315	5,346	5,561
1C	2,523	3,431	5,071	6,282	6,535
1D	2,749	3,739	5,525	6,845	7,120
2A	3,006	4,088	6,042	7,485	7,786
2B	3,544	4,820	7,123	8,825	9,179
2C	4,188	5,696	8,418	10,428	10,847
2D	4,724	6,425	9,495	11,763	12,235
3A	5,046	6,913	10,445	13,271	13,877
3B	5,584	7,650	11,559	14,686	15,356
4A	6,120	8,384	12,668	16,096	16,830
4B	6,657	9,120	13,780	17,508	18,307
5A	7,516	10,297	15,558	19,767	20,669
5B	8,375	11,474	17,336	22,026	23,031
6A	8,805	12,063	18,226	23,157	24,214
6B	9,879	13,534	20,450	25,982	27,167
7	11,381	15,592	23,559	29,932	31,298
8	16,321	22,360	33,784	42,924	44,883

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JAN 01 2007
SPRINGFIELD, ILLINOIS

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,543	3,458	5,111	6,332	6,586
1B	3,391	4,612	6,816	8,444	8,783
1C	3,984	5,418	8,008	9,920	10,319
1D	4,340	5,902	8,723	10,807	11,241
2A	4,747	6,456	9,541	11,820	12,295
2B	5,595	7,609	11,246	13,932	14,491
2C	6,612	8,992	13,290	16,464	17,125
2D	7,460	10,146	14,995	18,575	19,321
3A	7,968	10,916	16,494	20,956	21,912
3B	8,816	12,078	18,249	23,186	24,244
4A	9,664	13,240	20,004	25,416	26,576
4B	10,511	14,400	21,758	27,644	28,905
5A	11,868	16,259	24,567	31,213	32,637
5B	13,224	18,117	27,374	34,779	36,366
6A	13,902	19,046	28,777	36,562	38,231
6B	15,598	21,369	32,288	41,023	42,895
7	17,971	24,620	37,200	47,264	49,420
8	25,770	35,305	53,344	67,775	70,868

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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JAN 01 2007
SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,052	4,151	6,135	7,599	7,905
1B	4,069	5,534	8,179	10,132	10,539
1C	4,781	6,502	9,610	11,905	12,383
1D	5,208	7,083	10,468	12,968	13,489
2A	5,696	7,747	11,449	14,183	14,753
2B	6,714	9,131	13,495	16,718	17,389
2C	7,934	10,790	15,947	19,756	20,549
2D	8,951	12,173	17,992	22,288	23,183
3A	9,562	13,100	19,793	25,148	26,296
3B	10,580	14,495	21,901	27,825	29,095
4A	11,597	15,888	24,006	30,500	31,892
4B	12,614	17,281	26,111	33,175	34,689
5A	14,242	19,512	29,481	37,456	39,166
5B	15,869	21,741	32,849	41,735	43,640
6A	16,682	22,854	34,532	43,874	45,876
6B	18,717	25,642	38,744	49,226	51,472
7	21,565	29,544	44,640	56,716	59,304
8	30,924	42,366	64,013	81,330	85,041

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,221	4,381	6,474	8,020	8,342
1B	4,295	5,841	8,633	10,695	11,124
1C	5,046	6,863	10,142	12,565	13,069
1D	5,498	7,477	11,051	13,690	14,240
2A	6,013	8,178	12,086	14,972	15,574
2B	7,087	9,638	14,245	17,647	18,355
2C	8,375	11,390	16,834	20,854	21,691
2D	9,449	12,851	18,992	23,528	24,473
3A	10,093	13,827	20,893	26,545	27,756
3B	11,167	15,299	23,116	29,369	30,709
4A	12,241	16,770	25,339	32,194	33,663
4B	13,314	18,240	27,560	35,016	36,614
5A	15,033	20,595	31,118	39,537	41,341
5B	16,750	22,948	34,673	44,053	46,063
6A	17,609	24,124	36,451	46,312	48,425
6B	19,757	27,067	40,897	51,961	54,332
7	22,763	31,185	47,119	59,867	62,598
8	32,642	44,720	67,569	85,848	89,766

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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JAN 01 2007
SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,391	4,612	6,816	8,444	8,783
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,787	7,870	11,632	14,410	14,988
2A	6,329	8,607	12,721	15,759	16,392
2B	7,460	10,146	14,995	18,575	19,321
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,755	16,104	24,333	30,916	32,326
4A	12,885	17,652	26,672	33,888	35,434
4B	14,015	19,201	29,011	36,859	38,541
5A	15,824	21,679	32,756	41,617	43,516
5B	17,632	24,156	36,498	46,372	48,488
6A	18,536	25,394	38,370	48,750	50,974
6B	20,797	28,492	43,050	54,696	57,192
7	23,961	32,827	49,599	63,017	65,893
8	34,360	47,073	71,125	90,367	94,490

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

h. Area 8

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,036	1,409	2,082	2,580	2,683
1B	1,381	1,878	2,776	3,439	3,577
1C	1,623	2,207	3,262	4,041	4,204
1D	1,768	2,404	3,554	4,402	4,579
2A	1,934	2,630	3,887	4,816	5,009
2B	2,279	3,099	4,581	5,675	5,903
2C	2,694	3,664	5,415	6,708	6,977
2D	3,039	4,133	6,108	7,567	7,871
3A	3,246	4,447	6,719	8,537	8,927
3B	3,592	4,921	7,435	9,447	9,878
4A	3,937	5,394	8,150	10,354	10,827
4B	4,282	5,866	8,864	11,262	11,776
5A	4,835	6,624	10,008	12,716	13,296
5B	5,387	7,380	11,151	14,168	14,814
6A	5,663	7,758	11,722	14,894	15,573
6B	6,354	8,705	13,153	16,711	17,474
7	7,321	10,030	15,154	19,254	20,133
8	10,498	14,382	21,731	27,610	28,870

DIVISION OF INSURANCE
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1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,789	2,433	3,596	4,455	4,634
1B	2,386	3,245	4,796	5,941	6,180
1C	2,803	3,812	5,634	6,979	7,260
1D	3,054	4,153	6,139	7,604	7,910
2A	3,340	4,542	6,713	8,317	8,651
2B	3,937	5,354	7,913	9,803	10,197
2C	4,653	6,328	9,353	11,586	12,051
2D	5,249	7,139	10,550	13,070	13,595
3A	5,607	7,682	11,606	14,746	15,419
3B	6,204	8,499	12,842	16,317	17,061
4A	6,800	9,316	14,076	17,884	18,700
4B	7,396	10,133	15,310	19,451	20,339
5A	8,351	11,441	17,287	21,963	22,965
5B	9,305	12,748	19,261	24,472	25,589
6A	9,782	13,401	20,249	25,727	26,901
6B	10,975	15,036	22,718	28,864	30,181
7	12,645	17,324	26,175	33,256	34,774
8	18,133	24,842	37,535	47,690	49,866

DIVISION OF INSURANCE
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2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,825	3,842	5,678	7,034	7,317
1B	3,767	5,123	7,572	9,380	9,757
1C	4,427	6,021	8,898	11,023	11,466
1D	4,822	6,558	9,692	12,007	12,489
2A	5,274	7,173	10,601	13,132	13,660
2B	6,216	8,454	12,494	15,478	16,099
2C	7,346	9,991	14,765	18,292	19,026
2D	8,288	11,272	16,659	20,637	21,466
3A	8,853	12,129	18,326	23,283	24,346
3B	9,795	13,419	20,276	25,761	26,936
4A	10,737	14,710	22,226	28,238	29,527
4B	11,678	15,999	24,173	30,713	32,115
5A	13,186	18,065	27,295	34,679	36,262
5B	14,693	20,129	30,415	38,643	40,406
6A	15,446	21,161	31,973	40,623	42,477
6B	17,330	23,742	35,873	45,578	47,658
7	19,967	27,355	41,332	52,513	54,909
8	28,631	39,224	59,266	75,300	78,735

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,390	4,610	6,814	8,441	8,780
1B	4,521	6,149	9,087	11,257	11,709
1C	5,312	7,224	10,677	13,227	13,758
1D	5,786	7,869	11,630	14,407	14,986
2A	6,329	8,607	12,721	15,759	16,392
2B	7,459	10,144	14,993	18,573	19,319
2C	8,816	11,990	17,720	21,952	22,833
2D	9,946	13,527	19,991	24,766	25,760
3A	10,624	14,555	21,992	27,941	29,216
3B	11,754	16,103	24,331	30,913	32,324
4A	12,884	17,651	26,670	33,885	35,431
4B	14,014	19,199	29,009	36,857	38,539
5A	15,823	21,678	32,754	41,614	43,513
5B	17,631	24,154	36,496	46,370	48,485
6A	18,535	25,393	38,367	48,747	50,971
6B	20,795	28,489	43,046	54,691	57,186
7	23,960	32,825	49,597	63,015	65,890
8	34,358	47,070	71,121	90,362	94,485

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

4 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,579	4,867	7,194	8,912	9,270
1B	4,772	6,490	9,592	11,882	12,359
1C	5,607	7,626	11,270	13,961	14,522
1D	6,108	8,307	12,277	15,209	15,820
2A	6,680	9,085	13,427	16,633	17,301
2B	7,874	10,709	15,827	19,606	20,394
2C	9,305	12,655	18,703	23,169	24,100
2D	10,498	14,277	21,101	26,140	27,190
3A	11,214	15,363	23,213	29,493	30,839
3B	12,407	16,998	25,682	32,630	34,119
4A	13,600	18,632	28,152	35,768	37,400
4B	14,792	20,265	30,619	38,903	40,678
5A	16,702	22,882	34,573	43,926	45,931
5B	18,611	25,497	38,525	48,947	51,180
6A	19,564	26,803	40,497	51,453	53,801
6B	21,951	30,073	45,439	57,731	60,365
7	25,291	34,649	52,352	66,515	69,550
8	36,266	49,684	75,071	95,380	99,732

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

MATURE

Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,767	5,123	7,572	9,380	9,757
1B	5,023	6,831	10,096	12,507	13,010
1C	5,902	8,027	11,863	14,696	15,286
1D	6,429	8,743	12,922	16,008	16,651
2A	7,032	9,564	14,134	17,510	18,213
2B	8,288	11,272	16,659	20,637	21,466
2C	9,795	13,321	19,688	24,390	25,369
2D	11,051	15,029	22,213	27,517	28,622
3A	11,804	16,171	24,434	31,045	32,461
3B	13,060	17,892	27,034	34,348	35,915
4A	14,316	19,613	29,634	37,651	39,369
4B	15,571	21,332	32,232	40,952	42,820
5A	17,581	24,086	36,393	46,238	48,348
5B	19,590	26,838	40,551	51,522	53,873
6A	20,594	28,214	42,630	54,162	56,634
6B	23,106	31,655	47,829	60,769	63,542
7	26,622	36,472	55,108	70,016	73,211
8	38,175	52,300	79,022	100,400	104,981

DIVISION OF INSURANCE
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4. Increased Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

5. Excess Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
1M/1M xs 1M/3M	1.270	1.300	1.300
2M/2M xs 1M/3M	1.430	1.480	1.480
3M/3M xs 1M/3M	1.560	1.620	1.620
4M/4M xs 1M/3M	1.670	1.740	1.740

Note: For aggregate limits not listed above, refer to company.

DIVISION OF INSURANCE
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6. Extended Reporting Period Coverage Factors

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

7. Shared Limits Modification

Modification
Up to 25%

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

Physician & Surgeons	$250

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

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

AVAILABLE

4. **Temporary Staffing Agency Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

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6. **Physician Teaching Specialists**

   a. Training Activities

NOT AVAILABLE

   b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

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

Program	Credit
Occurrence	100%
Standard Claims Made	100%

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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 - 50% / + 50%		

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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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 Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 8	10%
8 but less than 10	15%
10 or more	20%

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

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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

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14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating 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	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code. ***Refer to the Classification Translation Table – Specialty Description to ISO Code at the end of this section.***

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

AVAILABLE

17. **Convertible Coverage Rating Plan**

An insured may be eligible for Convertible / Nose coverage. The rating for such coverage is based upon the insureds standard mature claims made rate times the factor identified in the table below.

Number of years before expiration date of Nose coverage	Factor
0	0.750
1	1.190
2	1.400
3	1.550
4 or more	1.550

The applicable premium under this plan shall be in addition to the insureds standard occurrence premium and shall be paid to the company over an installment period.

The above rating is subject to applicable part-time and schedule rating modifications.

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

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

NOT AVAILABLE

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

Refer to Quarterly Installment Option rule.

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

Credit
5%

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

Max AvailableCredit
50%

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27. **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.

*****Classification Translation Table – Specialty Description to ISO Code**

	SPECIALTY CODE	ISO CODE M.D.	D.O.	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otorhinolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B

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Rhinology	23	80247	84247	1B
Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Physician - N.O.C.	19	80268	84268	1B
SURGICAL SPECIALIST PERFORMING NO SURGERY, BUT STILL PRACTICING IN THAT SPECIALITY		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	2C
Dermatology	31	80282	84282	1B
Family/General Practice	19	80421	84421	2C
Geriatrics	32	80276	84276	2B
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80274	84274	2C
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287	84287	2B
Neurology	40	80288	84288	3A
Ophthalmology	16	80289	84289	1C
Otorhinolaryngology	23	80291	84291	2B
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B

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Radiology - Diagnostic	37	80280	84280	2D
Radiology - Therapy	37	80425	84425	2B
Pain Management	19, 30, 40	80295	84295	2A
Hospitalist	32	80296	84296	1D
SURGICAL SPECIALIST PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS WHILE PRACTICING IN THAT SPECIALITY:		80294	84294	2B
PHYSICIANS AND SURGICAL SPECIALIST PERFORMING THE FOLLOWING PROCEDURES: (XX = Code for Speciality)				
Radiation Therapy	XX	80425	84425	2B
Radiopaque Dye Injection	XX	80449	84449	2D
Radiology - incld. Mammography	37	80472	84472	2D
Shock Therapy	XX	80431	84431	2B
PHYSICIANS PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY:				
Family/General Practice	19	80117	84117	3B
Geriatrics	19	80105	84105	3B
Gastroenterology	32	80104	84104	3A
Emergency Medicine (No Major Surg)	25	80102	84102	4A
Surgical Specialists:				
Ophthalmology	16	80114	84114	1D
Colon and Rectal	24	80115	84115	3B
Emergency Medicine (Incl. Major Surg)	25	80157	84157	4B
SURGICAL SPECIALIST PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS WHIL PRACTICING IN THAT SPECIALITY, BUT NOT PRIMARLEY ENGAGED IN MAJOR SURGERY:		80117	84117	3B
PHYSICIANS AND SURGICAL SPECIALIST PERFORMING THE FOLLOWING PROCEDURES: (XX = Code for Speciality)				
Acupuncture	XX	80437	84437	3A
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
Urology	17	80145	84145	3A
Fam./Gen. Practice - incl. deliveries	29	80273	84273	3A
Anesthesiology	30	80151	84151	2A
Abdominal	10	80166	84166	6B

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General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	5A
Cosmetic Surgery	10, 15, 16, 20, 23, 31	80136	84136	5A
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

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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.

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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 and membership association credits.

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 a dentist's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program.

   a. The premium will be based upon the equivalent dental specialty rate and the average number of hours the insured practices per week.

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

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c. No other credits are to apply concurrent with this rule except risk management and membership credits.

d. The applicable modifications applicable to the manual rates are presented on the State Rate Pages.

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.

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;

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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:

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

2. Credits shall apply to the insureds first, second and third consecutive years of coverage. All other credits will apply to the reduced rate.

3. This credits 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.

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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.

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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.

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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.

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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.

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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.

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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 preformed 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 equally 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 insured's 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.

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.

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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, new to company, risk management 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.

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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. 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. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

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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.

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.

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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 dentistry in less than five years.

   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. At the time the insured permanently retires, he or she has attained the age of 55 and is associated with the group insured by the Company.

   f. Refer to the State Rate Pages for Availability.

F. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the State Rate Pages.

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, Membership Association or Deductible Credits.

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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 endodonticts not performing minor or major surgical procedures.*

CLASS I B

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

CLASS II A

Specialists in Dental Anesthesiology

CLASS II B

Specialist in Oral and Maxillofacial Surgery or any dentist performing major Dental surgical procedures not included in class III.

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CLASS III

Any Dental Specialist performing procedures not otherwise classified.

Specialists in Pain Management.

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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

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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
2A	6,993	7,972	8,531	9,091	9,790	10,490	11,189	11,888
2B	13,403	15,279	16,352	17,424	20,105	22,115	23,455	24,796
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
2A	5,829	6,645	7,111	7,578	8,161	8,744	9,326	9,909
2B	11,172	12,736	13,630	14,524	16,758	18,434	19,551	20,668
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
2A	4,662	5,315	5,688	6,061	6,527	6,993	7,459	7,925
2B	8,936	10,187	10,902	11,617	13,404	14,744	15,638	16,532
3	10,101	11,515	12,323	13,131	15,152	16,667	17,677	18,687

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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
2A	1,511	1,723	1,843	1,964	2,115	2,267	2,418	2,569
2B	2,897	3,303	3,534	3,766	4,346	4,780	5,070	5,359
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
2A	3,023	3,446	3,688	3,930	4,232	4,535	4,837	5,139
2B	5,793	6,604	7,067	7,531	8,690	9,558	10,138	10,717
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
2A	4,912	5,600	5,993	6,386	6,877	7,368	7,859	8,350
2B	9,414	10,732	11,485	12,238	14,121	15,533	16,475	17,416
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
2A	5,730	6,532	6,991	7,449	8,022	8,595	9,168	9,741
2B	10,983	12,521	13,399	14,278	16,475	18,122	19,220	20,319
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
2A	6,297	7,179	7,682	8,186	8,816	9,446	10,075	10,705
2B	12,069	13,759	14,724	15,690	18,104	19,914	21,121	22,328
3	13,644	15,554	16,646	17,737	20,466	22,513	23,877	25,241

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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
2A	1,259	1,435	1,536	1,637	1,763	1,889	2,014	2,140
2B	2,414	2,752	2,945	3,138	3,621	3,983	4,225	4,466
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
2A	2,519	2,872	3,073	3,275	3,527	3,779	4,030	4,282
2B	4,827	5,503	5,889	6,275	7,241	7,965	8,447	8,930
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
2A	4,093	4,666	4,993	5,321	5,730	6,140	6,549	6,958
2B	7,844	8,942	9,570	10,197	11,766	12,943	13,727	14,511
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
2A	4,775	5,444	5,826	6,208	6,685	7,163	7,640	8,118
2B	9,152	10,433	11,165	11,898	13,728	15,101	16,016	16,931
3	10,346	11,794	12,622	13,450	15,519	17,071	18,106	19,140

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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
2A	5,247	5,982	6,401	6,821	7,346	7,871	8,395	8,920
2B	10,057	11,465	12,270	13,074	15,086	16,594	17,600	18,605
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
2A	1,007	1,148	1,229	1,309	1,410	1,511	1,611	1,712
2B	1,931	2,201	2,356	2,510	2,897	3,186	3,379	3,572
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
2A	2,015	2,297	2,458	2,620	2,821	3,023	3,224	3,426
2B	3,861	4,402	4,710	5,019	5,792	6,371	6,757	7,143
3	4,365	4,976	5,325	5,675	6,548	7,202	7,639	8,075

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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
2A	3,274	3,732	3,994	4,256	4,584	4,911	5,238	5,566
2B	6,274	7,152	7,654	8,156	9,411	10,352	10,980	11,607
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
2A	3,819	4,354	4,659	4,965	5,347	5,729	6,110	6,492
2B	7,320	8,345	8,930	9,516	10,980	12,078	12,810	13,542
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
2A	4,197	4,785	5,120	5,456	5,876	6,296	6,715	7,135
2B	8,044	9,170	9,814	10,457	12,066	13,273	14,077	14,881
3	9,094	10,367	11,095	11,822	13,641	15,005	15,915	16,824

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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

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6. Shared Limits Modification

Modification
Up to 25%

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

Dentists	$100

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

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

NOT AVAILABLE

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	$25

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

AVAILABLE

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

Years New to Practice	Credit
1st	60%
2nd	40%
3rd	20%

5. **New to Company Credit**

Program	Credit
Standard Claims Made	25%
Occurrence	25%

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%

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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 - 50% / + 50%		

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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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

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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

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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: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

16. **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.

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

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

Refer to Quarterly Installment Option rule..

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

AVAILABLE

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

Credit
5%

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

Max AvailableCredit
50%

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25. **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.

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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 Allied Health Care Providers.

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 provider, shown on the State Rate Pages, in accordance with each provider's classification and class plan designation.

IV. CLASSIFICATIONS

A. Allied Health Care Providers

1. Each provider 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.

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B. Part Time Allied Health Care Providers

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. 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 the risk management credit.

C. Dental Hygienist Training

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

2. Coverage is available to students for activities directly related to their licensing.

   a. Coverage is available to students, on a short-term basis, for services rendered by the student during a dental hygiene externship prior to graduation and/or during the dental hygiene board exam pursuant to the student's professional licensing.

   b. The coverage for students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages. 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 hygiene board exam.

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D. Locum Tenens Allied Health Care Providers subsitituting for MPCo Insureds

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

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

E. Temporary Staffing Agency Coverage

1. Coverage for Temporary Staffing Agencies is available to organizations that provide healthcare provider staffing services to healthcare facilities (hospitals, clinics, nursing homes, etc).

2. Pricing is based upon the number of hours worked by the provider.

3. No additional premium modifications may apply with this rating, except Schedule Rating modifications.

4. Refer to the State Rate Pages for the rates associated with this coverage.

F. Allied Health Care Provider's Leave of Absence

1. An Allied 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 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.

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- 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.

G. Allied Healthcare Providers Military Leave of Absence

A 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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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 risk 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 therequired documentation of system capabilities and practice usage. Refer to the State Rate Pages for the limitations, schedule & value of the credits.

C. 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.

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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.

D. 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

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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

1. 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.

2. The application of this modification precludes the use of all other rules based upon loss experience criteria.

E. Large Group Rating

1. Physicians organized in a Large Group practice may be collectively rated.

2. For the purpose of this rule a Large Group is defined as any collective decision making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association. A Large Group will generally have 25 or more physicians and will have characteristics of operation similar to other large commercial ventures, CEO, CFO, Board of Directors, Business Manager, etc.

3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, New to Practice, Risk Management, Leave of Absence or Military Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.

4. Temporary Staffing Agency_Coverage is available under the Large Group Rating plan, when the criteria are met for Large Group Rating.

5. For Individual insureds within the group, Extension Contract Rating premium may be calculated by multiplying the mature allocated premium times the applicable claims made tail factor including any applicable deductible credits, part-time credits, and schedule rating modifications. Extension contract rating premium may be loss rated if the entire group cancels coverage.

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6. Refer to the State Rate Pages for availability.

G. Small Group Rating Rule

Any group practice consisting of two or more healthcare providers 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 preformed 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 equally 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 insured's 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.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual practitioner 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.

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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 part time or risk management credit cannot be used in conjunction with this rating rule.

B. Full Time Equivalency Rating

Coverage for an Allied Healthcare provider 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 allied healthcare provider'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 Allied Healthcare provider 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 Allied Healthcare rate to the corresponding FTE will be adjusted to reflect loss cost considerations recognized in the standard rates.

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The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification
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 Part Time Practice 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.

C. 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 practitioner basis. Coverage is provided on a shared or individual practitioner limit basis.

2. The number of out-patient visits equivalent to a practitioner 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 3 visits per hour and a maximum rate of 6 visits per hour.

