

December 6, 2007

Ms. Gayle Neuman  
Illinois Department of Insurance  
320 West Washington Street  
Springfield, IL 62767

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400  
A ProAssurance Company  
Line of Business - Medical Malpractice - Class 2 Clause (c)  
Medical Professional Liability  
Company Filing #PIC-MPL-1207

39-1567580 ✓

**FILED**

DEC 15 2007

Dear Ms. Neuman:

STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
SPRINGFIELD, ILLINOIS

I am submitting for your review and approval revisions to the underwriting rules for Physicians Insurance Company of Wisconsin. I request the effective date of December 15, 2007 for this filing submission.

The revisions to the rules are outlined on the marked pages of the underwriting manual and replace the pages in Company Filing Number PL IL2004R06, effective December 1, 2004. New language is underlined and deleted language is stated to the right of the page. I have also attached the manual pages in final form.

If this filing is acceptable, please return one copy of the filing with your stamp of approval in the postage paid envelope that is enclosed for your convenience. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at [lgoodwin@proassurance.com](mailto:lgoodwin@proassurance.com).

Sincerely,

LaQuita B. Goodwin  
Compliance Specialist

Enclosures

1-0  
MEM  
RUL

## Neuman, Gayle

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**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Monday, June 25, 2012 3:35 PM  
**To:** Neuman, Gayle  
**Subject:** RE: Physicians Ins Co of Wisconsin - Rate/Rule Filing #PIC-MPL-1207

Ms. Neuman,

This filing was put in effect on December 15, 2007 and we would like to keep this effective date.

Thanks.

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**From:** Neuman, Gayle [<mailto:Gayle.Neuman@illinois.gov>]  
**Sent:** Monday, June 25, 2012 3:32 PM  
**To:** Goodwin, LaQuita  
**Subject:** Physicians Ins Co of Wisconsin - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

The Department of Insurance has now completed its review of the filing referenced above. Originally, Physicians Insurance Company of Wisconsin requested the filing be effective December 15, 2007. Was the filing put in effect on December 15, 2007 or do you wish to have a different effective date?

Your prompt response is appreciated.

*Gayle Neuman*

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

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

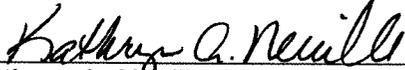
THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE DESTROY IT AND NOTIFY US BY SENDING AN E-MAIL TO: [GAYLE.NEUMAN@ILLINOIS.GOV](mailto:GAYLE.NEUMAN@ILLINOIS.GOV).

# 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, Kathryn A. Neville, a duly authorized officer of Physicians Insurance Company of Wisconsin, Inc., 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 also certify that all changes made were disclosed, no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

I, Howard H. Friedman, a duly authorized actuary of Physicians Insurance Company of Wisconsin, Inc., 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.

  
\_\_\_\_\_  
Kathryn A. Neville, Vice President  
Signature and Title of Authorized Insurance Company Officer

4/22/08  
Date

  
\_\_\_\_\_  
Howard H. Friedman, ACAS, MAAA, Senior Vice President  
Signature, Title and Designation of Authorized Actuary

4/22/08  
Date

Insurance Company FEIN 39-1567580 Filing Number PIC-MPL-1207

Insurer's Address 100 Brookwood Place

City Birmingham State Alabama Zip Code 35209

Contact Person's:

-Name and E-mail LaQuita B. Goodwin, Compliance Specialist - lgoodwin@proassurance.com

-Direct Telephone and Fax Number (205) 877-4426 - Fax (205) 414-2887

G. Fully Paid-Up Tail Benefit: If the insured meets any of the following conditions, he or she will receive the Death, Disability and Retirement (DDR) Extended Reporting Coverage at no additional cost:

1. Death;
2. Permanent and total disability that renders the insured completely unable to continue his or her practice;
3. Full retirement from practice (any specialty) and completion of at least five (5) continuous years coverage with us, ending on the date of retirement.

Before we issue such an Extended Reporting Coverage, we will require proof of eligibility from the insured.

The DDR Extended Reporting Coverage will become effective at the end of the policy period during which the insured meets one of the preceding conditions and will provide a new set of coverage limits and an unlimited extended reporting period.

H. Resumption of Practice: If at any time in the future the insured resumes his or her practice to any extent, any Extended Reporting Coverage issued pursuant to Sections XII.G or XII.H will terminate as of the time the insured resumes his or her practice.

The insured will then have the right to purchase Extended Reporting Coverage upon payment of the proper premiums, in accordance with the terms of our policy.

I. Eligibility: Any healthcare provider or entity insured under a primary policy issued by the Company is eligible for and entitled to purchase Extended Reporting Coverage.