3. The applicable classification 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.

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5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. For an insured, classified as 4B and above, 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 dentistry in less than five years.

   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. At the time the insured permanently retires, he or she has attained the age of 55 and is associated with the group insured by the Company.

   f. Refer to the State Rate Pages for availability.

E. 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, or Risk Management Credits.

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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

Dental Assistant, Dental Hygienist.

CLASS I-B

Cardiology Technologist, Clinical Laboratory Technologist, Counselor, Dietician, Electrocardiograph Technician, Electroneurodiagnostic Technologist, Licensed Practicing Nurse, Medical Laboratory Technician, Medical (Office) Assistant, Medical Records Technician, Nuclear Medicine Technologist, Ophthalmology Technician, Respiratory Therapy Assistant, Registered Nurse.

CLASS II

Audiologist/Speech Pathologist, Nurse Midwife Assistant, Occupational Therapist Assistant, Optician, Physical Therapy Assistant, Radiation Therapy Technologist, Social Worker, Surgical Technician, X-Ray Technician.

CLASS III

Optometrist, Paramedic/EMT, Pharmacist, Physical Therapist (Non-Owner).

CLASS IV

Case Manager, Occupational Therapist, Perfusionist, Physical Therapist (Owner), Psychologist, Respiratory Therapist.

CLASS V

Nurse Practitioner (Non-prescribing), Physician's Assistant (Non-prescribing).

CLASS VI

Nurse Surgical Assistant, Physician Surgical Assistant.
Nurse Practitioner (Prescribing), Physician's Assistant (Prescribing).

CLASS VII-A

Certified Registered Nurse Anesthetist, Registered Nurse Anesthetist.

CLASS VII-B

Nurse Midwife.

CLASS VIII-A

Podiatrist (No Surgery)

CLASS VIII-B

Podiatrist (Surgery).

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B. Manual Rates

1. Territory Definitions

Refer to Program Type for the Territory definition and description.

2. Occurrence Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

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3. Standard Claims Made Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. The Mature Standard Claims Made rate for is 0.920 of the corresponding Allied Health Care Provider Occurrence rate.

b. Allied Health Care Provider Claims Made Factors may be applied to the Mature Standard Claims Made base rate for the applicable year of claims made coverage.

c. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

4. Increased Limits Factors

Limits	Classes 1A-5	Classes 6-8B
100/300	1.000	1.000
200/600	1.220	1.260
500/1000	1.460	1.630
1000/1000	1.750	1.940
1000/3000	1.800	2.000
2000/2000	2.050	2.410
2000/4000	2.120	2.480
3000/3000	2.220	2.680
3000/5000	2.290	2.750

A minimum of 1000/3000 underlying limits required in order to purchase shared excess limits.

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5. Extended Reporting Period Coverage Factors

Years Retro. Date Precedes Expiration Date	Classes 1A-4	Classes 5-8B
1	0.750	0.700
2	1.000	1.000
3	1.100	1.150
4	1.150	1.200
5 or more	1.200	1.250

a. Factor applies to Mature Claims-Made Allied Health Care Provider rate.

6. Claims Made Factors

Years Since Retroactive Date	Class 1A-4	Classes 5-8B
0	0.60	0.45
1	0.80	0.70
2	0.90	0.85
3	0.95	0.90
4 or More	1.00	1.00

7. Shared Limits Modification

Modification
Up to 25%

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

Allied Health Care Provider	$50

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D. **Premium Modifications**

1. **Part Time Allied Health Care Provider**
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-10	515	50%
11-20	1050	30%

Part Time Credits are available for AHCP Classes 4-8B Only.

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Dental Hygienist in Training**

NOT AVAILABLE

3. **Locum Tenens**

NOT AVAILABLE

4. **Temporary Staffing Agency Rating Coverage**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

6. **Military Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

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7. **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 - 50% / + 50%		

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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8. **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%

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

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (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

	Incident Policy Limit (000's)				
Deductible (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.

10. **Self-Insured Retention Credits**

NOT AVAILABLE

11. **Experience Rating**

NOT AVAILABLE

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12. **Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

14. **Full-Time Equivalency Rating**

AVAILABLE

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

AVAILABLE

16. **Accelerated Extension Contract Rating**

NOT AVAILABLE

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

Max AvailableCredit
50%

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

AVAILABLE

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19. **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.

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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 coverage for Health Care Facilities.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. ELIGIBILITY

For the purpose of these rules, health care facilities shall be defined as entities such as hospitals and other health care organizations, identified in the classification schedule, as well as individual health care providers including, but not limited to, employed physicians, surgeons, residents, dentists and ancillary personnel which meet the Company's underwriting guidelines.

III. BASIC LIMITS OF LIABILITY

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

A. Occurrence Coverage

$200,000 Each Health Care Occurrence
$600,000 Aggregate

B. Claims-Made Coverage

$200,000 Each Health Care Occurrence
$600,000 Aggregate

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IV. PREMIUM COMPUTATION

A. Basic Limits Premium

Basic limits premium is computed by first multiplying the basic limits rates in effect at policy inception by exposures for beds, visits and ancillary services (if any). Next, charges for additional exposures are calculated under the rules in sections B through H below. The sum of the premium for all such charges shall be further modified by an experience and schedule rating modification factor and then by the applicable increase limits factor. *The sum of the premiums may be adjusted to a net of commission basis to provide for the appropriate brokerage expense associated with the particular facility.*

B. Employee Coverage

All employees not rated separately will be covered for a charge of 10% of the premium developed for beds and visits.

C. Employed Physicians, Surgeons and Dentists

The base rates used for employed physicians, surgeons and dentists will be those filed by MPCo for its individual professional liability programs. Different modification factors will be applied to that rate depending on whether a shared limit of liability or a separate limit of liability is provided. Refer to state rate pages.

1. Rates are filed for each class of physician and dentist. Determine the class from the Physician and Surgeons or Dentitsts Classification Schedule. If two or more classes apply to the same individual, apply the highest-rated class.

2. Determine the number of exposures for each classification. If a shared limit is provided, this is done by counting each full time employed physician or dentist as one. Part time physicians or dentists are counted by the average number of hours worked each week divided by 40. In no case will a part time physician or dentist ever count for more than one FTE.

   If a separate limit is provided each physician, surgeon and dentist will count as one exposure.

3. Multiply the rate for the appropriate rating territory for each classification in 1. above by the total number of exposures for each classification, and multiply that result by the appropriate modification (separate/shared) factor.

D. Contract Physicians, Surgeons and Dentists

Contract physicians, surgeons and dentists can be covered under the same rules as employed physicians, surgeons and dentists.

E. Residents (PGY-2 and above)

Residents shall be rated under the same rules as employed physicians, surgeons and dentists with an appropriate modification factor. Refer to state rate pages.

F. Interns (PGY-1)

There will be no additional charge for employed interns.

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G. Ancillary Personnel

1. Certified Registered Nurse Anesthetists (CRNA's) will be charged the base rate used by MPCo for its individual CRNA programs, with an appropriate modification factor. Refer to state rate pages.

2. Nurse Midwives will be charged the base rate used by MPCo for its individual Nurse Midwives programs, with an appropriate modification factor. Refer to state rate pages.

H. Faculty/Teaching

Faculty/Teaching physicians, surgeons and dentists will be rated under the same rules as employed physicians, surgeons and dentists with an appropriate modification factor. Refer to state rate pages.

I. Underlying Insurance

All rating rules will remain the same, for excess limits of insurance, whether the underlying coverage is provided by MPCo or another insurance carrier.

V. CLASSIFICATIONS

A. The basis of premium for each manual classification is defined below and the unit of exposure indicated.

1. "Beds" mean the daily average number of occupied beds used by patients during the policy period. This number is determined by dividing total patient days by 365 days for each class of bed. The unit of exposure is an "occupied bed".

2. "Visits" mean the total number of visits to any covered facilities by outpatients (patients not receiving bed and board services) during the policy period. The unit of exposure is "each 100 visits".

3. "Employed physicians, surgeons and dentists" are those health care providers regularly employed by a facility who receive reimbursement for services from the facility and not from patients. The unit of exposure for a shared limit of liability is "per full-time equivalent person" computed by dividing the number of hours worked per week by 40. A full-time employee's "full-time equivalent" should be equal to one. The unit of exposure for a separate limit of liability is "per person".

4. "Contract physicians, surgeons and dentists " are those physicians under contract with a facility to provide professional services to patients of that facility. The unit of exposure is the same as employed physicians.

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5. "Residents" are second-year or above postgraduate (PGY-2 and above) students. The unit of exposure is the same as employed physicians, surgeons and dentists.

6. "Interns" are first-year postgraduate (PGY-1) students. There will be no additional charge for such persons.

7. "Faculty/teaching physicians" are those employed or contracted physicians whose primary responsibility is to provide instruction in an authorized training program in the health professions. The unit of exposure is the same as employed physicians, surgeons and dentists.

8. "Ancillary Employees" means any employed allied health care providers specified in the state exception pages as chargeable exposures. The unit of exposure is "per full-time equivalent person" computed by dividing the number of hours worked per week by part-time employees by 40. A full-time employee's "full-time equivalent" shall be equal to one.

9. "Ancillary Services" means any one of the following services provided to non-related entities or persons, other than patients, at covered facilities: wellness and fitness centers, and pharmacies. The unit of exposure is "$1000 of annual revenue".

VI. PREMIUM MODIFICATIONS

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

A. Experience Rating

1. Eligibility

The term "risk" as used in this plan, means the exposures of any one (or more) insured facilities which is to be rated. Allied or subsidiary risks may be included if the insured holds a majority financial interest therein and the allied or subsidiary risks are being insured under the policy being rated.

2. Experience Used

The experience rating plan uses the latest complete five years of experience for the facility being rated. Experience incurred by carriers other than MPCo, or self-insured experience, may be used subject to the time frame described above, and given credence in accordance with its apparent reliability and verifiability.

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3. Determination of Experience Modifier

a. Basic Limits Premium

The term "basic limits premium" is defined as follows for experience rating purposes:

The premium developed for all facility liability exposures, including ancillary personnel, ancillary services, employed physicians, surgeons and dentists, additional insureds, and standard general liability.

b. Basic Limits Premium Subject to Experience Rating

The basic limits premium subject to experience rating (subject premium) is the policy period premium at present rates as defined in 3.a, detrended or otherwise adjusted and then summed for all experience years. This value is used in 3.e to calculate the "actual loss ratio".

c. Bed Equivalent Exposures

Bed equivalent exposures is the measure of the size of the facility, and will be used to determine the risk's Credibility and Adjusted Expected Loss Ratio (AELR) from the experience rating table. Bed equivalent exposures are calculated by dividing the average of the latest five years premium used for experience rating for the current policy period as described in 3.b by the basic limits acute care bed rate.

d. Losses Subject to Experience Rating

All paid and outstanding losses and Allocated Loss Adjustment Expense (ALE) for the experience period, adjusted according to the following provisions:

i. Loss Development

Paid loss and ALE will not be subject to loss development. Outstanding loss and ALE may be from other insurance carriers or MPCo and consideration must be given to the expected case development patterns of other carriers. These patterns vary from carrier to carrier. MPCo will determine the appropriate factors based on its analysis of rate filings, annual statements, and any other public information which may be available.

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ii. Loss Limitation

After the individual losses are developed, each loss will be subject to limitation by the Maximum Single Loss Amount (MSL). The MSL is the lesser of the premium as developed in 3.a, or the limits used in experience rating premium. Loss amounts greater than the MSL will be loaded into the rating plan at the amount of the MSL.

iii. IBNR for Occurrence Policies

If the present policy and the experience are on an occurrence basis, the amount will be loaded for IBNR losses and ALE. This load will be a function of the detrended premium for the experience periods and will decrease for the less recent experience periods.

e. Actual Loss Ratio

The actual loss ratio for the risk is determined by dividing the losses subject to experience rating in 3.d by the subject premium for experience rating in 3.b. This calculation yields a single average loss ratio for all years in the experience period.

f. Adjusted Expected Loss Ratio and Credibility

These values are obtained from the table by using the number of bed equivalent exposures calculated in 3.c.

g. Experience Modifier

The experience modifier is calculated as follows:

$$\text{Credibility} \times \frac{(\text{Actual loss ratio} - \text{AELR})}{\text{AELR}} = \text{Experience Modifier}$$

If the experience modifier is negative, it is a credit. If positive, it is a debit. The maximum credit under this plan will be 50% and the maximum debit will be 100%. This credit or debit will be multiplied by the amount of schedule credit or debit from the schedule rating plan, and that result will be the percentage by which the basic limits premium must be adjusted to arrive at the final basic limits premium for the risk.

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B. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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.

C. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Deductibles shall be offered to qualified insureds.

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 occurrence deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate deductible limit.

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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 occurrence SIR limit.

      ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

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HEALTH CARE FACILITIES

A. Classification

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 exposure.

Classification	ISO Code For Profit	ISO Code Not For Profit
Acute Care Beds	80611	80612
Bassinets	80611	80612
Maternity Beds	80611	80612
Neo Natal Beds	80611	80612
Psychiatric Beds	80997	80916
Chemical Dependency and Rehabilitation Beds	80601	80603
Long Term Care Beds	80923	80924
Inpatient Surgeries	N/A	N/A
Births	N/A	N/A
Outpatient Surgeries	80453	80453
ER Visits - Employed Physicians	80610	80617
ER Visits - Contracted Physicians with appropriate limits	80610	80617
Clinic Visits	80613	80614
Home Health Visits	N/A	N/A
Psychiatric Visits	80990	80917
Wellness Center Visits	N/A	N/A
All Other Outpatient Visits	80610	80617

Ancillary Services	ISO Code
Pharmacies	59181
Wellness and Fitness Centers	80614

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B. Manual Rates

1. Territory Definitions

Rating Area	Relativity
Area 1 - Cook, Lake, Madison, St. Clair, & Will counties	3.000
Area 2 - Jackson, Vermillion, DuPage, Kane, & McHenry counties	1.750
Area 3 - Champaign, Kankakee, Macon, Sangamon, Winnebego	1.400
Area 4 - Remainder of State	1.000

2. HPL Premium Basis

a. Occurrence Program

Acute Care Bed Rate at $200,000/$600,000: $1,290

b. Standard Claims-Made Program

Acute Care Bed Rate at $200,000/$600,000: $1,200

c. Classification Relativity Factors:

Classification	Relativity
Acute Care Beds	1.0000
Bassinets	1.0000
Maternity Beds	1.0000
Neo Natal Beds	1.2000
Psychiatric Beds	0.7500
Chemical Dependency and Rehabilitation Beds	0.2500
Long Term Care Beds	0.2000
Births	0.0400
Inpatient Surgeries	0.0180
Per 100 Visits:	
Outpatient Surgeries	0.4500
ER Visits - Employed Physicians	0.2000
ER Visits - Contracted Physicians with appropriate limits	0.2000
Clinic Visits	0.0500
Home Health Visits	0.0250
Psychiatric Visits	0.0380
Wellness Center Visits	0.0050
All Other Outpatient Visits	0.0500
Ancillary Services (Per (000's) annual revenue)	
Pharmacies	0.0010
Wellness and Fitness Centers	0.0010

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3. Increased Limits Factors

Limits ($000)	Factor
200/600	1.000
1000/1000	1.704
1000/3000	1.893

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor PL Relativity
0	0.50
1	0.75
2	0.90
3	0.95
Mature	1.00
CM to Occ Relativity	0.93

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor PL Relativity
1	0.80
2	1.25
3	1.85
4	2.00
Mature	2.00

6. Prior Acts Nose Coverage

Years Retro. Date Precedes Inception Date	Factor Based on the Occurrence Rate
1	0.61
2	0.92
3	1.05
4	1.25
Mature	1.35

7. Additional limits of liability

Not Applicable

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8. PPL and Ancillary Premium Basis

a. Employed physician, surgeon and dentist modification

Limit of Liability	Factor
Separate	0.750
Shared	0.600

b. Residents (PGY-2 and above) modification

Limit of Liability	Factor
Separate	0.500
Shared	0.400

c. Ancillary Personnel (Shared Limit)

Personnel	Factor
CRNA	0.750
Nurse Midwife	0.750

d. Faculty/Teaching physician, surgeon and dentist modification

Limit of Liability	Factor
Separate	0.500
Shared	0.400

C. Policy Writing Minimum Premium

HCF	$10,000

Note: The minimum premium is reduced to $500 in those instances in which coverage is provided to an entity associated with an insured facility.

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D. Premium Modifications

I. Experience Rating Plan

TABLE OF ADJUSTED EXPECTED LOSS RATIOS AND CREDIBILITY

BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES	AELR *	CREDIBILITY	BED EQUIVALENT EXPOSURES**	AELR *	CREDIBILITY
10 - 11	21.26%	10.25%	49 - 50	44.29%	22.25%	88 - 89	55.07%	29.75%
11 - 12	22.22%	10.72%	50 - 51	44.67%	22.47%	89 - 90	55.26%	29.92%
12 - 13	23.14%	11.18%	51 - 52	45.05%	22.69%	90 - 91	55.44%	30.08%
13 - 14	24.02%	11.62%	52 - 53	45.42%	22.91%	91 - 92	55.62%	30.25%
14 - 15	24.87%	12.04%	53 - 54	45.78%	23.13%	92 - 93	55.79%	30.41%
15 - 16	25.69%	12.45%	54 - 55	46.14%	23.35%	93 - 94	55.96%	30.58%
16 - 17	26.48%	12.85%	55 - 56	46.49%	23.56%	94 - 95	56.13%	30.74%
17 - 18	27.24%	13.23%	56 - 57	46.83%	23.77%	95 - 96	56.29%	30.90%
18 - 19	27.98%	13.60%	57 - 58	47.17%	23.98%	96 - 97	56.46%	31.06%
19 - 20	28.70%	13.96%	58 - 59	47.50%	24.19%	97 - 98	56.61%	31.23%
20 - 21	29.40%	14.32%	59 - 60	47.83%	24.39%	98 - 99	56.77%	31.38%
21 - 22	30.08%	14.66%	60 - 61	48.15%	24.60%	99 - 100	56.92%	31.54%
22 - 23	30.75%	15.00%	61 - 62	48.46%	24.80%	100 - 105	57.36%	32.02%
23 - 24	31.40%	15.33%	62 - 63	48.77%	25.00%	105 - 110	58.03%	32.79%
24 - 25	32.03%	15.65%	63 - 64	49.07%	25.20%	110 - 115	58.64%	33.54%
25 - 26	32.65%	15.97%	64 - 65	49.37%	25.40%	115 - 120	59.20%	34.28%
26 - 27	33.25%	16.28%	65 - 66	49.66%	25.59%	120 - 125	59.70%	35.00%
27 - 28	33.84%	16.58%	66 - 67	49.95%	25.79%	125 - 130	60.15%	35.71%
28 - 29	34.42%	16.88%	67 - 68	50.23%	25.98%	130 - 135	60.56%	36.40%
29 - 30	34.98%	17.18%	68 - 69	50.51%	26.17%	135 - 140	60.94%	37.08%
30 - 31	35.54%	17.46%	69 - 70	50.78%	26.36%	140 - 145	61.28%	37.75%
31 - 32	36.08%	17.75%	70 - 71	51.04%	26.55%	145 - 150	61.58%	38.41%
32 - 33	36.61%	18.03%	71 - 72	51.31%	26.74%	150 - 160	62.00%	39.37%
33 - 34	37.13%	18.30%	72 - 73	51.56%	26.93%	160 - 170	62.46%	40.62%
34 - 35	37.65%	18.57%	73 - 74	51.82%	27.11%	170 - 180	62.85%	41.83%
35 - 36	38.15%	18.84%	74 - 75	52.06%	27.29%	180 - 190	63.18%	43.01%
36 - 37	38.64%	19.10%	75 - 76	52.30%	27.48%	190 - 200	63.46%	44.16%
37 - 38	39.12%	19.36%	76 - 77	52.54%	27.66%	200 - 225	63.85%	46.10%
38 - 39	39.60%	19.62%	77 - 78	52.78%	27.84%	225 - 250	64.25%	48.73%
39 - 40	40.07%	19.87%	78 - 79	53.01%	28.02%	250 - 275	64.53%	51.23%
40 - 41	40.52%	20.12%	79 - 80	53.23%	28.20%	275 - 300	64.73%	53.62%
41 - 42	40.97%	20.37%	80 - 81	53.45%	28.37%	300 - 400	65.04%	59.16%
42 - 43	41.41%	20.62%	81 - 82	53.67%	28.55%	400 - 500	65.26%	67.08%
43 - 44	41.85%	20.86%	82 - 83	53.88%	28.72%	500 - 600	65.36%	74.16%
44 - 45	42.27%	21.10%	83 - 84	54.09%	28.90%	600 - 700	65.41%	80.62%
45 - 46	42.69%	21.33%	84 - 85	54.29%	29.07%	700 - 800	65.44%	86.60%
46 - 47	43.10%	21.56%	85 - 86	54.49%	29.24%	800 - 900	65.46%	92.20%
47 - 48	43.50%	21.79%	86 - 87	54.69%	29.41%	900 - 1,000	65.47%	97.47%
48 - 49	43.90%	22.02%	87 - 88	54.88%	29.58%	1,000 +	65.50%	100.00%

NOTES :

* AELR is the adjusted expected loss ratio.

** This is the average number of bed equivalent exposures for the latest five policy years.

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2. Schedule Rating Plan - Professional Liability

a. Risk Management Program

Considerations	Max. Credit	Max. Debit
Existence of a formal written risk management program with full time management position or committee	10%	10%
Employment of a full time patient advocate	5%	5%
The risk manager is a member of the Quality Assurance Committee	5%	5%
Existence of an effective medical audit system which includes surgical procedures and ties into the physician credentialing process	10%	10%
Existence of a formal risk management program for:		
Generic/Occurrence Screening	2%	2%
Incident Reporting	2%	2%
Infection Control Committee	2%	2%
Tissue Review Committee	2%	2%
A formal continuing education program for:		
Nursing Staff	5%	5%
Medical Staff	5%	5%
Allied Health Professionals	5%	5%
Administrative and medical staff commitment and involvement in risk management as exhibited by an established and enforced policy statement	15%	15%
Compliance with insurance company loss prevention recommendations, if any, relating to items other than above	10%	10%

b. Biomedical Equipment Program

Considerations	Max. Credit	Max. Debit
Existence of preventative maintenance and corrective maintenance program for equipment in the facility	5%	5%

c. JCAHO or Equivalent Accreditation

Considerations	Max. Credit	Max. Debit
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA) accreditation with no outstanding contingencies	10%	10%
Accreditation with commendation by one of the above accrediting organizations	10%	0%

d. Building and Physical Plant

Considerations	Max. Credit	Max. Debit
Compliance with National Fire Protection Association (NFPA) standards	10%	10%

e. Cooperation with Insurance Company Claims Department

Considerations	Max. Credit	Max. Debit
Adherence to clearly defined loss identification and reporting procedures	10%	10%

f. Maximum Modification: 50%

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3. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.5%
10,000	10.3%	13.8%
25,000	17.9%	22.9%
50,000	28.7%	36.1%
100,000	42.2%	53.9%
250,000	61.6%	83.5%
300,000	66.4%	88.3%

Notes:

a) The deductible amount applies per health care occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

b) Deductibles shall apply to indemnity only or to indemnity and defense costs.

c) Once a deductible is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower deductible.

d) Deductible amounts not shown will be interpolated using standard actuarial techniques.

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4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	59.4%
200,000	72.3%
250,000	86.8%
300,000	92.0%

Notes:

a) The SIR amount applies per health care occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

b) SIR's shall apply to indemnity and defense costs.

c) Once a SIR is elected, it applies to prior acts reported during the policy period if coverage is claims made. It also applies to reporting endorsement coverage. A Reporting Endorsement must be purchased to opt back to a lower SIR.

d) SIR amounts not shown will be interpolated using standard actuarial techniques.

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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 General Liability and Employee Benefits Liability coverage for Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. BASIC LIMITS OF LIABILITY

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

A. Occurrence Coverage

$200,000 Each Occurrence
$600,000 Aggregate

B. Claims-Made Coverage

$200,000 Each Occurrence
$600,000 Aggregate

III. PREMIUM COMPUTATION

A. General Liability

1. The standard General Liability premium will be a percentage of the PL premium, at the corresponding limit, developed for the corresponding health care provider(s). Refer to the state rate pages to determine the percentage applicable.

2. The standard General Liability premium may be subject to an additional charge if the insured elects to include *Employer's Liability or* Patients' Property Liability or increase the sublimits for the other miscellaneous coverages. Refer to the state rate pages to determine the specific premium charge for the following miscellaneous coverages:

   i. Employer's Liability

   ii. Fire Damage Legal Liability

   iii. Medical Payments

   iv. Patients' Property Liability

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B. Employee Benefits Liability

Refer to the state rate pages to determine the specific premium charge.

IV. CLASSIFICATIONS

General Liability and Employee Benefits Liability coverage shall be classified in accordance with the following types of health care providers:

A. Corporations, Partnerships and Associations

B. Physicians and Surgeons

C. Dentists

D. Allied Health Care Providers

E. Health Care Facilities.

V. PREMIUM MODIFICATIONS

A. General Liability Exposure Modification Table

1. The standard General Liability (GL) premium will be a percentage (see state rate pages) of the corresponding Professional Liability (PL) premium, subject to specific considerations identified on the State Rate Pages.

2. The GL exposure modifier will be subject to the maximum modification shown on the State Rate Pages. This modifier will be applied to the percentage rate to arrive at the standard GL charge.

B. Experience Rating

1. The standard General Liability premium shall be subject to an Experience Modifier based upon the modifier derived in the determination of the corresponding PL premium.

2. Refer to the applicable health care provider section to determine applicability.

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C. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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 applicable schedule of modifications may be found in the State Rate Pages for the corresponding health care providers.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Deductibles shall be offered to qualified insureds.

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 occurrence deductible limit.

ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate deductible limit.

e. The applicable deductible credit schedule may be found in the State Rate Pages for the corresponding health care providers.

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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 occurrence SIR limit.

      ii The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

   e. The applicable SIR credit schedule may be found in the State Rate Pages for the corresponding health care providers.

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GENERAL LIABILITY

A. Classification

1. Applicable to the Occurrence and Standard Claims-Made Programs.

2. The classification plan shall consist of the types of health care providers for which coverage is provided.

   a. Corporations, Partnerships and Associations

   b. Physicians and Surgeons

   c. Dentists

   d. Allied Health Care Providers

   e. Health Care Facilities

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B. Manual Rates

1. Territory Definitions

Refer to Healthcare Facilities

2. Corporations, Partnerships and Associations

Reserved for future use.

3. Physicians and Surgeons

Reserved for future use.

4. Dentists

Reserved for future use.

5. Allied Health Care Providers

Reserved for future use.

6. Health Care Facilities

a. Standard General Liability

i.

Standard Premium Percentage	25.0%

Standard occurrence premium will be a percentage of the PL premium developed for beds, visits and ancillary services at the applicable limit.

ii. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor GL Relativity
0	0.89
1	0.95
2	0.99
3	1.00
Mature	1.00
CM to Occ Relativity	0.9615

iii. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor GL Relativity
1	0.55
2	0.95
3	1.15
4	1.25
Mature	1.25

iv.

GL Nose Coverage Factor Based on the Occurrence Rate	1.10

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b. Employee Benefit Liability - Claims Made Only

Limit	Charge
Basic	$1,000

Note: Employee Benefit Liability will be subject to the same increased limits factors and extended reporting endorsement factors as HPL.

C. Policy Writing Minimum Premium

	Add'l Coverage	Stand Alone
GL	$100	$2,500
EBL	$100	N/A

D. Premium Modifications

1. Corporations, Partnerships and Associations

Reserved for future use.

2. Physicians and Surgeons

Reserved for future use.

3. Dentists

Reserved for future use.

4. Allied Health Care Providers

Reserved for future use.

5. Health Care Facilities

a. Exposure Modification

i. Presence/absence of characteristics

Characteristics	Present	Absent
Daycare Center	10%	-10%
Restaurant	10%	-10%
Helicopter Landing Pad	5%	-5%
Retail Pharmacy	10%	-10%
Major Construction in the last or next 12 months	15%	-15%
Health and/or Fitness Center	10%	-10%
Habitational Risk (Apartments or Hotel)	15%	-15%
Special athletic or fund raising events that attract the general public	5%	-5%

ii. Other characteristics of the underlying risk

Characteristics	Credit
Entire facility at ground level	10%
Adequate Security	10%

iii. Maximum Modification: 40%

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6. Schedule Rating Plan - General Liability

a. Risk Management Program

Considerations	Max. Credit	Max. Debit
Existence of a formal written risk management program with full time management position or committee	10%	10%
Employment of a full time patient advocate	5%	5%
The risk manager is a member of the Quality Assurance Committee	5%	5%
Existence of an effective medical audit system which includes surgical procedures and ties into the physician credentialing process	10%	10%
Existence of a formal risk management program for:		
Generic/Occurrence Screening	2%	2%
Incident Reporting	2%	2%
Infection Control Committee	2%	2%
Tissue Review Committee	2%	2%
A formal continuing education program for:		
Nursing Staff	5%	5%
Medical Staff	5%	5%
Allied Health Professionals	5%	5%
Administrative and medical staff commitment and involvement in risk management as exhibited by an established and enforced policy statement	15%	15%
Compliance with insurance company loss prevention recommendations, if any, relating to items other than above	10%	10%

b. Biomedical Equipment Program

Considerations	Max. Credit	Max. Debit
Existence of preventative maintenance and corrective maintenance program for equipment in the facility	5%	5%

c. JCAHO or Equivalent Accreditation

Considerations	Max. Credit	Max. Debit
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA) accreditation with no outstanding contingencies	10%	10%
Accreditation with commendation by one of the above accrediting organizations	10%	0%

d. Building and Physical Plant

Considerations	Max. Credit	Max. Debit
Compliance with National Fire Protection Association (NFPA) standards	10%	10%

e. Cooperation with Insurance Company Claims Department

Considerations	Max. Credit	Max. Debit
Adherence to clearly defined loss identification and reporting procedures	10%	10%

f. Maximum Modification: 50%

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E. Miscellaneous General Liability Coverages

1. Corporations, Partnerships and Associations

Reserved for future use.

2. Physicians and Surgeons

Reserved for future use.

3. Dentists

Reserved for future use.

4. Allied Health Care Providers

Reserved for future use.

5. Health Care Facilities

a. Employer's Liability

Limit	Charge
Basic	n/a

b. Fire Damage Legal Liability

Per Occ. Limit	Charge
50,000	No add'l charge
100,000	$500
250,000	$1000

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c. Medical Payments

Per Person Limit	Bed Equivalent Exposures				
	Less than 100	101-250	251-500	501-1000	1001+
1,000	No add'l charge	No add'l charge	No add'l charge	No add'l charge	No add'l charge
2,500	$375	$1,075	$2,200	$4,375	$6,250
5,000	$675	$1,925	$3,950	$7,875	$11,250
10,000	$1200	$3,400	$7,000	$14,000	$20,000

d. Patients' Property Liability ($1,000 limit per person)

Insured's Deductible	Bed Equivalent Exposures				
	Less than 100	101-250	251-500	501-1000	1001+
$250 per person	$375	$1,075	$2,200	$4,375	$6,250
$500 per person	$150	$425	$875	$1,750	$2,500

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I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing errors and omissions liability coverage for Managed Care Entities.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. MANAGED CARE ENTITIES

For the purpose of these rules, Managed Care Entities (MCE) shall be defined as entities created to integrate the financing and delivery of health care services by means of contracts with selected health care providers to a population of enrolled members. Some examples of these entities are health maintenance organizations, preferred provider organizations and exclusive provider organizations.

III. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for coverage, unless modified on a state exception basis, under this program shall be:

A. Claims-Made Coverage

$200,000 Each Managed Care Occurrence
$600,000 Aggregate

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IV. PREMIUM COMPUTATION

A. Exposure Unit

"Enrollees" means the average number of insured persons enrolled by the MCE during the policy period on an annualized basis. The unit of exposure is "100 enrollees".

From time to time, MCE's may contract to provide services for non-owned entities on a third party administration (TPA) basis. In the event that coverage is provided for an MCE performing TPA services for a non-owned entity, the enrollee count of that non-owned entity will be modified for the level of service being provided by the insured MCE. The enrollee count will be modified by the exposure adjustment factor, which is the sum of the adjustment factors for each of five categories of services provided. The following table identifies the adjustment factors for each of the five categories of service.

Utilization Review	45%	Business Services	10%
Peer Review and Credentialing	45%	Business Consulting	10%
Claims Handling	20%		

The number of enrollees, for rating purposes of a non-owned entity, will be the enrollees times the sum of the applicable exposure adjustment factors.

B. Basic Limits Premium

Basic limits premium is computed by first multiplying the basic limits rates in effect at policy inception by the number of enrollees. Next, the premium shall be modified by a schedule rating modification factor and then by the applicable increased limits factor.

C. Underlying Insurance

All rating rules will remain the same for excess limits of insurance, whether the underlying coverage is provided by MPCo or another insurance carrier.

V. CLASSIFICATIONS

A. Health Maintenance Organizations (HMO's)

For the purpose of these rules, an HMO shall be defined as an entity which accepts a fixed amount from an employer or the government per covered person to provide all the benefits the person's plan contains. All other managed care organizations will be rated as non-HMO's.

VI. PREMIUM MODIFICATIONS

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

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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 on the State Rate Pages.

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B. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Deductibles shall be offered to qualified insureds.

   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 occurrence deductible limit.

      ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% 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 occurrence SIR limit.

      ii. The insured may select an aggregate SIR limit in accordance with underwriting guidelines.

      iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

MANAGED CARE ENTITY LIABILITY

A. Classification

1. Applicable to the Standard Claims-Made Program

2. The classification plan shall consist of HMO's and All Other Managed Care Entities.

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B. Manual Rates

1. Territory Definitions

Rating Area	Relativity
Area 1 - Refer to Healthcare Facilities	2.915
Area 2 - Refer to Healthcare Facilities	1.848
Area 3 - Refer to Healthcare Facilities	1.530
Area 4 - Refer to Healthcare Facilities	1.000

2. MCO Premium Basis (Standard Claims-Made Program)

a. Non-HMO Basic Limits Rate per 100 Enrollees: $68.85

b. HMO Relativity Factor 1.75

3. Increased Limits Factors

Limits	Factor
200,000/600,000	1.000
1,000,000/1,000,000	1.537
2,000,000/2,000,000	1.777
3,000,000/3,000,000	1.906
4,000,000/4,000,000	1.989
5,000,000/5,000,000	2.061

Note: Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor
0	0.500
1	0.750
2	0.900
3	0.950
Mature	1.000

5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor
1	0.800
2	1.250
3	1.850
4	2.000
Mature	2.000

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C. Policy Writing Minimum Premium

MCE	$5,000

D. Premium Modifications

1. Schedule Rating Plan

a. Risk Management Program

Considerations	Max. Credit	Max. Debit
Formal written Risk Management Program	15%	15%
The existence of an effective management level risk management committee or position	5%	5%
Patient Advocate Policy: A mechanism exists for visitors, patients or their families to formally or informally communicate concerns regarding the MCE (i.e. satisfaction surveys)	4%	4%

b. Loss Experience

Considerations	Max. Credit	Max. Debit
Loss Ratio	25%	25%
Frequency, severity of claims	25%	25%

c. Effectiveness in MCE Operations

Considerations	Max. Credit	Max. Debit
Years in Business:		
0 - 4 years	0%	20%
5 - 9 years	10%	10%
10+ years	20%	0%
All contracts, sales literature and brochures approved by legal counsel prior to use	15%	15%
Composition of Staff Employed vs. Contracted	15%	15%
Annual Credentialing of health care providers	15%	15%
Written Utilization Review Procedures	15%	15%
Existence of written Claim Denial Appeal process that is clearly spelled out to plan participants	15%	15%

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d. MCE Operations for Others (E&O Coverage)

Characteristics	Max. Credit	Max. Debit
Claims Handling	5%	5%
Third Party Administration	5%	5%
Rehabilitation Services	5%	5%
Utilization Review	5%	5%
Peer Review/Credentialing	5%	5%
Electronic Data Processing or Computer Software	5%	5%
Loss Control or Safety Engineering	5%	5%
Premium Financing	5%	5%
Agency and Brokerage Operations	5%	5%
Insurance Consulting	5%	5%
Actuarial Services	5%	5%
Benefits Stop Loss Placement	5%	5%
Insurance Pool Management	5%	5%

e. Cooperation with Insurer's Loss Claim/Risk Management Department

Characteristics	Max. Credit	Max. Debit
Adherence to clearly defined Loss Identification/ Reporting procedures and compliance with formal risk management recommendations	10%	10%

f. Maximum Modification: 50%

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2. Deductible Credits

Deductible Amount	Credit Applicable to the 200/600 Limits Premium	
Per Occurrence	Indemnity Only	Indemnity and Defense
5,000	6.1%	8.5%
10,000	10.3%	13.8%
25,000	17.9%	22.9%
50,000	28.7%	36.1%
100,000	42.2%	53.9%
250,000	61.6%	83.5%
300,000	66.4%	88.3%

Notes:

a) The coverage is claims made. Once a deductible is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower deductible.

b) Deductibles shall apply to indemnity only or to indemnity and defense costs.

c) Deductible credits apply to the basic limits premium.

d) The deductible amount applies per occurrence. Aggregated deductible credits will be (a) rated based on insureds exposure to risk.

e) Deductible amounts not shown will be interpolated using standard actuarial techniques.

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4. SIR Credits

SIR Amount	Credit Applicable to the 200/600 Limits Premium
Per Occurrence	Indemnity and Defense
100,000	59.4%
200,000	72.3%
250,000	86.8%
300,000	92.0%

Notes:

a) The coverage is claims made. Once an SIR is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower SIR.

b) SIR's shall apply to indemnity and defense costs.

c) SIR credits apply to the basic limits premium.

d) The SIR amount applies per occurrence. Aggregated SIR credits will be (a) rated based on insureds exposure to risk.

e) SIR amounts not shown will be interpolated using standard actuarial techniques.

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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 Pollution Liability for Health Care Providers.

B. Any exceptions to these rules are contained in the respective State Rate Pages.

II. ELIGIBILITY

Eligibility is limited to health care providers which meet MPCo's underwriting guidelines.

III. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Liability Coverage under this program shall be:

A. Claims-Made Coverage

$200,000 Each Pollution Occurrence
$200,000 Aggregate

IV. PREMIUM COMPUTATION

A. Pollution Liability premium will be a percentage of the Professional Liability (PL) premium developed for the applicable health care provider. Refer to State Rate Pages to determine the percentage applicable.

B. Basic Limits Premium

Basic limits premium is computed by multiplying the PL premium at basic limits rates by the appropriate premium percentage. Next, the premium shall be modified by a schedule rating modification factor and then by the applicable increased limits factor.

V. CLASSIFICATIONS

Pollution Liability coverage shall be classified in accordance with the following types of health care providers:

A. Corporations, Partnerships and Associations

B. Physicians and Surgeons

C. Dentists

D. Allied Health Care Providers

E. Health Care Facilities.

VI. PREMIUM MODIFICATIONS

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for 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.

A maximum modification of 50%, subject to specific state limitations indicated on the State Rate Pages, 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. Retention Amounts

1. A minimum $5,000 retention is required for all insureds.

2. A higher retention amount may be elected by the insured. Retention amounts can only be revised at policy renewal.

3. The retention amounts shall apply to the primary limits premium, net of other applicable credits, identified on the State Rate Pages.

   a. The retention amounts are expressed as a function of the per occurrence retention limit.

   b. The credits assume no aggregate limit on the retention amount.

POLLUTION LIABILITY

A. Classification

1. Applicable to the Standard Claims-Made Program.

2. The classification plan shall consist of the types of health care providers for which coverage is provided.

   a. Corporations, Partnerships and Associations

   b. Physicians and Surgeons

   c. Dentists

   d. Allied Health Care Providers

   e. Health Care Facilities

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B. Manual Rates

1. Territory Definitions

Refer to Healthcare Facilities

2. Premium Basis

a. Corporations, Partnerships and Associations

Reserved for future use.

b. Physicians and Surgeons

Reserved for future use.

c. Dentists

Reserved for future use.

d. Allied Health Care Providers

Reserved for future use.

e. Health Care Facilities

i. Standard Claims Made Program

The Pollution basic limits premium will be 2.0% of the occurrence Health Care Facilities Professional Liability basic limits premium.

3. Increased Limits Factors

Limits	Factor
100,000/100,000	0.900
200,000/200,000	1.000
300,000/300,000	1.140

Notes:

a) Increased limits factors apply to the basic limits premium.
b) Increased limits not shown will be interpolated using standard actuarial techniques.

4. Claims Made Factors

Years Since Retroactive Date	Std. CM Factor (based on Occ.)
1	0.470
2	0.700
3	0.840
4	0.880
Mature	0.930

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5. Extended Reporting Period Coverage

Years Retro. Date Precedes Expiration Date	Std. CM Factor (based on CM)
1	0.800
2	1.250
3	1.850
4	2.000
Mature	2.000

C. Policy Writing Minimum Premium

POL	$1,500

D. Premium Modifications

1. Schedule Rating Plan

a. Risk Management/QA/Loss Control Program

Considerations	Max. Credit	Max. Debit
Existence of an environmental safety program	10%	10%
Required safety features in place (pollution controls)	10%	10%
Preventative equipment maintenance (oil tanks/gas cylinders) by outside contractors	10%	10%
Risk assessment previously conducted:		
Five or more years ago	0%	5%
Two or more years ago	5%	0%

b. Incinerators

Considerations	Max. Credit	Max. Debit
Incineration of medical waste for others	0%	25%

c. Disposal of Waste

Considerations	Max. Credit	Max. Debit
On site disposal of waste	0%	15%
Off site disposal of waste	15%	0%

d. Storage Tanks

Considerations	Max. Credit	Max. Debit
Above ground storage tanks filled with hazardous materials	10%	10%

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e. Loss Activity

Considerations	Max. Credit	Max. Debit
Governmental sanctions or claims	25%	25%
Loss experience	25%	25%
Unreported claims, such as voluntary cleanup	10%	10%

f. Maximum Modification: 50%

2. Retention Amounts

Retention Amount		Credit Applicable to the 200/600 Limits Premium
Per Pollution Occurrence	Aggregate	
5,000	none	0.0%
10,000	none	13.8%
25,000	none	22.9%

Notes:

a) The coverage is claims made. Once a retention is elected it applies to covered prior acts, which are reported during the policy period, including reporting endorsements. A reporting endorsement must be purchased to opt back to a lower retention.

b) Retention amounts include both indemnity and allocated loss adjustment expense.

c) Retention credits apply to the basic limits premium.

d) Retention amounts not shown will be interpolated using standard actuarial techniques.

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

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OCCURRENCE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS & SURGEONS RATE CLASSES

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

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CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

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CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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PHYSICIANS & SURGEONS

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 IA

NON-SURGICAL SPECIALISTS TO INCLUDE: AEROSPACE MEDICINE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHYSIATRY, PREVENTATIVE MEDICINE AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE: ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PHARMACOLOGY, PSYCHIATRY AND SURGICAL SPECIALISTS PERFORMING NO SURGERY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: DERMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE: FAMILY/GENERAL PRACTICE, NEPHROLOGY, PEDIATRICS AND RHEUMATOLOGY.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: OPHTHALMOLOGY.

CLASS ID

NON-SURGICAL SPECIALISTS TO INCLUDE: HOSPITALISTS AND INTERNAL MEDICINE.

SURGICAL SPECIALISTS IN: OPHTHALMOLOGY.

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), DIABETES, HEMATOLOGY/ONCOLOGY AND URGENT CARE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: ENDOCRINOLOGY.

SURGICAL SPECIALISTS IN: ANESTHESIOLOGY AND PAIN MANAGEMENT.

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CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, INFECTIOUS DISEASE, NEUROLOGY AND RADIOLOGY - DIAGNOSTIC.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: GERIATRICS, GYNECOLOGY, NEONATOLOGY, NEPHROLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PEDIATRICS, RADIATION THERAPY, SHOCK THERAPY AND SURGICAL SPECIALISTS PERFORMING MINOR SURGERY - NOT OTHERWISE CLASSIFIED.

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: PULMONARY DISEASE.

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: CARDIOLOGY (RIGHT HEART CATHETERIZATION), GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND INFECTIOUS DISEASE.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

CLASS IID

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTERNAL MEDICINE, RADIOLOGY-DIAGNOSTIC, RADIOLOGY-INCL MAMMOGRAPHY AND RADIOPAQUE DYE INJECTION.

CLASS IIIA

SPECIALTIES PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS INCLUDING: INTENSIVE CARE AND NEUROLOGY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY (INCLUDING DELIVERIES).

SURGICAL SPECIALISTS IN: GASTROENTEROLOGY, OTORHINOLARYNGOLOGY, PLASTIC SURGERY - NO ELECTED COSMETIC AND UROLOGY.

PHYSICIANS OTHERWISE IN CLASS IA, CLASS IB, CLASS IC, CLASS ID, CLASS IIA, CLASS IIB, CLASS IIC OR CLASS IID: CARDIOLOGY (LEFT HEART CATHETERIZATION) AND ACUPUNCTURE.

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CLASS IIIB

SURGICAL SPECIALISTS IN: COLON AND RECTAL, FAMILY/GENERAL PRACTICE AND GERIATRICS.

CLASS IVA

EMERGENCY MEDICINE WITH NO MAJOR SURGERY.

SURGICAL SPECIALISTS IN: GYNECOLOGY, HAND SURGERY, HEAD AND NECK SURGERY AND ORTHOPEDIC (EXCLUDING SPINAL).

CLASS IVB

SURGICAL SPECIALISTS IN: EMERGENCY MEDICINE.

CLASS VA

SURGICAL SPECIALISTS IN: PLASTIC - NOT OTHERWISE CLASSIFIED.

CLASS VB

SURGICAL SPECIALISTS IN: CARDIOVASCULAR SURGERY, THORACIC SURGERY AND VASCULAR SURGERY.

CLASS VIA

SURGICAL SPECIALISTS IN: ORTHOPEDIC SURGERY (INCLUDING SPINAL).

CLASS VIB

SURGICAL SPECIALISTS IN: ABDOMINAL SURGERY, GENERAL SURGERY AND OB/GYN.

CLASS VII

SURGICAL SPECIALISTS IN: TRAUMATIC SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN: NEUROLOGICAL SURGERY.

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B. Manual Rates

1. Territory Definitions

Area 1	Cook, Jackson, Madison, St. Clair, and Will Counties
Area 2	Lake, and Vermillion Counties
Area 3	Kane, McHenry, and Winnebago Counties.
Area 4	Dupage, Kankakee, and Macon, Counties
Area 5	Bureau, Champaign, Coles, Dekalb, Effingham, Lasalle, Ogle, and Randolph Counties
Area 6	Grundy and Sangamon Counties
Area 7	Peoria County
Area 8	Remainder of State

General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	5A
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

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

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

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18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

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

NOT AVAILABLE

superseded 3-1-07

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

Refer to Quarterly Installment Option rule.