**Deleted: Credit Toward Cost of Extended Reporting Coverage Upon Retirement:** If the insured chooses to retire completely from the private practice and is not eligible for the fully paid-up tail benefit described in Section XII.G, the insured may be eligible for credit toward the purchase price of Extended Reporting Coverage for which he or she may apply. (See Manual Pages.)¶

¶ Before we will provide this credit, we must receive written notification within thirty (30) days after the end of the policy period during which the insured fully retires. We will require reasonable proof that the insured has fully retired from his or her practice prior to issuing this Extended Reporting Coverage.¶

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### **XIII. *Partnership, Professional Corporation or Professional Association Coverage***

Partnerships, professional corporations (including solo corporations), or professional associations may receive a primary insurance policy at the option of the insured (unless required by law) at a charge that is based on the net premium charge for the individual healthcare providers of the entity, provided that the Company insures all principals as individuals. (See Manual Page A) Exceptions to this “all-or-none” rule may be made at the Company’s discretion. The minimum premium charge for this coverage is \$100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

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### **XIV. *Employee Professional Liability Coverage***

- A. Definitions: Employees (other than a physician or resident) are covered under an insured’s policy if they are employed by the named insured and are acting within the scope of their duties as such. Refer to the policy for the definition of employees.
- B. Limits of Liability: Such employees share in the limits of liability with their employer. They do not receive their own individual limits of liability. In some cases, individual limits of liability are available for employees at an additional charge. See Rate Pages.

All other manual rates are applicable.

### **XV. *Prior Acts Coverage -- Applies To Claims-Made Policies Only***

For insureds who have been covered under a claims-made policy with another insurance carrier, we can offer Prior Acts Coverage, subject to underwriting approval. Prior Acts Coverage will recognize the insured's retroactive date under the previous policy. However, special rules for claims apply to Prior Acts Coverage, as specified in the most current policy form.

Prior Acts Coverage is limited to activities in those states where PIC Wisconsin is licensed to write professional liability coverage, or where we are legally allowed to and have agreed to do so. If we are unable to provide Prior Acts Coverage due to licensing or underwriting restrictions, the insured must obtain Extended Reporting Coverage for that exposure from their previous carrier. Rating for Prior Acts Coverage is based on the same criteria as the insured's base coverage, including retroactive date, specialty classification and other applicable factors as described throughout this Rule and Rating Manual.

### **XVI. *Experience Rating Plan***

The experience rating plan provides an adjustment to a policyholder's current premium, based on the loss history of that particular policyholder.

The experience modification factor is applied to the rate developed from the rates and rules in our standard filing. The experience modification factor is derived from a formula-based credibility factor. The credibility factor is the result of the expected claim count of the policyholder, as developed from past claims history.

A. Surcharge and/or Coverage Exclusion

The surcharge mechanism will be used to account for claim severity, although it could be used for claim frequency, as identified through a review of the insured's claim file, through discussions with the claim examiner and evaluation of expert medical reviews. This surcharge system involves the assessment of a predetermined surcharge scale. (See Manual Pages.)

The five-year evaluation period is calculated on a calendar-year basis, retroactive from January 1 of the policy year in which the review is being conducted.

B. Mandatory Deductible

The deductible mechanism may be applicable when a policyholder exhibits a pattern of claim frequency that exceeds the average for his/her specialty. In the consideration of a deductible assessment, severity is usually not an issue.

Deductibles may be imposed in amounts from \$1,000 to \$250,000 per claim. There is no corresponding premium discount, and there are no aggregate limits on mandatory deductibles.

An amendatory deductible endorsement will be added to the policy at renewal and will be maintained for no less than one year. The policy will be subject to an annual review thereafter for consideration of a revised sanction.

**XVIII. Rate Adjustments for Changes in Exposure – Claims-made, Retroactive and Reporting Endorsement Coverage**

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

Deleted: *Reduction*

Deleted: *Medical*

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Healthcare providers who reduce their practice specialty may be eligible to be rated at a lower classification rate. There will also be a one-time charge to provide for the difference in specialty exposure anticipated for claims expected to be reported after the specialty change (claims-made coverage). This one-time charge may be reduced or eliminated (See Manual Pages).¶

¶

This also applies to healthcare providers who reduce their specialty as a result of partial disability.¶

Page Break

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

#### B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

#### C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

\_\_\_\_\_ Gynecology reporting endorsement premium for claims-made year two,  
\_\_\_\_\_ plus OB/GYN reporting endorsement premium for claims-made year five,  
\_\_\_\_\_ less OB/GYN reporting endorsement premium for claims-made year two.

#### D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

#### XIX. *Voluntary Deductibles*

In exchange for a reduction in their premium, some insureds opt to accept a portion of the risk. The Company maintains responsibility for making indemnity payments on the insured's behalf, up to the limits defined in the policy. However, the insureds who select a deductible option agree to reimburse us up to the deductible amount specified on their Declarations, Coverage Summary or any Deductible Endorsement.

Refer to the state programs section of the manual for the applicable deductible credits.