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

Credit
5%

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

Max AvailableCredit
50%

27. **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.

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***Classification Translation Table – Specialty Description to ISO Code

	SPECIALTY CODE	ISO CODE M.D.	D.O.	Class
Allergy	39	80254	84254	1A
Cardiology (Including Swan-Ganz)	33	80255	84255	2A
Dermatology	31	80256	84256	1A
Family/General Practice	19	80420	84420	1C
Aerospace	19	80230	84230	1A
Forensic Medicine	36	80240	84240	1A
Geriatrics	32	80243	84243	1B
Nuclear Medicine	37	80262	84262	1A
Nutrition	32	80248	84248	1A
Occupational Medicine	19	80233	84233	1A
Physiatry	19	80235	84235	1A
Public Health	19	80236	84236	1A
Gynecology	15	80244	84244	1B
Internal Medicine	32	80257	84257	1D
Diabetes	32	80237	84237	2A
Endocrinology	32	80238	84238	1B
Gastroenterology	32	80241	84241	2B
Hematology / Oncology	32	80245	84245	2A
Infectious Disease	32	80246	84246	2B
Nephrology	32	80260	84260	1C
Pharmacology	32	80234	84234	1B
Preventative Medicine	32	80231	84231	1A
Rheumatology	32	80252	84252	1C
Neonatology	34	80471	84471	2B
Neurology	40	80261	84261	2B
Ophthalmology	16	80263	84263	1A
Otorhinolaryngology	23	80265	84265	1B
Otology	23	80264	84264	1B
Larynogology	23	80258	84258	1B

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Rhinology	23	80247	84247	1B
Pathology	36	80266	84266	1B
Pediatrics	34	80267	84267	1C
Psychiatry - Inc. Child	35	80249	84249	1B
Hypnosis	35	80232	84232	1B
Psychoanalysis	35	80250	84250	1B
Psychosomatic	35	80251	84251	1B
Pulmonary Disease	38	80269	84269	2C
Radiology - Diagnostic	37	80253	84253	2B
Urgent Care	26	80102	84102	2A
Physician - N.O.C.	19	80268	84268	1B
SURGICAL SPECIALIST PERFORMING NO SURGERY, BUT STILL PRACTICING IN THAT SPECIALITY		80268	84268	1B
Cardiology (Right Heart Cath. Only)	33	80281	84281	2C
Dermatology	31	80282	84282	1B
Family/General Practice	19	80421	84421	2C
Geriatrics	32	80276	84276	2B
Physicians - N.O.C.	XX	80294	84294	2B
Gynecology	15	80277	84277	2B
Internal Medicine	32	80284	84284	2D
Endocrinology	32	80272	84272	2A
Gastroenterology	32	80274	84274	2C
Hematology / Oncology	32	80278	84278	2C
Infectious Disease	32	80279	84279	2C
Intensive Care	32	80283	84283	3A
Nephrology	32	80287	84287	2B
Neurology	40	80288	84288	3A
Ophthalmology	16	80289	84289	1C
Otorhinolaryngology	23	80291	84291	2B
Otology	23	80290	84290	2B
Laryngology	23	80285	84285	2B
Rhinology	23	80270	84270	2B
Pathology	36	80292	84292	2B
Pediatrics	34	80293	84293	2B
Psychiatry - Inc. Shock Therapy	35	80431	84431	2B

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Radiology - Diagnostic	37	80280	84280	2D
Radiology - Therapy	37	80425	84425	2B
Pain Management	19, 30, 40	80295	84295	2A
Hospitalist	32	80296	84296	1D
SURGICAL SPECIALIST PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS WHILE PRACTICING IN THAT SPECIALITY:		80294	84294	2B
PHYSICIANS AND SURGICAL SPECIALIST PERFORMING THE FOLLOWING PROCEDURES: (XX = Code for Speciality)				
Radiation Therapy	XX	80425	84425	2B
Radiopaque Dye Injection	XX	80449	84449	2D
Radiology - incld. Mammography	37	80472	84472	2D
Shock Therapy	XX	80431	84431	2B
PHYSICIANS PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS - NOT PRIMARILY ENGAGED IN MAJOR SURGERY:				
Family/General Practice	19	80117	84117	3B
Geriatrics	19	80105	84105	3B
Gastroenterology	32	80104	84104	3A
Emergency Medicine (No Major Surg)	25	80102	84102	4A
Surgical Specialists:				
Ophthalmology	16	80114	84114	1D
Colon and Rectal	24	80115	84115	3B
Emergency Medicine (Incl. Major Surg)	25	80157	84157	4B
SURGICAL SPECIALIST PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS WHIL PRACTICING IN THAT SPECIALITY, BUT NOT PRIMARLEY ENGAGED IN MAJOR SURGERY:		80117	84117	3B
PHYSICIANS AND SURGICAL SPECIALIST PERFORMING THE FOLLOWING PROCEDURES: (XX = Code for Speciality)				
Acupuncture	XX	80437	84437	3A
Cardiology (Incl. Left Heart Cath.)	33	80422	84422	3A
Internal Medicine (Incl. Left Heart Cath.)	32	80422	84422	3A
Urology	17	80145	84145	3A
Fam./Gen. Practice - incl. deliveries	29	80273	84273	3A
Anesthesiology	30	80151	84151	2A
Abdominal	10	80166	84166	6B

General - N.O.C.	10	80143	84143	6B
Otorhinolaryngology	23	80159	84159	3A
Otology	23	80158	84158	3A
Laryngology	23	80106	84106	3A
Rhinology	23	80160	84160	3A
Plastic (No elected cosmetic)	23	80155	84155	3A
Hand	13	80169	84169	4A
Head and Neck	13	80170	84170	4A
Obstetrics/Gynecology	15	80153	84153	6B
Obstetrics	15	80168	84168	6B
Gynecology	18	80167	84167	4A
Plastic - N.O.C.	20	80156	84156	5A
Cardiovascular	21	80150	84150	5B
Neurological	12	80152	84152	8
Orthopedic (Excl. back)	13	80176	84176	4A
Orthopedic (Incl. back)	13	80154	84154	6A
Thoracic	14	80144	84144	5B
Traumatic	10	80171	84171	7
Vascular	22	80146	84146	5B

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DENTISTS

OCCURRENCE

INCREASED LIMITS TABLE

LIMIT	CLASSES 1A - 2A	CLASSES 2B & 3
100/300	1.000	1.000
200/600	1.140	1.140
500/1000	1.310	1.310
1000/3000	1.500	1.500
2000/4000	1.700	1.770
3000/5000	1.810	1.890
4000/6000	1.890	1.980
5000/7000	1.940	2.050

Superseded 1-1-07

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ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS I A

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

CLASS I B

ANY DENTIST PERFORMING IMPLANTS INVOLVING OSSEOINTEGRATION OR MINOR SURGICAL PROCEDURES.*

GENERAL DENTISTS OR SPECIALISTS OTHER THAN ORAL SURGEONS OR DENTAL ANESTHESIOLOGISTS ALLOWING (HOSTING) UNCONSCIOUS SEDATION OUTSIDE OF A HOSPITAL, BUT ONLY IF THE SEDATION IS ADMINISTERED BY AN ORAL SURGEON, DENTAL OR MEDICAL ANESTHESIOLOGIST OR CRNA.

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DENTISTS

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RATE CLASSES

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY OR ORAL PATHOLOGY.

CLASS II B

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY OR ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES NOT INCLUDED IN CLASS III.

CLASS III

ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

PROCEDURES NOT OTHERWISE CLASSIFIED.

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ILLINOIS - AREA 1

DENTISTS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,021	2,304	2,648	3,032	4,093	3,436	3,658	3,820	3,921
1B	2,526	2,880	3,309	3,789	5,115	4,294	4,572	4,774	4,900
	6,063	6,912	7,943	9,095	12,278	10,307	10,974	11,459	11,762
2B	11,116	12,672	14,562	16,674	22,510	19,675	21,009	22,010	22,788
3	13,137	14,976	17,209	19,706	26,602	23,252	24,829	26,011	26,931

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ILLINOIS - AREA 2

DENTISTS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
1B	2,105	2,400	2,758	3,158	4,263	3,579	3,810	3,978	4,084
	5,052	5,759	6,618	7,578	10,230	8,588	9,144	9,548	9,801
2B	9,262	10,559	12,133	13,893	18,756	16,394	17,505	18,339	18,987
3	10,946	12,478	14,339	16,419	22,166	19,374	20,688	21,673	22,439

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ILLINOIS - AREA 3

DENTISTS

OCCURRENCE RATES

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,347	1,536	1,765	2,021	2,728	2,290	2,438	2,546	2,613
1B	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
	4,041	4,607	5,294	6,062	8,183	6,870	7,314	7,637	7,840
2B	7,409	8,446	9,706	11,114	15,003	13,114	14,003	14,670	15,188
3	8,756	9,982	11,470	13,134	17,731	15,498	16,549	17,337	17,950

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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 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 15% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR THIRD YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR DENTAL TRAINING PROGRAM.

JUN 0 1 2003

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OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL EQUAL 10% 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. 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.

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ILLINOIS

DENTISTS

STANDARD CLAIMS-MADE

INCREASED LIMITS TABLE

LIMIT	CLASSES 1A - 2A	CLASSES 2B & 3
100/300	1.000	1.000
200/600	1.140	1.140
500/1000	1.310	1.310
1000/3000	1.500	1.500
2000/4000	1.700	1.770
3000/5000	1.810	1.890
4000/6000	1.890	1.980
5000/7000	1.940	2.050

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS I A

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

CLASS I B

ANY DENTIST PERFORMING IMPLANTS INVOLVING OSSEOINTEGRATION OR MINOR SURGICAL PROCEDURES.*

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DENTISTS

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RATE CLASSES

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY OR ORAL PATHOLOGY.

CLASS II B

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY OR ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES NOT INCLUDED IN CLASS III.

CLASS III

ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

PROCEDURES NOT OTHERWISE CLASSIFIED.

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	436	497	571	654	883	741	789	824	846
1B	546	622	715	819	1,106	928	988	1,032	1,059
	1,309	1,492	1,715	1,964	2,651	2,225	2,369	2,474	2,539
2B	2,400	2,736	3,144	3,600	4,860	4,248	4,536	4,752	4,920
3	2,836	3,233	3,715	4,254	5,743	5,020	5,360	5,615	5,814

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
1B	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
	2,618	2,985	3,430	3,927	5,301	4,451	4,739	4,948	5,079
2B	4,800	5,472	6,288	7,200	9,720	8,496	9,072	9,504	9,840
3	5,672	6,466	7,430	8,508	11,486	10,039	10,720	11,231	11,628

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DENTISTS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,418	1,617	1,858	2,127	2,871	2,411	2,567	2,680	2,751
1B	1,773	2,021	2,323	2,660	3,590	3,014	3,209	3,351	3,440
	4,254	4,850	5,573	6,381	8,614	7,232	7,700	8,040	8,253
2B	7,799	8,891	10,217	11,699	15,793	13,804	14,740	15,442	15,988
3	9,217	10,507	12,074	13,826	18,664	16,314	17,420	18,250	18,895

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,654	1,886	2,167	2,481	3,349	2,812	2,994	3,126	3,209
1B	2,068	2,358	2,709	3,102	4,188	3,516	3,743	3,909	4,012
	4,963	5,658	6,502	7,445	10,050	8,437	8,983	9,380	9,628
2B	9,099	10,373	11,920	13,649	18,425	16,105	17,197	18,016	18,653
3	10,753	12,258	14,086	16,130	21,775	19,033	20,323	21,291	22,044

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ILLINOIS - AREA 1

DENTISTS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,818	2,073	2,382	2,727	3,681	3,091	3,291	3,436	3,527
1B	2,273	2,591	2,978	3,410	4,603	3,864	4,114	4,296	4,410
	5,454	6,218	7,145	8,181	11,044	9,272	9,872	10,308	10,581
2B	9,999	11,399	13,099	14,999	20,248	17,698	18,898	19,798	20,498
3	11,817	13,471	15,480	17,726	23,929	20,916	22,334	23,398	24,225

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	364	415	477	546	737	619	659	688	706
1B	455	519	596	683	921	774	824	860	883
	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2B	2,000	2,280	2,620	3,000	4,050	3,540	3,780	3,960	4,100
3	2,364	2,695	3,097	3,546	4,787	4,184	4,468	4,681	4,846

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
1B	909	1,036	1,191	1,364	1,841	1,545	1,645	1,718	1,763
	2,182	2,487	2,858	3,273	4,419	3,709	3,949	4,124	4,233
2B	4,000	4,560	5,240	6,000	8,100	7,080	7,560	7,920	8,200
3	4,727	5,389	6,192	7,091	9,572	8,367	8,934	9,359	9,690

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
1B	1,477	1,684	1,935	2,216	2,991	2,511	2,673	2,792	2,865
	3,545	4,041	4,644	5,318	7,179	6,027	6,416	6,700	6,877
2B	6,500	7,410	8,515	9,750	13,163	11,505	12,285	12,870	13,325
3	7,681	8,756	10,062	11,522	15,554	13,595	14,517	15,208	15,746

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
1B	1,724	1,965	2,258	2,586	3,491	2,931	3,120	3,258	3,345
	4,136	4,715	5,418	6,204	8,375	7,031	7,486	7,817	8,024
2B	7,583	8,645	9,934	11,375	15,356	13,422	14,332	15,014	15,545
3	8,962	10,217	11,740	13,443	18,148	15,863	16,938	17,745	18,372

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ILLINOIS - AREA 2

DENTISTS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
1B	1,894	2,159	2,481	2,841	3,835	3,220	3,428	3,580	3,674
	4,545	5,181	5,954	6,818	9,204	7,727	8,226	8,590	8,817
2B	8,333	9,500	10,916	12,500	16,874	14,749	15,749	16,499	17,083
3	9,848	11,227	12,901	14,772	19,942	17,431	18,613	19,499	20,188

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

ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	291	332	381	437	589	495	527	550	565
1B	364	415	477	546	737	619	659	688	706
	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
2B	1,600	1,824	2,096	2,400	3,240	2,832	3,024	3,168	3,280
3	1,891	2,156	2,477	2,837	3,829	3,347	3,574	3,744	3,877

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ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	582	663	762	873	1,179	989	1,053	1,100	1,129
1B	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
	1,745	1,989	2,286	2,618	3,534	2,967	3,158	3,298	3,385
2B	3,200	3,648	4,192	4,800	6,480	5,664	6,048	6,336	6,560
3	3,781	4,310	4,953	5,672	7,657	6,692	7,146	7,486	7,751

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ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	945	1,077	1,238	1,418	1,914	1,607	1,710	1,786	1,833
1B	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
	2,836	3,233	3,715	4,254	5,743	4,821	5,133	5,360	5,502
2B	5,199	5,927	6,811	7,799	10,528	9,202	9,826	10,294	10,658
3	6,145	7,005	8,050	9,218	12,444	10,877	11,614	12,167	12,597

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ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,103	1,257	1,445	1,655	2,234	1,875	1,996	2,085	2,140
1B	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
	3,309	3,772	4,335	4,964	6,701	5,625	5,989	6,254	6,419
2B	6,066	6,915	7,946	9,099	12,284	10,737	11,465	12,011	12,435
3	7,169	8,173	9,391	10,754	14,517	12,689	13,549	14,195	14,696

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ILLINOIS - AREA 3

DENTISTS

STANDARD CLAIMS MADE RATES

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,212	1,382	1,588	1,818	2,454	2,060	2,194	2,291	2,351
1B	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
	3,636	4,145	4,763	5,454	7,363	6,181	6,581	6,872	7,054
2B	6,666	7,599	8,732	9,999	13,499	11,799	12,599	13,199	13,665
3	7,878	8,981	10,320	11,817	15,953	13,944	14,889	15,598	16,150

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THE
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ILLINOIS

DENTISTS

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.

JUN 01 2003

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DENTISTS

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 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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DENTISTS

STANDARD CLAIMS MADE 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 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR, CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR, AND CREDITS IN THE AMOUNT OF 15% 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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DENTISTS

STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMIUM WILL EQUAL 10% 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. 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.

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

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

CLASS I B

Any Dentist performing implants involving osseointegration or minor surgical procedures.*

General Dentists or Specialists other than Oral Surgeons or dental anesthesiologists allowing (hosting) unconscious sedation outside of a hospital, but only if the sedation is administered by an oral surgeon, dental or medical anesthesiologist or CRNA.

*Procedures do not include the administration of a general anesthetic intended to cause unconsciousness unless administered in a hospital.

CLASS II A

Specialists in Dental Anesthesiology or Oral Pathology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery or any dentist performing major surgical procedures not included in class III.

CLASS III

Any dentist performing major surgical procedures.

Procedures not otherwise classified.

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CLASS III

Specialist in Oral and Maxillofacial Surgery or any dentist who administers, personally or by an employed/contracted anesthesiologist any general anesthetic intended to cause unconsciousness if administered outside of a hospital setting, excluding "hosting" dentists under class IB. Any dentist performing major surgical procedures.

Procedures not otherwise classified.

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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

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2. Occurrence Program

a. Area 1

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	2,021	2,304	2,648	3,032	4,093	3,436	3,658	3,820	3,921
1B	2,526	2,880	3,309	3,789	5,115	4,294	4,572	4,774	4,900
2A	6,063	6,912	7,943	9,095	12,278	10,307	10,974	11,459	11,762
2B	11,116	12,672	14,562	16,674	22,510	19,675	21,009	22,010	22,788
3	13,137	14,976	17,209	19,706	26,602	23,252	24,829	26,011	26,931

b. Area 2

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
1B	2,105	2,400	2,758	3,158	4,263	3,579	3,810	3,978	4,084
2A	5,052	5,759	6,618	7,578	10,230	8,588	9,144	9,548	9,801
2B	9,262	10,559	12,133	13,893	18,756	16,394	17,505	18,339	18,987
3	10,946	12,478	14,339	16,419	22,166	19,374	20,688	21,673	22,439

c. Area 3

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,347	1,536	1,765	2,021	2,728	2,290	2,438	2,546	2,613
1B	1,684	1,920	2,206	2,526	3,410	2,863	3,048	3,183	3,267
2A	4,041	4,607	5,294	6,062	8,183	6,870	7,314	7,637	7,840
2B	7,409	8,446	9,706	11,114	15,003	13,114	14,003	14,670	15,188
3	8,756	9,982	11,470	13,134	17,731	15,498	16,549	17,337	17,950

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3. Standard Claims Made Program

a. Area 1

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	436	497	571	654	883	741	789	824	846
1B	546	622	715	819	1,106	928	988	1,032	1,059
2A	1,309	1,492	1,715	1,964	2,651	2,225	2,369	2,474	2,539
2B	2,400	2,736	3,144	3,600	4,860	4,248	4,536	4,752	4,920
3	2,836	3,233	3,715	4,254	5,743	5,020	5,360	5,615	5,814

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
1B	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2A	2,618	2,985	3,430	3,927	5,301	4,451	4,739	4,948	5,079
2B	4,800	5,472	6,288	7,200	9,720	8,496	9,072	9,504	9,840
3	5,672	6,466	7,430	8,508	11,486	10,039	10,720	11,231	11,628

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,418	1,617	1,858	2,127	2,871	2,411	2,567	2,680	2,751
1B	1,773	2,021	2,323	2,660	3,590	3,014	3,209	3,351	3,440
2A	4,254	4,850	5,573	6,381	8,614	7,232	7,700	8,040	8,253
2B	7,799	8,891	10,217	11,699	15,793	13,804	14,740	15,442	15,988
3	9,217	10,507	12,074	13,826	18,664	16,314	17,420	18,250	18,895

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3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,654	1,886	2,167	2,481	3,349	2,812	2,994	3,126	3,209
1B	2,068	2,358	2,709	3,102	4,188	3,516	3,743	3,909	4,012
2A	4,963	5,658	6,502	7,445	10,050	8,437	8,983	9,380	9,628
2B	9,099	10,373	11,920	13,649	18,425	16,105	17,197	18,016	18,653
3	10,753	12,258	14,086	16,130	21,775	19,033	20,323	21,291	22,044

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,818	2,073	2,382	2,727	3,681	3,091	3,291	3,436	3,527
1B	2,273	2,591	2,978	3,410	4,603	3,864	4,114	4,296	4,410
2A	5,454	6,218	7,145	8,181	11,044	9,272	9,872	10,308	10,581
2B	9,999	11,399	13,099	14,999	20,248	17,698	18,898	19,798	20,498
3	11,817	13,471	15,480	17,726	23,929	20,916	22,334	23,398	24,225

b. Area 2

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	364	415	477	546	737	619	659	688	706
1B	455	519	596	683	921	774	824	860	883
2A	1,091	1,244	1,429	1,637	2,209	1,855	1,975	2,062	2,117
2B	2,000	2,280	2,620	3,000	4,050	3,540	3,780	3,960	4,100
3	2,364	2,695	3,097	3,546	4,787	4,184	4,468	4,681	4,846

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
1B	909	1,036	1,191	1,364	1,841	1,545	1,645	1,718	1,763
2A	2,182	2,487	2,858	3,273	4,419	3,709	3,949	4,124	4,233
2B	4,000	4,560	5,240	6,000	8,100	7,080	7,560	7,920	8,200
3	4,727	5,389	6,192	7,091	9,572	8,367	8,934	9,359	9,690

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2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
1B	1,477	1,684	1,935	2,216	2,991	2,511	2,673	2,792	2,865
2A	3,545	4,041	4,644	5,318	7,179	6,027	6,416	6,700	6,877
2B	6,500	7,410	8,515	9,750	13,163	11,505	12,285	12,870	13,325
3	7,681	8,756	10,062	11,522	15,554	13,595	14,517	15,208	15,746

3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
1B	1,724	1,965	2,258	2,586	3,491	2,931	3,120	3,258	3,345
2A	4,136	4,715	5,418	6,204	8,375	7,031	7,486	7,817	8,024
2B	7,583	8,645	9,934	11,375	15,356	13,422	14,332	15,014	15,545
3	8,962	10,217	11,740	13,443	18,148	15,863	16,938	17,745	18,372

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
1B	1,894	2,159	2,481	2,841	3,835	3,220	3,428	3,580	3,674
2A	4,545	5,181	5,954	6,818	9,204	7,727	8,226	8,590	8,817
2B	8,333	9,500	10,916	12,500	16,874	14,749	15,749	16,499	17,083
3	9,848	11,227	12,901	14,772	19,942	17,431	18,613	19,499	20,188

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c. Area 3

0 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	291	332	381	437	589	495	527	550	565
1B	364	415	477	546	737	619	659	688	706
2A	873	995	1,144	1,310	1,768	1,484	1,580	1,650	1,694
2B	1,600	1,824	2,096	2,400	3,240	2,832	3,024	3,168	3,280
3	1,891	2,156	2,477	2,837	3,829	3,347	3,574	3,744	3,877

1 YEAR SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	582	663	762	873	1,179	989	1,053	1,100	1,129
1B	727	829	952	1,091	1,472	1,236	1,316	1,374	1,410
2A	1,745	1,989	2,286	2,618	3,534	2,967	3,158	3,298	3,385
2B	3,200	3,648	4,192	4,800	6,480	5,664	6,048	6,336	6,560
3	3,781	4,310	4,953	5,672	7,657	6,692	7,146	7,486	7,751

2 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	945	1,077	1,238	1,418	1,914	1,607	1,710	1,786	1,833
1B	1,182	1,347	1,548	1,773	2,394	2,009	2,139	2,234	2,293
2A	2,836	3,233	3,715	4,254	5,743	4,821	5,133	5,360	5,502
2B	5,199	5,927	6,811	7,799	10,528	9,202	9,826	10,294	10,658
3	6,145	7,005	8,050	9,218	12,444	10,877	11,614	12,167	12,597

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3 YEARS SINCE RETROACTIVE DATE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,103	1,257	1,445	1,655	2,234	1,875	1,996	2,085	2,140
1B	1,379	1,572	1,806	2,069	2,792	2,344	2,496	2,606	2,675
2A	3,309	3,772	4,335	4,964	6,701	5,625	5,989	6,254	6,419
2B	6,066	6,915	7,946	9,099	12,284	10,737	11,465	12,011	12,435
3	7,169	8,173	9,391	10,754	14,517	12,689	13,549	14,195	14,696

MATURE

Class	100/300	200/600	500/1000	1000/3000	1000/10000	2000/4000	3000/5000	4000/6000	5000/7000
1A	1,212	1,382	1,588	1,818	2,454	2,060	2,194	2,291	2,351
1B	1,515	1,727	1,985	2,273	3,068	2,576	2,742	2,863	2,939
2A	3,636	4,145	4,763	5,454	7,363	6,181	6,581	6,872	7,054
2B	6,666	7,599	8,732	9,999	13,499	11,799	12,599	13,199	13,665
3	7,878	8,981	10,320	11,817	15,953	13,944	14,889	15,598	16,150

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
JUN 01 2005
SPRINGFIELD, ILLINOIS

6. Shared Limits Modification

Modification
Up to 25%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
AUG 01 2006
SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
JAN 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE

INCREASED LIMITS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

Superseded 9-14-06

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ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE

EXCESS LIMITS FACTORS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
1M/1M xs 1M/3M	1.280	1.320	1.320
2M/2M xs 1M/3M	1.473	1.502	1.502
3M/3M xs 1M/3M	1.556	1.592	1.592
4M/4M xs 1M/3M	1.615	1.660	1.660
5M/5M xs 1M/3M	1.661	1.727	1.727
6M/6M xs 1M/3M	1.706	1.778	1.778
7M/7M xs 1M/3M	1.751	1.825	1.825
8M/8M xs 1M/3M	1.790	1.866	1.866
9M/9M xs 1M/3M	1.829	1.895	1.895

Note: For aggregate limits not listed above, refer to company.

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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE

INCREASED LIMITS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS MADE

EXCESS LIMITS FACTORS TABLE

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8
1M/1M xs 1M/3M	1.280	1.320	1.320
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9M/9M xs 1M/3M	1.829	1.895	1.895

Note: For aggregate limits not listed above, refer to company.

4. Increased Limits Factors

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8-8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

* A minimum of 1000/3000 underlying limits required

5. Excess Limits Factors

LIMIT	CLASS 1A-2D	CLASS 3A-7	CLASS 8-8
1M/1M xs 1M/3M	1.280	1.320	1.320
2M/2M xs 1M/3M	1.473	1.502	1.502
3M/3M xs 1M/3M	1.556	1.592	1.592
4M/4M xs 1M/3M	1.615	1.660	1.660
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7M/7M xs 1M/3M	1.751	1.825	1.825
8M/8M xs 1M/3M	1.790	1.866	1.866
9M/9M xs 1M/3M	1.829	1.895	1.895

Note: For aggregate limits not listed above, refer to company.

6. Extended Reporting Period Coverage Factors

Years Since Retroactive Date	Standard Claims-Made Factor *	Enhanced Factor *
1	0.900	N/A
2	1.500	N/A
3	1.700	N/A
4 OR MORE	1.820	N/A

* Factors are applicable to mature claims-made rate

7. Shared Limits Modification

Modification
Up to 25%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

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

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.

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

Credit
5%

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

AVAILABLE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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12. **Large Group Rating**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

14. **Full-Time Equivalency Rating**

NOT AVAILABLE

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

AVAILABLE

16. **Accelerated Extension Contract Rating**

NOT AVAILABLE

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

AVAILABLE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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SPRINGFIELD, ILLINOIS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS I A

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

CLASS I B

ANY DENTIST PERFORMING IMPLANTS INVOLVING OSSEOINTEGRATION OR MINOR SURGICAL PROCEDURES.*

GENERAL DENTISTS OR SPECIALISTS OTHER THAN ORAL SURGEONS OR DENTAL ANESTHESIOLOGISTS ALLOWING (HOSTING) UNCONSCIOUS SEDATION OUTSIDE OF A HOSPITAL, BUT ONLY IF THE SEDATION IS ADMINISTERED BY AN ORAL SURGEON, DENTAL OR MEDICAL ANESTHESIOLOGIST OR CRNA.

*PROCEDURES DO NOT INCLUDE THE ADMINISTRATION OF A GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS UNLESS ADMINISTERED IN A HOSPITAL.

DIVISION OF INSURANCE
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JUN 01 2004
SPRINGFIELD, ILLINOIS

Superseded 8-1-06

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MEDICAL PROTECTIVE COMPANY
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ILLINOIS

DENTISTS

OCCURRENCE PROGRAM

RATE CLASSES

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY OR ORAL PATHOLOGY.

CLASS II B

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY OR ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES NOT INCLUDED IN CLASS III (ADMINISTRATION OF A GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS MUST BE ADMINISTERED IN A HOSPITAL).

CLASS III

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY OR ANY DENTIST WHO ADMINISTERS, PERSONALLY OR BY AN EMPLOYED/CONTRACTED ANESTHESIOLOGIST ANY GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS IF ADMINISTERED OUTSIDE OF A HOSPITAL SETTING, EXCLUDING "HOSTING" DENTISTS UNDER CLASS IB. ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

PROCEDURES NOT OTHERWISE CLASSIFIED.

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STATE OF ILLINOIS/IDFPR
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THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835
Professional Protection Exclusively since 1899

ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS I A

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

CLASS I B

ANY DENTIST PERFORMING IMPLANTS INVOLVING OSSEOINTEGRATION OR MINOR SURGICAL PROCEDURES.*

GENERAL DENTISTS OR SPECIALISTS OTHER THAN ORAL SURGEONS OR DENTAL ANESTHESIOLOGISTS ALLOWING (HOSTING) UNCONSCIOUS SEDATION OUTSIDE OF A HOSPITAL, BUT ONLY IF THE SEDATION IS ADMINISTERED BY AN ORAL SURGEON, DENTAL OR MEDICAL ANESTHESIOLOGIST OR CRNA.

*PROCEDURES DO NOT INCLUDE THE ADMINISTRATION OF A GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS UNLESS ADMINISTERED IN A HOSPITAL.

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THE
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FORT WAYNE, INDIANA 46835
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ILLINOIS

DENTISTS

STANDARD CLAIMS MADE PROGRAM

RATE CLASSES

CLASS II A

SPECIALISTS IN DENTAL ANESTHESIOLOGY OR ORAL PATHOLOGY.

CLASS II B

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY OR ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES NOT INCLUDED IN CLASS III (ADMINISTRATION OF A GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS MUST BE ADMINISTERED IN A HOSPITAL).

CLASS III

SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY OR ANY DENTIST WHO ADMINISTERS, PERSONALLY OR BY AN EMPLOYED/CONTRACTED ANESTHESIOLOGIST ANY GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS IF ADMINISTERED OUTSIDE OF A HOSPITAL SETTING, EXCLUDING "HOSTING" DENTISTS UNDER CLASS IB. ANY DENTIST PERFORMING MAJOR SURGICAL PROCEDURES.

PROCEDURES NOT OTHERWISE CLASSIFIED.

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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

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

CLASS I B

Any Dentist performing implants involving osseointegration or minor surgical procedures.*

General Dentists or Specialists other than Oral Surgeons or dental anesthesiologists allowing (hosting) unconscious sedation outside of a hospital, but only if the sedation is administered by an oral surgeon, dental or medical anesthesiologist or CRNA.

*Procedures do not include the administration of a general anesthetic intended to cause unconsciousness unless administered in a hospital.

CLASS II A

Specialists in Dental Anesthesiology or Oral Pathology.

CLASS II B

Specialist in Oral and Maxillofacial Surgery or any dentist performing major surgical procedures not included in class III (Administration of a general anesthetic intended to cause unconsciousness must be administered in a hospital).

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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	1.310	1.310
1000/3000	1.500	1.500
2000/4000	1.700	1.770
3000/5000	1.810	1.890
4000/6000	1.890	1.980
5000/7000	1.940	2.050

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

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6. Shared Limits Modification

Modification
Up to 25%

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

Dentists	$100

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

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

NOT AVAILABLE

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	$25

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

AVAILABLE

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

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

5. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

6. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	75%
Standard Claims Made	50%

7. **Dentists Military Leave of Absence**

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Dental Standards, Quality & Claim Review.	Presence of (1) committees that meet on a routine basis to review dental 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 undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification - 50% / + 50%	

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

Years Since Training	Credit
1	5%
2	5%
3	5%

10. **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%

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

12. **Self-Insured Retention Credits**

NOT AVAILABLE

13. **Experience Rating**

NOT AVAILABLE

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14. **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: 80201 AND 80210. Table A shall apply to insureds practicing under any other ISO code.

15. **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.

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

19. **Renewal Rate Rule**

NOT AVAILABLE

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

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.

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

AVAILABLE

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

Credit
5%

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

AVAILABLE

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
APR 01 2006
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THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
MAY 01 2003
SPRINGFIELD, ILLINOIS

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 -50% / +50%, 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:

1. <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.

Superseded 1-1-07

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES 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 INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

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OCCURRENCE PROGRAM

SCHEDULE RATING PLAN

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. MEDICAL STANDARDS, QUALITY AND CLAIMS 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.

9. OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:
ADDITIONAL ACTIVITIES 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.

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SCHEDULE RATING PLAN

11. RECORD-KEEPING PRACTICES:
DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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.

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.

THE

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FORT WAYNE, INDIANA 46835

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DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	12,627	17,173	25,380	31,441	32,704
1B	16,836	22,897	33,840	41,922	43,605
1C	19,782	26,904	39,762	49,257	51,235
2A	24,412	33,200	49,068	60,786	63,227
2B	27,779	37,779	55,836	69,170	71,948
2C	32,830	44,649	65,988	81,747	85,030
2D	35,356	48,084	71 066	88,036	91,572
3A	42,090	57,663	87,126	110,697	115,748
3B	45,457	62,276	94,096	119,552	125,007
4A	53,875	73,809	111,521	141,691	148,156
4B	61,451	84,188	127,204	161,616	168,990
5A	67,344	92,261	139,402	177,115	185,196
5B	79,129	108,407	163,797	208,109	217,605
6	92,598	126,859	191,678	243,533	254,645
7	99,332	136,085	205,617	261,243	273,163
8	130,479	178,756	270,092	343,160	358,817

THE

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FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

ILLINOIS - AREA 2

PHYSICIANS AND SURGEONS

OCCURRENCE RATES

DIVISION OF INSURANCE
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	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	7,997	10,876	16,074	19,913	20,712
1B	10,663	14,502	21,433	26,551	27,617
1C	12,529	17,039	25,183	31,197	32,450
2A	15,461	21,027	31,077	38,498	40,044
2B	17,594	23,928	35,364	43,809	45,568
2C	20,793	28,278	41,794	51,775	53,854
2D	22,392	30,453	45,008	55,756	57,995
3A	26,658	36,521	55,182	70,111	73,310
3B	28,790	39,442	59,595	75,718	79,173
4A	34,122	46,747	70,633	89,741	93,836
4B	38,920	53,320	80,564	102,360	107,030
5A	42,652	58,433	88,290	112,175	117,293
5B	50,116	68,659	103,740	131,805	137,819
6	58,647	80,346	121,399	154,242	161,279
7	62,912	86,189	130,228	165,459	173,008
8	82,638	113,214	171,061	217,338	227,255

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PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

...ON OF INSURANCE
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THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

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 PHYSICIANS.

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OCCURRENCE 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 10, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

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NEW TO PRACTICE CREDIT

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A "NEW" PHYSICIAN SHALL BE A PHYSICIAN WHO HAS RECENTLY COMPLETED ONE OF THE FOLLOWING PROGRAMS AND WILL BEGIN A FULL TIME PRACTICE FOR THE FIRST TIME:

A) RESIDENCY;
B) FELLOWSHIP PROGRAM IN THEIR MEDICAL SPECIALITY;
C) FULFILLMENT OF A MILITARY OBLIGATION IN REMUNERATION FOR MEDICAL SCHOOL TUITION;
D) MEDICAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

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

CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR AND CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR FOLLOWING COMPLETION OF THEIR MEDICAL TRAINING PROGRAM.

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OCCURRENCE PROGRAM

PHYSICIANS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE:
AEROSPACE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHARMACOLOGY, PHYSIATRY, PHYSICIANS NOT OTHERWISE CLASSIFIED, PREVENTATIVE MEDICINE, AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:
ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PSYCHIATRY, AND RHEUMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:
DIABETES, FAMILY/GENERAL PRACTICE, NEPHROLOGY, AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: DERMATOLOGY AND OPHTHALMOLOGY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE INTERNAL MEDICINE, AND PEDIATRICS.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, AND OTORHINOLARYNGOLOGY.

SURGICAL SPECIALISTS PERFORMING ANESTHESIOLOGY, OPHTHALMOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE HEMATOLOGY/ONCOLOGY, INFECTIOUS DISEASE, AND RADIOLOGY – DIAGNOSTIC.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE NEPHROLOGY, PATHOLOGY, PEDIATRICS, PSYCHIATRY - INCLUDING SHOCK THERAPY, PHYSICIANS NOT OTHERWISE CLASSIFIED, AND RADIOLOGY – THERAPY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, NEUROLOGY, AND PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: INFECTIOUS DISEASE, NEONATOLOGY, NEUROLOGY AND RADIOPAQUE DYE INJECTION.

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY SPECIALISTS PERFORMING RIGHT HEART CATHETERIZATION ONLY, CARDIOLOGY SPECIALISTS PERFORMING CATHETERIZATION INCLUDING LEFT HEART, GASTROENTEROLOGY, INTERNAL MEDICINE, INTENSIVE CARE AND RADIOLOGY – DIAGNOSTIC.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: ACUPUNCTURISTS, FAMILY/GENERAL PRACTICE, AND HEMATOLOGY/ONCOLOGY.

SURGICAL SPECIALISTS IN GASTROENTEROLOGY, AND GERIATRICS.

CLASS IIIB

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: AND FAMILY PRACTICE AND GENERAL PRACTICE – INCLUDING DELIVERIES.

SURGICAL SPECIALISTS IN COLON AND RECTAL SURGERY, FAMILY/GENERAL PRACTICE, OTORHINOLARYNGOLOGY (EXCLUDING PLASTIC), AND UROLOGY.

EMERGENCY MEDICINE - NO MAJOR SURGERY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IV-A

SURGICAL SPECIALISTS IN PLASTIC SURGERY (NO ELECTED COSMETIC), ORTHOPEDIC - HAND, AND ORTHOPEDIC - HEAD AND NECK.

CLASS IV-B

SURGICAL SPECIALISTS IN GYNECOLOGY, AND ORTHOPEDIC SURGERY (EXCLUDING SPINAL).

CLASS V-A

EMERGENCY MEDICINE - INCLUDING MAJOR SURGERY.

CLASS V-B

SURGICAL SPECIALISTS IN GENERAL SURGERY, PLASTIC SURGERY (NOT OTHERWISE CLASSIFIED), AND ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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PHYSICIANS RATE CLASSES (CONT.)

CLASS VI

SURGICAL SPECIALISTS IN ABDOMINAL SURGERY.

CLASS VII

SURGICAL SPECIALISTS IN CARDIOVASCULAR SURGERY, TRAUMATIC SURGERY, THORACIC SURGERY, OBSTETRICS, AND OB/GYN AND VASCULAR SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

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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 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 -50% / +50%, 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:

1. <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.

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STANDARD CLAIMS MADE PROGRAM

SCHEDULE RATING PLAN

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.

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.

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).

5. MANAGEMENT CONTROL PROCEDURES:
SPECIFIC OPERATIONAL ACTIVITIES 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 INFLUENCES THE FREQUENCY AND/OR SEVERITY OF CLAIMS.

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SCHEDULE RATING PLAN

7. ORGANIZATIONAL SIZE/STRUCTURE:
THE ORGANIZATION'S SIZE AND PROCESSES ARE SUCH THAT ECONOMIES OF SCALE ARE ACHIEVED WHILE SERVICING THE INSURED.

8. MEDICAL STANDARDS, QUALITY AND CLAIMS 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.

9. OTHER RISK MANAGEMENT PRACTICES AND PROCEDURES:
ADDITIONAL ACTIVITIES 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.

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SCHEDULE RATING PLAN

11. RECORD-KEEPING PRACTICES:
    DEGREE TO WHICH INSURED INCORPORATES METHODS TO MAINTAIN QUALITY PATIENT RECORDS, REFERRALS, AND TEST RESULTS.

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.

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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STANDARD CLAIMS MADE PROGRAM

PARTNERSHIP OR CORPORATION COVERAGE

THE PREMIUM WILL BE BASED ON THE NUMBER OF YEARS THAT THE RETROACTIVE DATE OF THE PARTNERSHIP OR CORPORATION POLICY PRECEDES THE POLICY EXPIRATION DATE. AT THIS MATURITY LEVEL, THE PREMIUM WILL EQUAL 10% OF THE SUM OF THE INDIVIDUAL RATES OF THE PARTNERS, SHAREHOLDERS AND EMPLOYED/CONTRACTED PHYSICIANS, INSURED BY THE COMPANY, AT THE LIMITS SELECTED FOR THE PARTNERSHIP OR CORPORATION. IRRESPECTIVE OF THE NUMBER OF INDIVIDUALS, THE MAXIMUM PREMIUM WILL BE BASED ON THE FIVE HIGHEST RATED CLASSIFICATIONS AND WILL BE SUBJECT TO THE CAPS IN THE FOLLOWING TABLE.

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

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 PHYSICIANS.

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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 YEARS, 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 10 YEARS, A 10% CREDIT SHALL BE APPLIED TO THE NEXT RENEWAL.

3. IF INSURED BY THE COMPANY AND CLAIM FREE FOR 10 YEARS OR MORE, A CREDIT OF 20% 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH THE COMPANY'S GUIDELINES.

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STANDARD CLAIMS MADE PROGRAM

NEW TO PRACTICE CREDIT

A "NEW" PHYSICIAN SHALL BE A PHYSICIAN WHO HAS RECENTLY COMPLETED ONE OF THE FOLLOWING PROGRAMS AND WILL BEGIN A FULL TIME PRACTICE FOR THE FIRST TIME:

A) RESIDENCY;
B) FELLOWSHIP PROGRAM IN THEIR MEDICAL SPECIALITY;
C) FULFILLMENT OF A MILITARY OBLIGATION IN REMUNERATION FOR MEDICAL SCHOOL TUITION;
D) MEDICAL SCHOOL OR SPECIALTY TRAINING PROGRAM.

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

CREDITS IN THE AMOUNT OF 50% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR FIRST YEAR AND CREDITS IN THE AMOUNT OF 30% OF FILED MANUAL RATES SHALL APPLY TO NEW INSUREDS FOR THEIR SECOND YEAR OF PRACTICE FOLLOWING COMPLETION OF THEIR MEDICAL TRAINING PROGRAM.

A. **Classification**

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

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists	10%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

2. **Miscellaneous Entities**

NOT AVAILABLE

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3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.750	1.150	1.200
5 or more	1.820	1.750	1.200	1.250

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

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$25
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 35%
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

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2. Deductible Credits
(Occurrence & Standard Claims Made Programs)

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 20%	6% to 16%	5% to 15%	3% to 12%	2% to 11%
100	14% to 34%	13% to 26%	11% to 24%	8% to 19%	7% to 16%
200		24% to 42%	21% to 38%	17% to 30%	14% to 25%
250			25% to 44%	20% to 34%	17% to 28%
500				33% to 51%	28% to 42%
1000					39% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	14% to 32%	12% to 25%	10% to 22%	7% to 18%	6% to 15%
100	23% to 49%	21% to 38%	18% to 34%	14% to 26%	11% to 22%
200		34% to 57%	30% to 52%	24% to 39%	20% to 32%
250			35% to 59%	28% to 45%	23% to 36%
500				43% to 65%	36% to 52%
1000					49% to 69%

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.

3. Self-Insured Retention Credits

NOT AVAILABLE

4. **Large Group & Locum Tenens Group Rating – Corporations**
(Occurrence & Standard Claims Made Programs)

AVAILABLE

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PHYSICIANS & SURGEONS

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.

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CLASS IA

Non-Surgical Specialists to include:
Aerospace, Allergy, Dermatology, Forensic Medicine, Nuclear, Nutrition, Occupational Medicine, Ophthalmology, Pharmacology, Physiatry, Physicians Not Otherwise Classified, Preventative Medicine, and Public Health.

CLASS IB

Non-Surgical Specialists to include:
Endocrinology, Geriatrics, Gynecology, Otorhinolaryngology, Pathology, Psychiatry, and Rheumatology.

CLASS IC

Non-Surgical Specialists to include:
Diabetes, Family/General Practice, Nephrology, and Urgent Care.

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Dermatology and Ophthalmology.

CLASS IIA

Non-Surgical Specialists to include Internal Medicine, and Pediatrics.

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Cardiology (Including Swan-Ganz), Endocrinology, Geriatrics, Gynecology, and Otorhinolaryngology.

Surgical specialists performing Anesthesiology, Ophthalmology and Pain Management.

CLASS IIB

Non-Surgical Specialists to include Hematology/Oncology, Infectious Disease, and Radiology – Diagnostic.

Specialists performing minor surgery or assisting in major surgery on their own patients to include Nephrology, Pathology, Pediatrics, Psychiatry - including Shock Therapy, physicians not otherwise classified, and Radiology – Therapy.

CLASS IIC

Non-Surgical Specialists to include: Gastroenterology, Neurology, and Pulmonary Disease.

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Infectious Disease, Neonatology, Neurology and Radiopaque Dye Injection.

CLASS IID

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Cardiology specialists performing right heart catheterization only, Cardiology specialists performing catheterization including left heart, Gastroenterology, Internal Medicine, Intensive Care and Radiology – diagnostic.

CLASS IIIA

Specialists performing minor surgery or assisting in major surgery on their own patients to include: Acupuncturists, Family/General Practice, and Hematology/Oncology.

Surgical specialists in Gastroenterology, and Geriatrics.

CLASS IIIB

Specialists performing minor surgery or assisting in major surgery on their own patients to include: and Family Practice and General Practice – including deliveries.

Surgical specialists in Colon and Rectal Surgery, Family/General Practice, Otorhinolaryngology (excluding plastic), and Urology.

Emergency Medicine - no major surgery.

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CLASS IV-A

Surgical specialists in Plastic Surgery (no elected cosmetic), Orthopedic - Hand, and Orthopedic - Head and Neck.

CLASS IV-B

Surgical Specialists in Gynecology, and Orthopedic Surgery (excluding spinal).

CLASS V-A

Emergency Medicine - including major surgery.

CLASS V-B

Surgical Specialists in General Surgery, Plastic Surgery (not otherwise classified), and Orthopedic Surgery (including spinal).

CLASS VI

Surgical Specialists in Abdominal Surgery.

CLASS VII

Surgical specialists in Cardiovascular Surgery, Traumatic Surgery, Thoracic Surgery, Obstetrics, and OB/GYN and Vascular Surgery.

CLASS VIII

Surgical specialists in Neurological Surgery.

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B. Manual Rates

1. Territory Definitions

Area 1	Cook, Madison, St. Clair, and Will Counties
Area 2	DuPage, Jackson, Kane, Lake, McHenry and Vermilion Counties
Area 3	Champaign, Kankakee, Macon, Sangamon, and Winnebago Counties
Area 4	Bureau, Coles DeKalb, LaSalle, Ogle and Randolph Counties
Area 5	Remainder of State

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2. Occurrence Program

a. Area 1

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	12,627	17,173	25,380	31,441	32,704
1B	16,836	22,897	33,840	41,922	43,605
1C	19,782	26,904	39,762	49,257	51,235
2A	24,412	33,200	49,068	60,786	63,227
2B	27,779	37,779	55,836	69,170	71,948
2C	32,830	44,649	65,988	81,747	85,030
2D	35,356	48,084	71,066	88,036	91,572
3A	42,090	57,663	87,126	110,697	115,748
3B	45,457	62,276	94,096	119,552	125,007
4A	53,875	73,809	111,521	141,691	148,156
4B	61,451	84,188	127,204	161,616	168,990
5A	67,344	92,261	139,402	177,115	185,196
5B	79,129	108,407	163,797	208,109	217,605
6	92,598	126,859	191,678	243,533	254,645
7	99,332	136,085	205,617	261,243	273,163
8	130,479	178,756	270,092	343,160	358,817

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b. Area 2

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,997	10,876	16,074	19,913	20,712
1B	10,663	14,502	21,433	26,551	27,617
1C	12,529	17,039	25,183	31,197	32,450
2A	15,461	21,027	31,077	38,498	40,044
2B	17,594	23,928	35,364	43,809	45,568
2C	20,793	28,278	41,794	51,775	53,854
2D	22,392	30,453	45,008	55,756	57,995
3A	26,658	36,521	55,182	70,111	73,310
3B	28,790	39,442	59,595	75,718	79,173
4A	34,122	46,747	70,633	89,741	93,836
4B	38,920	53,320	80,564	102,360	107,030
5A	42,652	58,433	88,290	112,175	117,293
5B	50,116	68,659	103,740	131,805	137,819
6	58,647	80,346	121,399	154,242	161,279
7	62,912	86,189	130,228	165,459	173,008
8	82,638	113,214	171,061	217,338	227,255

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c. Area 3

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	6,734	9,158	13,535	16,768	17,441
1B	8,979	12,211	18,048	22,358	23,256
1C	10,550	14,348	21,206	26,270	27,325
2A	13,020	17,707	26,170	32,420	33,722
2B	14,815	20,148	29,778	36,889	38,371
2C	17,509	23,812	35,193	43,597	45,348
2D	18,856	25,644	37,901	46,951	48,837
3A	22,448	30,754	46,467	59,038	61,732
3B	24,243	33,213	50,183	63,759	66,668
4A	28,733	39,364	59,477	75,568	79,016
4B	32,773	44,899	67,840	86,193	90,126
5A	35,916	49,205	74,346	94,459	98,769
5B	42,201	57,815	87,356	110,989	116,053
6	49,385	67,657	102,227	129,883	135,809
7	52,976	72,577	109,660	139,327	145,684
8	69,587	95,334	144,045	183,014	191,364

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d. Area 4

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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e. Area 5

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,209	5,724	8,460	10,480	10,901
1B	5,612	7,632	11,280	13,974	14,535
1C	6,594	8,968	13,254	16,419	17,078
2A	8,137	11,066	16,355	20,261	21,075
2B	9,260	12,594	18,613	23,057	23,983
2C	10,943	14,882	21,995	27,248	28,342
2D	11,785	16,028	23,688	29,345	30,523
3A	14,030	19,221	29,042	36,899	38,583
3B	15,152	20,758	31,365	39,850	41,668
4A	17,958	24,602	37,173	47,230	49,385
4B	20,484	28,063	42,402	53,873	56,331
5A	22,448	30,754	46,467	59,038	61,732
5B	26,376	36,135	54,598	69,369	72,534
6	30,866	42,286	63,893	81,178	84,882
7	33,111	45,362	68,540	87,082	91,055
8	43,493	59,585	90,031	114,387	119,606

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3. Standard Claims-Made Programs

a. Area 1

0 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,001	5,441	8,042	9,962	10,363
1B	5,335	7,256	10,723	13,284	13,818
1C	6,269	8,526	12,601	15,610	16,237
2A	7,736	10,521	15,549	19,263	20,036
2B	8,803	11,972	17,694	21,919	22,800
2C	10,404	14,149	20,912	25,906	26,946
2D	11,204	15,237	22,520	27,898	29,018
3A	13,338	18,273	27,610	35,079	36,680
3B	14,405	19,735	29,818	37,885	39,614
4A	17,073	23,390	35,341	44,902	46,951
4B	19,473	26,678	40,309	51,214	53,551
5A	21,341	29,237	44,176	56,127	58,688
5B	25,075	34,353	51,905	65,947	68,956
6	29,344	40,201	60,742	77,175	80,696
7	31,478	43,125	65,159	82,787	86,565
8	41,348	56,647	85,590	108,745	113,707

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1 Year Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	5,540	7,534	11,135	13,795	14,349
1B	7,387	10,046	14,848	18,394	19,132
1C	8,680	11,805	17,447	21,613	22,481
2A	10,711	14,567	21,529	26,670	27,741
2B	12,189	16,577	24,500	30,351	31,570
2C	14,405	19,591	28,954	35,868	37,309
2D	15,513	21,098	31,181	38,627	40,179
3A	18,468	25,301	38,229	48,571	50,787
3B	19,945	27,325	41,286	52,455	54,849
4A	23,639	32,385	48,933	62,171	65,007
4B	26,963	36,939	55,813	70,913	74,148
5A	29,549	40,482	61,166	77,714	81,260
5B	34,720	47,566	71,870	91,314	95,480
6	40,630	55,663	84,104	106,857	111,733
7	43,584	59,710	90,219	114,626	119,856
8	57,251	78,434	118,510	150,570	157,440

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2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	9,234	12,558	18,560	22,993	23,916
1B	12,312	16,744	24,747	30,657	31,888
1C	14,467	19,675	29,079	36,023	37,470
2A	17,852	24,279	35,883	44,451	46,237
2B	20,315	27,628	40,833	50,584	52,616
2C	24,008	32,651	48,256	59,780	62,181
2D	25,856	35,164	51,971	64,381	66,967
3A	30,780	42,169	63,715	80,951	84,645
3B	33,242	45,542	68,811	87,426	91,416
4A	39,398	53,975	81,554	103,617	108,345
4B	44,939	61,566	93,024	118,190	123,582
5A	49,248	67,470	101,943	129,522	135,432
5B	57,866	79,276	119,783	152,188	159,132
6	67,716	92,771	140,172	178,093	186,219
7	72,641	99,518	150,367	191,046	199,763
8	95,418	130,723	197,515	250,949	262,400

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Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	12,312	16,744	24,747	30,657	31,888
1B	16,416	22,326	32,996	40,876	42,517
1C	19,289	26,233	38,771	48,030	49,959
2A	23,803	32,372	47,844	59,269	61,650
2B	27,086	36,837	54,443	67,444	70,153
2C	32,011	43,535	64,342	79,707	82,908
2D	34,474	46,885	69,293	85,840	89,288
3A	41,040	56,225	84,953	107,935	112,860
3B	44,323	60,723	91,749	116,569	121,888
4A	52,531	71,967	108,739	138,157	144,460
4B	59,918	82,088	124,030	157,584	164,775
5A	65,664	89,960	135,924	172,696	180,576
5B	77,155	105,702	159,711	202,918	212,176
6	90,288	123,695	186,896	237,457	248,292
7	96,854	132,690	200,488	254,726	266,349
8	127,224	174,297	263,354	334,599	349,866

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b. Area 2

0 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,534	3,446	5,093	6,310	6,563
1B	3,379	4,595	6,792	8,414	8,752
1C	3,970	5,399	7,980	9,885	10,282
2A	4,900	6,664	9,849	12,201	12,691
2B	5,575	7,582	11,206	13,882	14,439
2C	6,589	8,961	13,244	16,407	17,066
2D	7,096	9,651	14,263	17,669	18,379
3A	8,448	11,574	17,487	22,218	23,232
3B	9,123	12,499	18,885	23,993	25,088
4A	10,813	14,814	22,383	28,438	29,736
4B	12,333	16,896	25,529	32,436	33,916
5A	13,516	18,517	27,978	35,547	37,169
5B	15,881	21,757	32,874	41,767	43,673
6	18,585	25,461	38,471	48,879	51,109
7	19,936	27,312	41,268	52,432	54,824
8	26,188	35,878	54,209	68,874	72,017

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1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,509	4,772	7,053	8,737	9,088
1B	4,679	6,363	9,405	11,651	12,119
1C	5,497	7,476	11,049	13,688	14,237
2A	6,784	9,226	13,636	16,892	17,571
2B	7,720	10,499	15,517	19,223	19,995
2C	9,123	12,407	18,337	22,716	23,629
2D	9,825	13,362	19,748	24,464	25,447
3A	11,697	16,025	24,213	30,763	32,167
3B	12,632	17,306	26,148	33,222	34,738
4A	14,972	20,512	30,992	39,376	41,173
4B	17,077	23,395	35,349	44,913	46,962
5A	18,715	25,640	38,740	49,220	51,466
5B	21,990	30,126	45,519	57,834	60,473
6	25,733	35,254	53,267	67,678	70,766
7	27,604	37,817	57,140	72,599	75,911
8	36,260	49,676	75,058	95,364	99,715

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2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,849	7,955	11,756	14,564	15,149
1B	7,798	10,605	15,674	19,417	20,197
1C	9,162	12,460	18,416	22,813	23,730
2A	11,307	15,378	22,727	28,154	29,285
2B	12,866	17,498	25,861	32,036	33,323
2C	15,206	20,680	30,564	37,863	39,384
2D	16,376	22,271	32,916	40,776	42,414
3A	19,495	26,708	40,355	51,272	53,611
3B	21,054	28,844	43,582	55,372	57,899
4A	24,953	34,186	51,653	65,626	68,621
4B	28,462	38,993	58,916	74,855	78,271
5A	31,191	42,732	64,565	82,032	85,775
5B	36,650	50,211	75,866	96,390	100,788
6	42,888	58,757	88,778	112,795	117,942
7	46,007	63,030	95,234	120,998	126,519
8	60,433	82,793	125,096	158,939	166,191

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3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	7,018	9,544	14,106	17,475	18,177
1B	9,357	12,726	18,808	23,299	24,235
1C	10,994	14,952	22,098	27,375	28,474
2A	13,568	18,452	27,272	33,784	35,141
2B	15,440	20,998	31,034	38,446	39,990
2C	18,247	24,816	36,676	45,435	47,260
2D	19,651	26,725	39,499	48,931	50,896
3A	23,394	32,050	48,426	61,526	64,334
3B	25,265	34,613	52,299	66,447	69,479
4A	29,943	41,022	61,982	78,750	82,343
4B	34,154	46,791	70,699	89,825	93,924
5A	37,429	51,278	77,478	98,438	102,930
5B	43,979	60,251	91,037	115,665	120,942
6	51,466	70,508	106,535	135,356	141,532
7	55,208	75,635	114,281	145,197	151,822
8	72,519	99,351	150,114	190,725	199,427

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Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	7,798	10,605	15,674	19,417	20,197
1B	10,397	14,140	20,898	25,889	26,928
1C	12,216	16,614	24,554	30,418	31,639
2A	15,076	20,503	30,303	37,539	39,047
2B	17,155	23,331	34,482	42,716	44,431
2C	20,274	27,573	40,751	50,482	52,510
2D	21,834	29,694	43,886	54,367	56,550
3A	25,993	35,610	53,806	68,362	71,481
3B	28,072	38,459	58,109	73,829	77,198
4A	33,270	45,580	68,869	87,500	91,493
4B	37,949	51,990	78,554	99,806	104,360
5A	41,588	56,976	86,087	109,376	114,367
5B	48,866	66,946	101,153	128,518	134,382
6	57,184	78,342	118,371	150,394	157,256
7	61,342	84,039	126,978	161,329	168,691
8	80,577	110,390	166,794	211,918	221,587

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

c. Area 3

0 Years Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,134	2,902	4,289	5,314	5,527
1B	2,845	3,869	5,718	7,084	7,369
1C	3,343	4,546	6,719	8,324	8,658
2A	4,126	5,611	8,293	10,274	10,686
2B	4,695	6,385	9,437	11,691	12,160
2C	5,548	7,545	11,151	13,815	14,369
2D	5,975	8,126	12,010	14,878	15,475
3A	7,114	9,746	14,726	18,710	19,564
3B	7,683	10,526	15,904	20,206	21,128
4A	9,105	12,474	18,847	23,946	25,039
4B	10,386	14,229	21,499	27,315	28,562
5A	11,382	15,593	23,561	29,935	31,301
5B	13,373	18,321	27,682	35,171	36,776
6	15,650	21,441	32,396	41,160	43,038
7	16,788	23,000	34,751	44,152	46,167
8	22,052	30,211	45,648	57,997	60,643

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,955	4,019	5,940	7,358	7,653
1B	3,940	5,358	7,919	9,811	10,205
1C	4,629	6,295	9,304	11,526	11,989
2A	5,713	7,770	11,483	14,225	14,797
2B	6,501	8,841	13,067	16,187	16,838
2C	7,682	10,448	15,441	19,128	19,896
2D	8,274	11,253	16,631	20,602	21,430
3A	9,850	13,495	20,390	25,906	27,088
3B	10,638	14,574	22,021	27,978	29,255
4A	12,607	17,272	26,096	33,156	34,669
4B	14,380	19,701	29,767	37,819	39,545
5A	15,759	21,590	32,621	41,446	43,337
5B	18,517	25,368	38,330	48,700	50,922
6	21,669	29,687	44,855	56,989	59,590
7	23,245	31,846	48,117	61,134	63,924
8	30,533	41,830	63,203	80,302	83,966

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,925	6,698	9,899	12,263	12,756
1B	6,566	8,930	13,198	16,349	17,006
1C	7,715	10,492	15,507	19,210	19,982
2A	9,521	12,949	19,137	23,707	24,659
2B	10,835	14,736	21,778	26,979	28,063
2C	12,804	17,413	25,736	31,882	33,162
2D	13,790	18,754	27,718	34,337	35,716
3A	16,416	22,490	33,981	43,174	45,144
3B	17,729	24,289	36,699	46,627	48,755
4A	21,012	28,786	43,495	55,262	57,783
4B	23,967	32,835	49,612	63,033	65,909
5A	26,265	35,983	54,369	69,077	72,229
5B	30,862	42,281	63,884	81,167	84,871
6	36,115	49,478	74,758	94,982	99,316
7	38,741	53,075	80,194	101,889	106,538
8	50,888	69,717	105,338	133,835	139,942

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,909	8,036	11,877	14,713	15,304
1B	7,880	10,717	15,839	19,621	20,409
1C	9,258	12,591	18,609	23,052	23,978
2A	11,426	15,539	22,966	28,451	29,593
2B	13,001	17,681	26,132	32,372	33,673
2C	15,365	20,896	30,884	38,259	39,795
2D	16,547	22,504	33,259	41,202	42,857
3A	19,699	26,988	40,777	51,808	54,172
3B	21,275	29,147	44,039	55,953	58,506
4A	25,214	34,543	52,193	66,313	69,339
4B	28,760	39,401	59,533	75,639	79,090
5A	31,518	43,180	65,242	82,892	86,675
5B	37,034	50,737	76,660	97,399	101,844
6	43,338	59,373	89,710	113,979	119,180
7	46,490	63,691	96,234	122,269	127,848
8	61,066	83,660	126,407	160,604	167,932

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	6,566	8,930	13,198	16,349	17,006
1B	8,755	11,907	17,598	21,800	22,675
1C	10,287	13,990	20,677	25,615	26,643
2A	12,695	17,265	25,517	31,611	32,880
2B	14,446	19,647	29,036	35,971	37,415
2C	17,072	23,218	34,315	42,509	44,216
2D	18,386	25,005	36,956	45,781	47,620
3A	21,888	29,987	45,308	57,565	60,192
3B	23,639	32,385	48,933	62,171	65,007
4A	28,016	38,382	57,993	73,682	77,044
4B	31,956	43,780	66,149	84,044	87,879
5A	35,020	47,977	72,491	92,103	96,305
5B	41,149	56,374	85,178	108,222	113,160
6	48,153	65,970	99,677	126,642	132,421
7	51,655	70,767	106,926	135,853	142,051
8	67,851	92,956	140,452	178,448	186,590

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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OCT 01 2004
SPRINGFIELD, ILLINOIS

d. Area 4

0 Years Since Retroactive Date

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

e. Area 5

0 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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SPRINGFIELD, ILLINOIS

1 Year Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

2 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

3 Years Since Retroactive Date

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
OCT 01 2004
SPRINGFIELD, ILLINOIS

Mature

Class	LIMITS 100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

DIVISION OF INSURANCE
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4. Increased Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
100/300	1.000	1.000	1.000
200/600	1.360	1.370	1.370
500/1000	2.010	2.070	2.070
1000/1000	2.490	2.630	2.630
1000/3000	2.590	2.750	2.750

5. Excess Limit Factors

LIMIT	CLASSES 1A-2D	CLASSES 3A-7	CLASS 8
1M/1M xs 1M/3M	1.270	1.300	1.300
2M/2M xs 1M/3M	1.430	1.480	1.480
3M/3M xs 1M/3M	1.560	1.620	1.620
4M/4M xs 1M/3M	1.670	1.740	1.740

Note: For aggregate limits not listed above, refer to company.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

6. Extended Reporting Period Coverage Factors

YEARS RETROACTIVE DATE PRECEDES EXPIRATION DATE	FACTOR
1	0.900
2	1.500
3	1.700
4 OR MORE	1.820

7. Shared Limits Modification

Modification
Up to 25%

DIVISION OF INSURANCE
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SPRINGFIELD, ILLINOIS

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

Physician & Surgeons	$250

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

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

AVAILABLE

4. **Locum Tenens Group Rating**
(Occurrence & Standard Claims Made Programs)

Formula
(Applicable Manual Rate / 3120) * 1.60

5. **New Physicians & Surgeons**
(Occurrence & Standard Claims Made Programs)

Years New to Practice	Credit
1st	50%
2nd	30%

DIVISION OF INSURANCE
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6. **Physician Teaching Specialists**

   a. Training Activities

NOT AVAILABLE

   b. Teaching Specialists

NOT AVAILABLE

7. **Physicians Leave of Absence**

Program	Credit
Occurrence	75%
Standard Claims Made	50%

8. **Physicians Military Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
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SPRINGFIELD, ILLINOIS

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Medical 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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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

Year	Credit
1	5%
2	5%
3	5%

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

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 10	10%
10 or more	20%

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

PREMIUM CREDIT FOR LOSS ONLY DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	7% to 20%	6% to 16%	5% to 15%	3% to 12%	2% to 11%
100	14% to 34%	13% to 26%	11% to 24%	8% to 19%	7% to 16%
200		24% to 42%	21% to 38%	17% to 30%	14% to 25%
250			25% to 44%	20% to 34%	17% to 28%
500				33% to 51%	28% to 42%
1000					39% to 56%

PREMIUM CREDIT FOR LOSS AND ALE DEDUCTIBLE

	Incident Policy Limit (000's)				
Deductible (000's)	100	200	250	500	1000
50	14% to 32%	12% to 25%	10% to 22%	7% to 18%	6% to 15%
100	23% to 49%	21% to 38%	18% to 34%	14% to 26%	11% to 22%
200		34% to 57%	30% to 52%	24% to 39%	20% to 32%
250			35% to 59%	28% to 45%	23% to 36%
500				43% to 65%	36% to 52%
1000					49% to 69%

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.

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13. **Self-Insured Retention Credits**

NOT AVAILABLE

14. **Experience Rating**

NOT AVAILABLE

15. **Non-Discretionary Debit Rating 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	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code.

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

AVAILABLE

17. **Convertible Coverage Rating Plan**

NOT AVAILABLE

18. **Enhanced Claims Made Rating**

NOT AVAILABLE

19. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

23. **Renewal Rate Rule**

NOT AVAILABLE

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

Refer to Quarterly Installment Option rule.

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

Credit
5%

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

AVAILABLE

27. **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.

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THE

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Professional Protection Exclusively since 1899

ILLINOIS

PHYSICIANS AND SURGEONS

OCCURRENCE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: DUPAGE, JACKSON, KANE, LAKE, MCHENRY, AND VERMILLION COUNTIES .

TERRITORY 3: CHAMPAIGN, KANKAKEE, MACON, SANGAMON, AND WINNEBAGO COUNTIES.

TERRITORY 4: BUREAU, COLES, DEKALB, LASALLE, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 5: REMAINDER OF STATE.

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FILED
MAY 01 2003
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ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE PROGRAM

RATING TERRITORIES

TERRITORY 1: COOK, MADISON, ST. CLAIR, AND WILL COUNTIES

TERRITORY 2: DUPAGE, JACKSON, KANE, LAKE, MCHENRY, AND VERMILLION COUNTIES .

TERRITORY 3: CHAMPAIGN, KANKAKEE, MACON, SANGAMON, AND WINNEBAGO COUNTIES.

TERRITORY 4: BUREAU, COLES, DEKALB, LASALLE, OGLE, AND RANDOLPH COUNTIES.

TERRITORY 5: REMAINDER OF STATE.

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
FILED
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SPRINGFIELD, ILLINOIS

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ILLINOIS STATEWIDE

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE

DEPARTMENT OF INSURANCE
STATE OF ILLINOIS
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CLAIMS-MADE FACTORS

YEARS SINCE RETROACTIVE DATE	FACTOR
0	0.325
1	0.450
2	0.750
3	0.900
4 OR MORE	1.000
MATURE CLAIMS-MADE TO OCCURRENCE FACTOR	0.975

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	4,001	5,441	8,042	9,962	10,363
1B	5,335	7,256	10,723	13,284	13,818
1C	6,269	8,526	12,601	15,610	16,237
2A	7,736	10,521	15,549	19,263	20,036
2B	8,803	11,972	17,694	21,919	22,800
2C	10,404	14,149	20,912	25,906	26,946
2D	11,204	15,237	22,520	27,898	29,018
3A	13,338	18,273	27,610	35,079	36,680
3B	14,405	19,735	29,818	37,885	39,614
4A	17,073	23,390	35,341	44,902	46,951
4B	19,473	26,678	40,309	51,214	53,551
5A	21,341	29,237	44,176	56,127	58,688
5B	25,075	34,353	51,905	65,947	68,956
6	29,344	40,201	60,742	77,175	80,696
7	31,478	43,125	65,159	82,787	86,565
8	41,348	56,647	85,590	108,745	113,707

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ILLINOIS - AREA 1

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,540	7,534	11,135	13,795	14,349
1B	7,387	10,046	14,848	18,394	19,132
1C	8,680	11,805	17,447	21,613	22,481
2A	10,711	14,567	21,529	26,670	27,741
2B	12,189	16,577	24,500	30,351	31,570
2C	14,405	19,591	28,954	35,868	37,309
2D	15,513	21,098	31,181	38,627	40,179
3A	18,468	25,301	38,229	48,571	50,787
3B	19,945	27,325	41,286	52,455	54,849
4A	23,639	32,385	48,933	62,171	65,007
4B	26,963	36,939	55,813	70,913	74,148
5A	29,549	40,482	61,166	77,714	81,260
5B	34,720	47,566	71,870	91,314	95,480
6	40,630	55,663	84,104	106,857	111,733
7	43,584	59,710	90,219	114,626	119,856
8	57,251	78,434	118,510	150,570	157,440

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	9,234	12,558	18,560	22,993	23,916
1B	12,312	16,744	24,747	30,657	31,888
1C	14,467	19,675	29,079	36,023	37,470
2A	17,852	24,279	35,883	44,451	46,237
2B	20,315	27,628	40,833	50,584	52,616
2C	24,008	32,651	48,256	59,780	62,181
2D	25,856	35,164	51,971	64,381	66,967
3A	30,780	42,169	63,715	80,951	84,645
3B	33,242	45,542	68,811	87,426	91,416
4A	39,398	53,975	81,554	103,617	108,345
4B	44,939	61,566	93,024	118,190	123,582
5A	49,248	67,470	101,943	129,522	135,432
5B	57,866	79,276	119,783	152,188	159,132
6	67,716	92,771	140,172	178,093	186,219
7	72,641	99,518	150,367	191,046	199,763
8	95,418	130,723	197,515	250,949	262,400

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STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	11,081	15,070	22,273	27,592	28,700
1B	14,774	20,093	29,696	36,787	38,265
1C	17,360	23,610	34,894	43,226	44,962
2A	21,423	29,135	43,060	53,343	55,486
2B	24,377	33,153	48,998	60,699	63,136
2C	28,810	39,182	57,908	71,737	74,618
2D	31,027	42,197	62,364	77,257	80,360
3A	36,936	50,602	76,458	97,142	101,574
3B	39,891	54,651	82,574	104,913	109,700
4A	47,278	64,771	97,865	124,341	130,015
4B	53,926	73,879	111,627	141,825	148,297
5A	59,098	80,964	122,333	155,428	162,520
5B	69,440	95,133	143,741	182,627	190,960
6	81,259	111,325	168,206	213,711	223,462
7	87,169	119,422	180,440	229,254	239,715
8	114,502	156,868	237,019	301,140	314,881

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	12,312	16,744	24,747	30,657	31,888
1B	16,416	22,326	32,996	40,876	42,517
1C	19,289	26,233	38,771	48,030	49,959
2A	23,803	32,372	47,844	59,269	61,650
2B	27,086	36,837	54,443	67,444	70,153
2C	32,011	43,535	64,342	79,707	82,908
2D	34,474	46,885	69,293	85,840	89,288
3A	41,040	56,225	84,953	107,935	112,860
3B	44,323	60,723	91,749	116,569	121,888
4A	52,531	71,967	108,739	138,157	144,460
4B	59,918	82,088	124,030	157,584	164,775
5A	65,664	89,960	135,924	172,696	180,576
5B	77,155	105,702	159,711	202,918	212,176
6	90,288	123,695	186,896	237,457	248,292
7	96,854	132,690	200,488	254,726	266,349
8	127,224	174,297	263,354	334,599	349,866

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,534	3,446	5,093	6,310	6,563
1B	3,379	4,595	6,792	8,414	8,752
1C	3,970	5,399	7,980	9,885	10,282
2A	4,900	6,664	9,849	12,201	12,691
2B	5,575	7,582	11,206	13,882	14,439
2C	6,589	8,961	13,244	16,407	17,066
2D	7,096	9,651	14,263	17,669	18,379
3A	8,448	11,574	17,487	22,218	23,232
3B	9,123	12,499	18,885	23,993	25,088
4A	10,813	14,814	22,383	28,438	29,736
4B	12,333	16,896	25,529	32,436	33,916
5A	13,516	18,517	27,978	35,547	37,169
5B	15,881	21,757	32,874	41,767	43,673
6	18,585	25,461	38,471	48,879	51,109
7	19,936	27,312	41,268	52,432	54,824
8	26,188	35,878	54,209	68,874	72,017

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,509	4,772	7,053	8,737	9,088
1B	4,679	6,363	9,405	11,651	12,119
1C	5,497	7,476	11,049	13,688	14,237
2A	6,784	9,226	13,636	16,892	17,571
2B	7,720	10,499	15,517	19,223	19,995
2C	9,123	12,407	18,337	22,716	23,629
2D	9,825	13,362	19,748	24,464	25,447
3A	11,697	16,025	24,213	30,763	32,167
3B	12,632	17,306	26,148	33,222	34,738
4A	14,972	20,512	30,992	39,376	41,173
4B	17,077	23,395	35,349	44,913	46,962
5A	18,715	25,640	38,740	49,220	51,466
5B	21,990	30,126	45,519	57,834	60,473
6	25,733	35,254	53,267	67,678	70,766
7	27,604	37,817	57,140	72,599	75,911
8	36,260	49,676	75,058	95,364	99,715

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,849	7,955	11,756	14,564	15,149
1B	7,798	10,605	15,674	19,417	20,197
1C	9,162	12,460	18,416	22,813	23,730
2A	11,307	15,378	22,727	28,154	29,285
2B	12,866	17,498	25,861	32,036	33,323
2C	15,206	20,680	30,564	37,863	39,384
2D	16,376	22,271	32,916	40,776	42,414
3A	19,495	26,708	40,355	51,272	53,611
3B	21,054	28,844	43,582	55,372	57,899
4A	24,953	34,186	51,653	65,626	68,621
4B	28,462	38,993	58,916	74,855	78,271
5A	31,191	42,732	64,565	82,032	85,775
5B	36,650	50,211	75,866	96,390	100,788
6	42,888	58,757	88,778	112,795	117,942
7	46,007	63,030	95,234	120,998	126,519
8	60,433	82,793	125,096	158,939	166,191

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	7,018	9,544	14,106	17,475	18,177
1B	9,357	12,726	18,808	23,299	24,235
1C	10,994	14,952	22,098	27,375	28,474
2A	13,568	18,452	27,272	33,784	35,141
2B	15,440	20,998	31,034	38,446	39,990
2C	18,247	24,816	36,676	45,435	47,260
2D	19,651	26,725	39,499	48,931	50,896
3A	23,394	32,050	48,426	61,526	64,334
3B	25,265	34,613	52,299	66,447	69,479
4A	29,943	41,022	61,982	78,750	82,343
4B	34,154	46,791	70,699	89,825	93,924
5A	37,429	51,278	77,478	98,438	102,930
5B	43,979	60,251	91,037	115,665	120,942
6	51,466	70,508	106,535	135,356	141,532
7	55,208	75,635	114,281	145,197	151,822
8	72,519	99,351	150,114	190,725	199,427

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PHYSICIANS AND SURGEONS

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MATURE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	7,798	10,605	15,674	19,417	20,197
1B	10,397	14,140	20,898	25,889	26,928
1C	12,216	16,614	24,554	30,418	31,639
2A	15,076	20,503	30,303	37,539	39,047
2B	17,155	23,331	34,482	42,716	44,431
2C	20,274	27,573	40,751	50,482	52,510
2D	21,834	29,694	43,886	54,367	56,550
3A	25,993	35,610	53,806	68,362	71,481
3B	28,072	38,459	58,109	73,829	77,198
4A	33,270	45,580	68,869	87,500	91,493
4B	37,949	51,990	78,554	99,806	104,360
5A	41,588	56,976	86,087	109,376	114,367
5B	48,866	66,946	101,153	128,518	134,382
6	57,184	78,342	118,371	150,394	157,256
7	61,342	84,039	126,978	161,329	168,691
8	80,577	110,390	166,794	211,918	221,587

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Professional Protection Exclusively since 1899

ILLINOIS - AREA 3

DIVISION OF INSURANCE
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OCT 01 2004
SPRINGFIELD, ILLINOIS

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	2,134	2,902	4,289	5,314	5,527
1B	2,845	3,869	5,718	7,084	7,369
1C	3,343	4,546	6,719	8,324	8,658
2A	4,126	5,611	8,293	10,274	10,686
2B	4,695	6,385	9,437	11,691	12,160
2C	5,548	7,545	11,151	13,815	14,369
2D	5,975	8,126	12,010	14,878	15,475
3A	7,114	9,746	14,726	18,710	19,564
3B	7,683	10,526	15,904	20,206	21,128
4A	9,105	12,474	18,847	23,946	25,039
4B	10,386	14,229	21,499	27,315	28,562
5A	11,382	15,593	23,561	29,935	31,301
5B	13,373	18,321	27,682	35,171	36,776
6	15,650	21,441	32,396	41,160	43,038
7	16,788	23,000	34,751	44,152	46,167
8	22,052	30,211	45,648	57,997	60,643

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	2,955	4,019	5,940	7,358	7,653
1B	3,940	5,358	7,919	9,811	10,205
1C	4,629	6,295	9,304	11,526	11,989
2A	5,713	7,770	11,483	14,225	14,797
2B	6,501	8,841	13,067	16,187	16,838
2C	7,682	10,448	15,441	19,128	19,896
2D	8,274	11,253	16,631	20,602	21,430
3A	9,850	13,495	20,390	25,906	27,088
3B	10,638	14,574	22,021	27,978	29,255
4A	12,607	17,272	26,096	33,156	34,669
4B	14,380	19,701	29,767	37,819	39,545
5A	15,759	21,590	32,621	41,446	43,337
5B	18,517	25,368	38,330	48,700	50,922
6	21,669	29,687	44,855	56,989	59,590
7	23,245	31,846	48,117	61,134	63,924
8	30,533	41,830	63,203	80,302	83,966

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,925	6,698	9,899	12,263	12,756
1B	6,566	8,930	13,198	16,349	17,006
1C	7,715	10,492	15,507	19,210	19,982
2A	9,521	12,949	19,137	23,707	24,659
2B	10,835	14,736	21,778	26,979	28,063
2C	12,804	17,413	25,736	31,882	33,162
2D	13,790	18,754	27,718	34,337	35,716
3A	16,416	22,490	33,981	43,174	45,144
3B	17,729	24,289	36,699	46,627	48,755
4A	21,012	28,786	43,495	55,262	57,783
4B	23,967	32,835	49,612	63,033	65,909
5A	26,265	35,983	54,369	69,077	72,229
5B	30,862	42,281	63,884	81,167	84,871
6	36,115	49,478	74,758	94,982	99,316
7	38,741	53,075	80,194	101,889	106,538
8	50,888	69,717	105,338	133,835	139,942

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SPRINGFIELD, ILLINOIS

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	5,909	8,036	11,877	14,713	15,304
1B	7,880	10,717	15,839	19,621	20,409
1C	9,258	12,591	18,609	23,052	23,978
2A	11,426	15,539	22,966	28,451	29,593
2B	13,001	17,681	26,132	32,372	33,673
2C	15,365	20,896	30,884	38,259	39,795
2D	16,547	22,504	33,259	41,202	42,857
3A	19,699	26,988	40,777	51,808	54,172
3B	21,275	29,147	44,039	55,953	58,506
4A	25,214	34,543	52,193	66,313	69,339
4B	28,760	39,401	59,533	75,639	79,090
5A	31,518	43,180	65,242	82,892	86,675
5B	37,034	50,737	76,660	97,399	101,844
6	43,338	59,373	89,710	113,979	119,180
7	46,490	63,691	96,234	122,269	127,848
8	61,066	83,660	126,407	160,604	167,932

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ILLINOIS - AREA 3

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	6,566	8,930	13,198	16,349	17,006
1B	8,755	11,907	17,598	21,800	22,675
1C	10,287	13,990	20,677	25,615	26,643
2A	12,695	17,265	25,517	31,611	32,880
2B	14,446	19,647	29,036	35,971	37,415
2C	17,072	23,218	34,315	42,509	44,216
2D	18,386	25,005	36,956	45,781	47,620
3A	21,888	29,987	45,308	57,565	60,192
3B	23,639	32,385	48,933	62,171	65,007
4A	28,016	38,382	57,993	73,682	77,044
4B	31,956	43,780	66,149	84,044	87,879
5A	35,020	47,977	72,491	92,103	96,305
5B	41,149	56,374	85,178	108,222	113,160
6	48,153	65,970	99,677	126,642	132,421
7	51,655	70,767	106,926	135,853	142,051
8	67,851	92,956	140,452	178,448	186,590

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	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

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ILLINOIS - AREA 4

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	100/300	200/600	500/1000	1000/1000	1000/3000
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

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ILLINOIS - AREA 5

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

0 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,334	1,814	2,681	3,322	3,455
1B	1,778	2,418	3,574	4,427	4,605
1C	2,090	2,842	4,201	5,204	5,413
2A	2,579	3,507	5,184	6,422	6,680
2B	2,934	3,990	5,897	7,306	7,599
2C	3,468	4,716	6,971	8,635	8,982
2D	3,735	5,080	7,507	9,300	9,674
3A	4,446	6,091	9,203	11,693	12,227
3B	4,802	6,579	9,940	12,629	13,206
4A	5,691	7,797	11,780	14,967	15,650
4B	6,491	8,893	13,436	17,071	17,850
5A	7,114	9,746	14,726	18,710	19,564
5B	8,358	11,450	17,301	21,982	22,985
6	9,781	13,400	20,247	25,724	26,898
7	10,493	14,375	21,721	27,597	28,856
8	13,783	18,883	28,531	36,249	37,903

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ILLINOIS - AREA 5

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

1 YEAR SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	1,847	2,512	3,712	4,599	4,784
1B	2,462	3,348	4,949	6,130	6,377
1C	2,894	3,936	5,817	7,206	7,495
2A	3,570	4,855	7,176	8,889	9,246
2B	4,063	5,526	8,167	10,117	10,523
2C	4,802	6,531	9,652	11,957	12,437
2D	5,171	7,033	10,394	12,876	13,393
3A	6,156	8,434	12,743	16,190	16,929
3B	6,648	9,108	13,761	17,484	18,282
4A	7,880	10,796	16,312	20,724	21,670
4B	8,988	12,314	18,605	23,638	24,717
5A	9,850	13,495	20,390	25,906	27,088
5B	11,573	15,855	23,956	30,437	31,826
6	13,543	18,554	28,034	35,618	37,243
7	14,528	19,903	30,073	38,209	39,952
8	19,084	26,145	39,504	50,191	52,481

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

2 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,078	4,186	6,187	7,664	7,972
1B	4,104	5,581	8,249	10,219	10,629
1C	4,823	6,559	9,694	12,009	12,492
2A	5,951	8,093	11,962	14,818	15,413
2B	6,772	9,210	13,612	16,862	17,539
2C	8,003	10,884	16,086	19,927	20,728
2D	8,618	11,720	17,322	21,459	22,321
3A	10,260	14,056	21,238	26,984	28,215
3B	11,081	15,181	22,938	29,143	30,473
4A	13,133	17,992	27,185	34,540	36,116
4B	14,980	20,523	31,009	39,397	41,195
5A	16,416	22,490	33,981	43,174	45,144
5B	19,289	26,426	39,928	50,730	53,045
6	22,572	30,924	46,724	59,364	62,073
7	24,214	33,173	50,123	63,683	66,589
8	31,806	43,574	65,838	83,650	87,467

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PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

3 YEARS SINCE RETROACTIVE DATE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	3,694	5,024	7,425	9,198	9,567
1B	4,925	6,698	9,899	12,263	12,756
1C	5,787	7,870	11,632	14,410	14,988
2A	7,141	9,712	14,353	17,781	18,495
2B	8,126	11,051	16,333	20,234	21,046
2C	9,603	13,060	19,302	23,911	24,872
2D	10,342	14,065	20,787	25,752	26,786
3A	12,312	16,867	25,486	32,381	33,858
3B	13,297	18,217	27,525	34,971	36,567
4A	15,759	21,590	32,621	41,446	43,337
4B	17,976	24,627	37,210	47,277	49,434
5A	19,699	26,988	40,777	51,808	54,172
5B	23,146	31,710	47,912	60,874	63,652
6	27,086	37,108	56,068	71,236	74,487
7	29,057	39,808	60,148	76,420	79,907
8	38,167	52,289	79,006	100,379	104,959

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ILLINOIS - AREA 5

PHYSICIANS AND SURGEONS

STANDARD CLAIMS-MADE RATES

MATURE

	LIMITS				
Class	**100/300**	**200/600**	**500/1000**	**1000/1000**	**1000/3000**
1A	4,104	5,581	8,249	10,219	10,629
1B	5,472	7,442	10,999	13,625	14,172
1C	6,430	8,745	12,924	16,011	16,654
2A	7,934	10,790	15,947	19,756	20,549
2B	9,029	12,279	18,148	22,482	23,385
2C	10,670	14,511	21,447	26,568	27,635
2D	11,491	15,628	23,097	28,613	29,762
3A	13,680	18,742	28,318	35,978	37,620
3B	14,774	20,240	30,582	38,856	40,629
4A	17,510	23,989	36,246	46,051	48,153
4B	19,973	27,363	41,344	52,529	54,926
5A	21,888	29,987	45,308	57,565	60,192
5B	25,718	35,234	53,236	67,638	70,725
6	30,096	41,232	62,299	79,152	82,764
7	32,285	44,230	66,830	84,910	88,784
8	42,408	58,099	87,785	111,533	116,622

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS RATE CLASSES

CLASS IA

NON-SURGICAL SPECIALISTS TO INCLUDE:
AEROSPACE, ALLERGY, DERMATOLOGY, FORENSIC MEDICINE, NUCLEAR, NUTRITION, OCCUPATIONAL MEDICINE, OPHTHALMOLOGY, PHARMACOLOGY, PHYSIATRY, PHYSICIANS NOT OTHERWISE CLASSIFIED, PREVENTATIVE MEDICINE, AND PUBLIC HEALTH.

CLASS IB

NON-SURGICAL SPECIALISTS TO INCLUDE:
ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, OTORHINOLARYNGOLOGY, PATHOLOGY, PSYCHIATRY, AND RHEUMATOLOGY.

CLASS IC

NON-SURGICAL SPECIALISTS TO INCLUDE:
DIABETES, FAMILY/GENERAL PRACTICE, NEPHROLOGY, AND URGENT CARE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: DERMATOLOGY AND OPHTHALMOLOGY.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIA

NON-SURGICAL SPECIALISTS TO INCLUDE INTERNAL MEDICINE, AND PEDIATRICS.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY (INCLUDING SWAN-GANZ), ENDOCRINOLOGY, GERIATRICS, GYNECOLOGY, AND OTORHINOLARYNGOLOGY.

SURGICAL SPECIALISTS PERFORMING ANESTHESIOLOGY, OPHTHALMOLOGY AND PAIN MANAGEMENT.

CLASS IIB

NON-SURGICAL SPECIALISTS TO INCLUDE HEMATOLOGY/ONCOLOGY, INFECTIOUS DISEASE, AND RADIOLOGY – DIAGNOSTIC.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE NEPHROLOGY, PATHOLOGY, PEDIATRICS, PSYCHIATRY - INCLUDING SHOCK THERAPY, PHYSICIANS NOT OTHERWISE CLASSIFIED, AND RADIOLOGY – THERAPY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS IIC

NON-SURGICAL SPECIALISTS TO INCLUDE: GASTROENTEROLOGY, NEUROLOGY, AND PULMONARY DISEASE.

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: INFECTIOUS DISEASE, NEONATOLOGY, NEUROLOGY AND RADIOPAQUE DYE INJECTION.

CLASS IID

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: CARDIOLOGY SPECIALISTS PERFORMING RIGHT HEART CATHETERIZATION ONLY, CARDIOLOGY SPECIALISTS PERFORMING CATHETERIZATION INCLUDING LEFT HEART, GASTROENTEROLOGY, INTERNAL MEDICINE, INTENSIVE CARE AND RADIOLOGY – DIAGNOSTIC.

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PHYSICIANS RATE CLASSES (CONT.)

CLASS IIIA

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: ACUPUNCTURISTS, FAMILY/GENERAL PRACTICE, AND HEMATOLOGY/ONCOLOGY.

SURGICAL SPECIALISTS IN GASTROENTEROLOGY, AND GERIATRICS.

CLASS IIIB

SPECIALISTS PERFORMING MINOR SURGERY OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS TO INCLUDE: AND FAMILY PRACTICE AND GENERAL PRACTICE – INCLUDING DELIVERIES.

SURGICAL SPECIALISTS IN COLON AND RECTAL SURGERY, FAMILY/GENERAL PRACTICE, OTORHINOLARYNGOLOGY (EXCLUDING PLASTIC), AND UROLOGY.

EMERGENCY MEDICINE - NO MAJOR SURGERY.

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STANDARD CLAIMS MADE PROGRAM

PHYSICIANS RATE CLASSES (CONT.)

CLASS IV-A

SURGICAL SPECIALISTS IN PLASTIC SURGERY (NO ELECTED COSMETIC), ORTHOPEDIC - HAND, AND ORTHOPEDIC - HEAD AND NECK.

CLASS IV-B

SURGICAL SPECIALISTS IN GYNECOLOGY, AND ORTHOPEDIC SURGERY (EXCLUDING SPINAL).

CLASS V-A

EMERGENCY MEDICINE - INCLUDING MAJOR SURGERY.

CLASS V-B

SURGICAL SPECIALISTS IN GENERAL SURGERY, PLASTIC SURGERY (NOT OTHERWISE CLASSIFIED), AND ORTHOPEDIC SURGERY (INCLUDING SPINAL).

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PHYSICIANS RATE CLASSES (CONT.)

CLASS VI

SURGICAL SPECIALISTS IN ABDOMINAL SURGERY.

CLASS VII

SURGICAL SPECIALISTS IN CARDIOVASCULAR SURGERY, TRAUMATIC SURGERY, THORACIC SURGERY, OBSTETRICS, AND OB/GYN AND VASCULAR SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY.

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DENTISTS

OCCURRENCE PROGRAM

CLAIM FREE CREDIT

IF NO CLAIM HAS BEEN ATTRIBUTED TO AN INSURED, THE INSURED WILL BE ELIGIBLE FOR PREMIUM CREDITS 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH STANDARD GUIDELINES APPLICABLE TO THE COMPANY'S INSUREDS.

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DENTISTS

STANDARD CLAIMS MADE PROGRAM

CLAIM FREE CREDIT

IF NO CLAIM HAS BEEN ATTRIBUTED TO AN INSURED, THE INSURED WILL BE ELIGIBLE FOR PREMIUM CREDITS 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.

YEARS IN PART-TIME PRACTICE WILL NOT BE CONSIDERED IN THE DETERMINATION OF YEARS CLAIM FREE. INSUREDS CONVERTING COVERAGE TO THE MEDICAL PROTECTIVE COMPANY, WHO WERE CLAIM FREE WHILE INSURED BY ANOTHER CARRIER, SHALL QUALIFY FOR CREDIT AT THE POLICY INCEPTION DATE IN ACCORDANCE WITH STANDARD GUIDELINES APPLICABLE TO THE COMPANY'S INSUREDS.

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DENTISTS

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 AND SCHEDULE RATING MODIFICATIONS.

MANUAL PAGES
FOR
COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

A. This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the following health care providers:

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Section

II. Corporations, Partnerships and Associations
III. Physicians and Surgeons
IV. Dentists
V. Allied Health Care Providers
VI. Health Care Facilities

B. This manual also specifies rules, rates, premiums, classifications and territories for the purpose of providing the following optional associated coverages to health care providers:

Section

VII. General Liability
VIII. Managed Care Entity Liability
IX. Pollution Liability

II. APPLICATION OF GENERAL RULES

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the respective Section or State Rate Pages.

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

III. POLICY TERM

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

IV. LOCATION OF PRACTICE

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

V. PREMIUM COMPUTATION

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

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

VI. FACTORS OR MULTIPLIERS

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

VII. WHOLE DOLLAR RULE

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

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

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

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

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

C. The Company may waive an additional premium of $100 or less for coverages related to Healthcare facilities. This waiver only applies to cash exchange due on an endorsement effective date.

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IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. a policy is canceled at the Company's request;

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider and is shown on the appropriate State Rate Pages.

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

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate State Rate Pages.

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XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the State Rate Pages.

XIII. COVERAGE

Coverage may be provided on either an Occurrence or Claims-Made basis, unless noted otherwise in the respective section or State Rate Pages. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Occurrence or Standard Claims-Made, subject to availability and identified on the State Rate Pages.

XIV. BASIC LIMITS OF LIABILITY

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

XV. INCREASED LIMITS OF LIABILITY

A. Individual Limits of Liability

1. Increased Limits factors shall be those shown as applicable for the respective insureds and be used to develop the applicable premium.

B. Shared Limits of Liability

1. Limits of Liability may be increased on a shared limits basis excess of an individual limit per insured.

2. The rate for the shared excess limits shall be computed in the following manner:

   a. The rate for the individual limit of liability and the total limit of liability shall be calculated in accordance with the State Rate Pages. The total limit of liability is the sum of the individual per occurrence limit and the shared per occurrence limit.

   b. The initial shared limits rate is the difference between the total limits rate and the individual limits rate .

   c. The initial shared limits rate may be modified subject to the restrictions identified on the State Rate Pages, based on the following objective considerations:

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i. The number and distribution by classification of insureds.

ii. The amount of the shared limit and its relationship to the size and distribution of the group.

iii. The amount of the individual limit (attachment point) underlying the shared limit.

3. The minimum individual limit over which a shared excess limit may be provided is identified on the State Rate Pages.

4. Requests for total limits of liability (the sum of the individual per health care occurrence limit and the shared excess per health care occurrence limit) that exceed the maximum limit of liability identified on the State Rate Pages shall be referred to the Company and (a) rated.

XVI. PRIOR ACTS COVERAGE

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

XVII. EXTENDED REPORTING PERIOD COVERAGE (Claims-Made Coverage only)

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

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the State Rate Pages to the standard mature claims made rate, applicable to the expiring policy, and subject to Experience, Part Time, Non -Discretionary Debit and Schedule Rating Modifications.

D. Premium must be paid, in accordance with state statutes, promptly when due.

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XVIII. GROUP PRACTICE

For the purpose of these rules, group practice shall be defined as a group of entities, physicians, dentists and/or allied health care providers rendering out-patient care who:

A. number 2 or more;

B. are organized as a legal entity;

C. share common facilities (including multiple locations) and support personnel.

XIX. MEMBERSHIP IN QUALIFIED ASSOCIATIONS

A. The unique characteristics of medical/dental practices and their membership in qualified professional associations shall make them eligible for premium modifications in addition to those available to all other groups.

B. Members of a qualified medical/dental group professional association shall be eligible for additional premium modifications.

1. Membership Credit

   a. A premium credit, identified on the State Rate Pages, shall be given to those insureds whose group is a member of a qualified association.

   b. A Qualified Association may include State Medical or Dental Societies.

2. Renewal Rate Rule

   a. If the group practice generates a manual premium in excess of $50,000, 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 and loss/claim free credit and non-discretionary credits will be applied in the usual manner.

   b. Only one consecutive renewal may receive application of this rule. The group practice may again qualify for this rule after the payment of one renewal premium based upon currently filed rates.

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I. APPLICATION OF MANUAL

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

1. Professional Corporations, Partnerships and Associations

2. Miscellaneous Entities

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

1. are organized as a legal entity;

2. maintain common facilities (including multiple locations) and support personnel; and

3. maintain medical/dental records of patients of the group as a historical record of patient care.

C. 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

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III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates (or premium per FTE/OPV rated policy) of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated on the State Rate Pages.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any modifications presented on the State Rate Pages.

3. 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 physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met.

4. The premium for professional corporations, partnerships and associations may be subject to premium caps or flat rates as indicated on the State Rate Pages and may be reduced or eliminated as part of credits provided to multi-physician practices.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy or FTE/OPV rated policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

C. The premium for other entities shall be referred to the Home Office for the determination of premium and filing with the state insurance department.

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IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

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

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

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

2. Including the following types of entities:

   a. Urgicare Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center
   f. Home Health Agency
   g. Nursing Home
   h. Physical Fitness Center

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 risk 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.

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B. Deductible/Self-Insured Retention Credits

1. Deductibles

a. Deductibles shall be offered to qualified insureds.

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 75% 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 SIR limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

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A. **Classification**

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

2. Not otherwise identified as a Miscellaneous Entity.

B. **Manual Rates**

1. **Corporations, Partnerships & Associations Rating Factors**
(Occurrence & Standard Claims Made Programs)

Specialty	Factor	Solo Corporation Rating
Physicians	10%	Available
Dentists	10%	Available
Allied	$500	Available

a. Subject to Premium Caps (Applicable to Physicians and Surgeons Only)

LIMIT	Area 1 CAP	Area 2 CAP	Area 3 CAP	Area 4 CAP	Area 5 CAP
1000/3000 and below	$70,500	$44,600	$37,600	$23,500	$23,500
2000/4000	$93,000	$58,900	$49,600	$31,000	$31,000
3000/5000	$94,000	$59,600	$50,200	$31,300	$31,300
4000/6000	$99,700	$63,100	$53,200	$33,200	$33,200
5000/7000	$103,900	$65,800	$55,400	$34,600	$34,600
6000/8000	$108,100	$68,500	$57,700	$36,000	$36,000
7000/9000	$111,300	$70,500	$59,400	$37,100	$37,100
8000/10000	$114,300	$72,400	$60,900	$38,100	$38,100
9000/11000	$116,800	$74,000	$62,300	$38,900	$38,900
10000/12000	$118,600	$75,100	$63,300	$39,500	$39,500

b. A flat fee of $500 for 100/300 limits shall apply if the Corporation, Partnership or Association consists only of Allied Health Care Providers. For higher limits, apply the AHCP increased limits factors found in Section V rate pages for AHCP classes 1A-5.

2. **Miscellaneous Entities**

NOT AVAILABLE

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3. **Extended Reporting Period Coverage Factors**

Years Retroactive Date Precedes Expiration Date	Physicians & Surgeons	Dentists	Allied – Classes 1A-4	Allied – Classes 5-8B
1	0.900	0.900	.7500	.7000
2	1.500	1.500	1.000	1.000
3	1.700	1.750	1.100	1.150
4	1.820	1.750	1.150	1.200
5 or more	1.820	1.750	1.200	1.250

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

Specialty Type	Minimum Premium
Physician & Surgeons	$250
Dentists	$25
Allied Health Care Providers	$50

The highest applicable minimum premium shall prevail.

D. **Premium Modifications**

1. **Schedule Rating – Partnerships & Corporations**
(Occurrence & Standard Claims Made Programs)

Specialty Type	Limited to a Maximum Modification of:
Physician & Surgeons	+/- 50%
Dentists	+/- 35%
Allied Health Care Providers	+/- 50%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers and can be found in the Physician/Surgeon, Dentists or Allied Health Care Provider Section of the State Rate Pages.

2. Deductible Credits

NOT AVAILABLE

3. Self-Insured Retention Credits

NOT AVAILABLE

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I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons.

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 physician, shown on the State Rate Pages, in accordance with each physician's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons

1. Each medical 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.

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B. Part Time Physicians

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 and membership association credits.

C. Physicians in Training

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

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

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

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

   Note: Do not confuse a physician in a fellowship training program with a fellow, for example, of American College of Surgeons.

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

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. Refer to the Company to determine the applicable credit.

3. Coverage is available for a physician's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program. The applicable physician class for moonlighting activities, as identified in the class plan, will be utilized to determine the rate. If no such classification is identified, the applicable premium will be computed as follows.

   a. The premium will be based upon the equivalent medical specialty rate and the average number of hours the insured practices per week.

   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.

D. Locum Tenens Physician

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

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

E. New Physician

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

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a. Residency;

b. Fellowship program in their medical specialty;

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

d. Medical school or specialty training program.

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

3. A reduced rate will be applied in accordance with the credits shown on the State Rate Pages.

F. Physician Teaching Specialists

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

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

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

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

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.

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G. Physician's Leave of Absence

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

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

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

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

H. Military Leave of Absence

1. A dentist who is on military leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a discount presented in the state rate pages. This will apply retroactively to the first day of the leave of absence. Only on application of this credit may be applied to an annual policy period.

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 risk 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.

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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.

C. Claim Free Credits

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit 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, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidlines.

   c. Years Part time will not be considered in the determination of years claim free.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Deductibles shall be offered to qualified insureds.

   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.

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iii. The maximum premium credit is limited to 75% 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 claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

a. Premiums paid
b. Number of claims
c. Incurred losses
d. 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.

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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 made against the insured during the past 5 years pursuant to the Schedule A, located in the State Rate Pages.

However, Providers who have been insured with the Company for less than five years will have their points adjusted pursuant to the following formula:

Adjusted Points = (5 / # of Full Years of Experience) x Points

Insureds with Less than one year of experience shall be assumed to have one year of experience.

A debit shall then be applied to the insured's rate based upon Schedule B, located 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.

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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 losses attributed to the insured. (A loss 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 coverage.

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 and schedule rating modifications.

B. Enhanced Claims-Made

1. Insureds shall be provided the option, subject to underwriting guidelines, to purchase Claims-Made coverage under the Enhanced rating structure.

2. The Enhanced Claims-Made base rate is developed as a percentage of the applicable Occurrence rate. The applicable percentage is identified on the State Rate Pages.

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3. The Enhanced Claims-Made base rate is subject to Loss Free Credits in accordance with the schedule provided on the State Rate Pages. The application of the credits shall be consistent with the criteria identified in V(C) of this section of the manual.

C. Slot Rating

1. Coverage for group practices is available, at the Company's option, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

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

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit cannot be used in conjunction with this rating rule.

D. 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 physician basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each physician's number of hours of medical practice per year. The definition of one FTE is based on the following number of hours per year:

2,500 - Group Practice
2,100 - Residency Programs

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2. For group practices, the minimum average FTE assigned to individual physicians is .05 (125 hours), subject to a total FTE per policy of no less than 1.0. Residency programs (and other similar programs) are not subject to the group practice minimums.

3. The premium developed by applying the applicable per physician rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the physician rates. This adjustment will not apply to residency programs since the individual policies generally represent less than one FTE.

4. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

5. Premium modifications for new physician, part time, moonlighting, teaching, loss free credit or other similar credit cannot be used in conjunction with this rating rule.

E. 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 physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of out-patient visits equivalent to a physician 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.

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3. The applicable medical 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 physician, part time, moonlighting, teaching, loss free credit, or other similar credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and an Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability or permanent retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. Insureds within a group may qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

   a. The insured anticipates permanent retirement from his or her profession in less than five years.

   b. The insured has attained age 55.

   c. The insured has claims-made coverage with the Company in a group practice.

   d. The insured has limited prior acts exposure based upon underwriting review.

   e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 3.

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G. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the state rate pages.

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

Physician & Surgeons	$250

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit	Max Agg Hours Per Year
0-10	50%	515
11-20	30%	1050

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. **Physicians in Training**

a. Training Activities

NOT AVAILABLE

b. Moonlighting Activities

NOT AVAILABLE

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

AVAILABLE

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

Years New to Practice	Credit
1st	50%
2nd	30%

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5. **Physician Teaching Specialists**

   a. Training Activities

NOT AVAILABLE

   b. Teaching Specialists

NOT AVAILABLE

6. **Physicians Leave of Absence**

Program	Credit
Occurrence	75%
Standard Claims Made	50%

7. **Physicians Military Leave of Absence**

Program	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Medical 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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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

Year	Credit
1	5%
2	5%
3	5%

10. **Claim Free Credits**
(Occurrence & Standard Claims Made Programs)

Years Claim Free at Renewal	Credit
3 but less than 5	5%
5 but less than 10	10%
10 or more	20%

11. **Deductible Credits**

NOT AVAILABLE

12. **Self-Insured Retention Credits**

NOT AVAILABLE

13. **Experience Rating**

NOT AVAILABLE

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14. **Non-Discretionary Debit Rating Plan**
(Occurrence & Standard Claims Made Programs)

Schedule A:

Closed 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 $100,00 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	10%	0%
4	25%	10%
5	25%	25%
6	35%	35%
7	35%	35%
8	50%	50%
9	100%	100%
10+	200%	200%

For the purposes of schedule B, table B shall apply to all insureds practicing under the following ISO codes: 80106, 80143-80146, 80150-80156, 80158-80160, 80166-80171, 80176, 80273, 84106, 84143-84146, 84150-84156, 84158-84160, 84166-84171, 84176 and 84273. Table A, in Schedule B, shall apply to Insureds practicing under any other ISO Code.

15. **Convertible Coverage Rating Plan**

NOT AVAILABLE

16. **Enhanced Claims Made Rating**

NOT AVAILABLE

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17. **Slot Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

19. **Accelerated Extension Contract Rating**
(Standard Claims Made Programs)

AVAILABLE

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

AVAILABLE

21. **Renewal Rate Rule**

NOT AVAILABLE

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

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.

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

Credit
5%

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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.

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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 and membership association credits.

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 a dentist's "moonlighting" activities. The coverage will not apply to any aspect of the insured's training program.

   a. The premium will be based upon the equivalent dental specialty rate and the average number of hours the insured practices per week.

   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 modifications applicable to the manual rates are presented on the State Rate Pages.

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.

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. 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.

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G. Dentist's Leave of Absence

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

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

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

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

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 risk 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.

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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, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with standard guidelines.

   c. Years Part time will not be considered in the determination of years claim free.

D. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Deductibles shall be offered to qualified insureds.

   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 75% 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.

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 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.

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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. 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. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

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.

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. Insureds within a group may qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

a. The insured anticipates retirement from his or her profession in less than five years.

b. The insured has attained age 55.

c. The insured has claims-made coverage with the Company in a group practice.

d. The insured has limited prior acts exposure based upon underwriting review.

e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 3.

F. Deferred Premium Payment Plan.

1. The Company may, at its discretion, offer the insured various premium payment options. For determination and eligibility, refer to the State Rate Pages.

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

Dentists	$100

D. **Premium Modifications**

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

Hours Practicing Per Week	Credit
0-10	50%
11-20	30%

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

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

NOT AVAILABLE

c. Dental Externship / Board Exam
(Occurrence Program)

Coverage Type	Limit	Premium
Occurrence	1000/3000	$25

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

AVAILABLE

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

Years New to Practice	Credit
1st	50%
2nd	30%
3rd	15%

5. **Dentist Teaching Specialists**

a. Training Activities

NOT AVAILABLE

b. Teaching Specialists

NOT AVAILABLE

6. **Dentist Leave of Absence**

Program Type	Credit
Occurrence	75%
Standard Claims Made	50%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Dental Standards, Quality & Claim Review.	Presence of (1) committees that meet on a routine basis to review dental 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 undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures.	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in dental treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification - 50% / + 50%	

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

Years Since Training	Credit
1	5%
2	5%
3	5%

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

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

10. **Deductible Credits**

NOT AVAILABLE

11. **Self-Insured Retention Credits**

NOT AVAILABLE

12. **Experience Rating**

NOT AVAILABLE

13. **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.

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

AVAILABLE

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

AVAILABLE

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

AVAILABLE

17. **Renewal Rate Rule**

NOT AVAILABLE

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

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.

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

AVAILABLE

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

Credit
5%

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 Allied Health Care Providers.

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 provider, shown on the State Rate Pages, in accordance with each provider's classification and class plan designation.

IV. CLASSIFICATIONS

A. Allied Health Care Providers

1. Each provider 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.

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B. Part Time Allied Health Care Providers

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. 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 the risk management credit.

C. Dental Hygienist Training

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

2. Coverage is available to students for activities directly related to their licensing.

   a. Coverage is available to students, on a short-term basis, for services rendered by the student during a dental hygiene externship prior to graduation and/or during the dental hygiene board exam pursuant to the student's professional licensing.

   b. The coverage for students will be provided on an occurrence basis. The limits and premium are identified on the State Rate Pages. 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 hygiene board exam.

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D. Locum Tenens Allied Health Care Provider

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

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

E. Allied Health Care Provider's Leave of Absence

1. An allied health care provider who becomes disabled, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

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

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

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

F. Military Leave of Absence

1. A dentist who is on military leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a discount presented in the state rate pages. This will apply retroactively to the first day of the leave of absence. Only on application of this credit may be applied to an annual policy period.

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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 risk 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.

C. Deductible/Self-Insured Retention Credits

1. Deductibles

   a. Deductibles shall be offered to qualified insureds.

   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.

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ii. The insured may select an aggregate deductible limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% 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.

D. 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

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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.

3. The application of this modification precludes the use of all other rules based upon loss experience criteria.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

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

B. 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 practitioner basis. Coverage is provided on a shared or individual limit basis. Full time equivalency is based on each practitioner's number of hours of service per year. The definition of one FTE is based on the following number of hours per year:

   2,500 - Group Practice

2. For group practices, the minimum average FTE assigned to individual practitioners is .05 (125 hours), subject to a total FTE per policy of no less than 1.0.

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3. The premium developed by applying the applicable per practitioner rate to the corresponding FTE will be adjusted to reflect loss cost considerations not recognized in the practitioner rates.

4. The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

FTE* Per Policy	Premium Modification	FTE* Per Policy	Premium Modification
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.

5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

C. 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 practitioner basis. Coverage is provided on a shared or individual practitioner limit basis.

2. The number of out-patient visits equivalent to a practitioner 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 3 visits per hour and a maximum rate of 6 visits per hour.

3. The applicable classification 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.

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4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for part time credit cannot be used in conjunction with this rating rule.

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

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of disability or retirement by the insured, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. An insured, classified as 4B and above, shall qualify for Accelerated Extended Reporting Period Coverage, for no additional premium, if the following underwriting requirements have been met:

   a. The insured anticipates retirement from his or her profession in less than five years.

   b. The insured has attained age 55.

   c. The insured has claims-made coverage with the Company in a group practice.

   d. The insured has limited prior acts exposure based upon underwriting review.

   e. The total number of insureds, within a group practice, qualifying for Accelerated Extended Reporting Period Coverage should not exceed a ratio of 1 in 10.

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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

Dental Assistant, Dental Hygienist.

CLASS I-B

Cardiology Technologist, Clinical Laboratory Technologist, Counselor, Dietician, Electrocardiograph Technician, Electroneurodiagnostic Technologist, Licensed Practicing Nurse, Medical Laboratory Technician, Medical (Office) Assistant, Medical Records Technician, Nuclear Medicine Technologist, Ophthalmology Technician, Respiratory Therapy Assistant, Registered Nurse.

CLASS II

Audiologist/Speech Pathologist, Nurse Midwife Assistant, Occupational Therapist Assistant, Optician, Physical Therapy Assistant, Radiation Therapy Technologist, Social Worker, Surgical Technician, X-Ray Technician.

CLASS III

Optometrist, Paramedic/EMT, Pharmacist, Physical Therapist (Non-Owner).

CLASS IV

Case Manager, Occupational Therapist, Perfusionist, Physical Therapist (Owner), Psychologist, Respiratory Therapist.

CLASS V

Nurse Practitioner (Non-prescribing), Physician's Assistant (Non-prescribing).

CLASS VI

Nurse Surgical Assistant, Physician Surgical Assistant.
Nurse Practitioner (Prescribing), Physician's Assistant (Prescribing).

CLASS VII-A

Certified Registered Nurse Anesthetist, Registered Nurse Anesthetist.

CLASS VII-B

Nurse Midwife.

CLASS VIII-A

Podiatrist (No Surgery)

CLASS VIII-B

Podiatrist (Surgery).

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B. Manual Rates

1. Territory Definitions

Refer to Program Type for the Territory definition and description.

2. Occurrence Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

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3. Standard Claims Made Program.

Class	Rate
1A	5% of 80211 base rate (General Dentistry)
1B	3% of 80420 base rate (Family/General Practice – No Surgery)
2	5% of 80420 base rate (Family/General Practice – No Surgery)
3	7% of 80420 base rate (Family/General Practice – No Surgery)
4	14% of 80420 base rate (Family/General Practice – No Surgery)
5	18% of 80420 (Family/General Practice – No Surgery)
6	22% of 80420 (Family/General Practice – No Surgery)
7A	25% of 80151 (Anesthesiology)
7B	40% of 80153 (Obstetrics/Gynecology)
8A	25% of 80176 (Orthopedic Surgery – Excluding Spinal)
8B	50% of 80176 (Orthopedic Surgery – Excluding Spinal)

a. The Mature Standard Claims Made rate for is 0.920 of the corresponding Allied Health Care Provider Occurrence rate.

b. Allied Health Care Provider Claims Made Factors may be applied to the Mature Standard Claims Made base rate for the applicable year of claims made coverage.

c. Rates for limits higher than 100/300 limits are calculated by applying the Allied Health Care Provider increased limit factors to the base rate.

3. Increased Limits Factors

Limits	Classes 1A-5	Classes 6-8B
100/300	1.000	1.000
200/600	1.220	1.260
500/1000	1.460	1.630
1000/1000	1.750	1.940
1000/3000	1.800	2.000
2000/2000	2.050	2.410
2000/4000	2.120	2.480
3000/3000	2.220	2.680
3000/5000	2.290	2.750

A minimum of 1000/3000 underlying limits required in order to purchase shared excess limits.

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4. Extended Reporting Period Coverage Factors

Years Retro. Date Precedes Expiration Date	Classes 1A-4	Classes 5-8B
1	0.750	0.700
2	1.000	1.000
3	1.100	1.150
4	1.150	1.200
5 or more	1.200	1.250

a. Factor applies to Mature Claims-Made Allied Health Care Provider rate.

5. Claims Made Factors

Years Since Retroactive Date	Class 1A-4	Classes 5-8B
0	0.60	0.45
1	0.80	0.70
2	0.90	0.85
3	0.95	0.90
4 or More	1.00	1.00

6. Shared Limits Modification

Modification
Up to 25%

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

Allied Health Care Provider	$50

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D. Premium Modifications

1. Part Time Allied Health Care Provider
(Occurrence & Standard Claims Made Programs)

Hours Practicing Per Week	Max Aggregate Hours Per Year	Credit
0-10	515	50%
11-20	1050	30%

Part Time Credits are available for AHCP Classes 4-8B Only.

*The part-time credit is not applied to the Extended Reporting Period Coverage rating unless the part time practice did not exceed an average of 1050 hours/year over the previous five consecutive policy years with the company.

2. Dental Hygienist in Training

NOT AVAILABLE

3. Locum Tenens

NOT AVAILABLE

4. Leave of Absence

NOT AVAILABLE

5. Military Leave of Absence

Program Type	Credit
Occurrence	100%
Standard Claims Made	100%

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

Consideration(s)	Description
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 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 from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures.	Specific operational activities 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 influences the frequency and/or severity of claims.
7. Organizational Size / Structure.	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
8. Medical 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.
9. Other Risk Management Practices and Procedures.	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & 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.
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.
Maximum Modification - 50% / + 50%	

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

Years Since Training	Credit
1	5%
2	5%
3	5%

8. **Deductible Credits**

NOT AVAILABLE

9. **Self-Insured Retention Credits**

NOT AVAILABLE

10. **Experience Rating**

NOT AVAILABLE

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

AVAILABLE

12. **Full-Time Equivalency Rating**

NOT AVAILABLE

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

AVAILABLE

14. **Accelerated Extension Contract Rating**

NOT AVAILABLE

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