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**HEALTHCARE PROVIDERS  
PROFESSIONAL LIABILITY  
MANUAL PAGES**

• ***Healthcare Entities, Partnership, Professional Corporation or Professional Association Coverage***

Healthcare entities, professional corporations, associations or partnerships (including solo corporations) may receive a primary policy at the option of the insured (unless required by law) at a 0 - 10 percent charge, unless specified in the State Program pages, that is based on the net premium charge for the individual insured healthcare providers of the entity, provided that the Company insures all principals and employed healthcare providers as individuals. The covered entity will receive a separate set of limits for the 0 - 25 percent charge, unless where specified in the State Exceptions pages. The minimum premium charge for this coverage is \$100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

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• ***Employee Professional Liability***

Professional employees (other than nurse anesthetists, certified nurse midwives, physicians, residents, surgeons or dentists) of a partnership, professional corporation, professional association or an individual practitioner may be included under policies issued to their employers at no additional charge. The employees' limits of liability will be shared with the named insured, unless separate limits of liability are purchased. These employees may also receive their own individual policy with separate limits of liability, dependent on the scope of their practice.

Additional Professional Employee Charges

If the professional employee shares in the limits of liability with their employer, the following additional charges will be added to the named insured's policy, as appropriate.

• Physician or Surgeon Assistant: 80116

No Additional Charge.

• Certified Nurse Midwives:

Refer to rate page for Ancillary Coverages.

• Advanced Practice Nurse Prescribers:

No Additional Charge.

• Vicarious Liability for Contract Healthcare Providers:

The rate for vicarious liability for contract healthcare providers will be 10% of the mature claims-made rate, regardless of maturation, or 10% of occurrence, depending on the policy, for the self-employed healthcare provider. The additional charge does not apply if the employer/ full-time contractor is also insured by our Company.

• ***Suspension of Coverage (Not available in Nebraska)***

The rate for healthcare providers who are eligible for the Suspension of Coverage benefit will be 0 percent of the applicable claims-made premium that corresponds to the period of time during which the healthcare provider suspends coverage. The healthcare provider's premium will still account for any previous exposure that the healthcare provider faced.

The Suspension of Coverage provision in the Exposure Reduction Endorsement will indicate the date on which the healthcare provider anticipates to return to practice. For rating purposes, this date will serve as the ending date of the suspension of coverage period. However, if the healthcare provider actually returns to active practice on a date that differs from this indicated date, we will adjust the premium to reflect the actual ending date of the suspension period. Upon returning to practice, the healthcare provider will receive an Amendatory Endorsement that will clearly specify the period of suspension of coverage. Please note State Exceptions pages for specific state rules.

• ***Anesthesiologist's Program***

Anesthesiologists and certified registered nurse anesthetists (CRNAs) who indicate that they utilize a pulse oximeter and an end-tidal CO2 analyzer in the administration of anesthesia will be rated at 60 percent of the applicable claims-made premium. It is assumed that this equipment is being utilized, and the credit is built into the manual rate. If the equipment is not used, a surcharge will be applied to the premium for the insured that does not utilize this equipment.

• ***Schedule Credit / Debit Program***

To recognize the unique risk characteristics of our insureds, we may apply debits or credits that reflect the nature of a particular insured's practice. The maximum deviation available under this program varies by state. See unique state program pages per state.

Credits for insureds will be determined on the basis of our evaluation of each insured's risk profile. This assessment may consider such characteristics as loss experience, management, employees, patient medical records, quality assurance, facilities and billing procedures, and other criteria, as appropriate. This program only applies if a schedule rating plan is shown in this manual for the applicable market.

**Deleted:** • *Extended Reporting Coverage Credit Options*

If the insured chooses to retire completely from their private practice and is not eligible for the fully paid-up tail benefit, that insured may be eligible for credit toward the purchase price of Extended Reporting Coverage for which he or she may apply.

.....Section Break (Next Page).....

• Rate Adjustments for Changes in Exposure – Claims-Made, Retroactive and Reporting Endorsement Coverage

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the current practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the previous practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the current practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

**Deleted:** The credit for this Extended Reporting Coverage is calculated in the following manner:¶

¶  
¶ If the insured retires, the insured will receive credit for one-sixtieth (1/60th) of the premium for the Extended Reporting Coverage for each consecutive month of claims-made coverage that the insured has had with us, ending on the date of retirement.¶

¶  
¶ Before we will provide this credit, we must receive written notification within thirty (30) days after the end of the policy period which the insured fully retires. We will require reasonable proof that the insured has fully retired from their practice prior to issuing this Extended Reporting Coverage.¶

**Deleted:** ¶

• Change in Practice Specialty¶

¶  
¶ Healthcare providers who reduce their practice specialty may be rated at a lower classification at the time of the change. For claims-made coverage, the new rate will be based on the maturity of claims-made coverage for the lower rated specialty.¶

¶  
¶ Similarly, healthcare providers who increase their practice specialty may be rated at a higher classification rate at the time of change. For claims-made coverage, the new rate will be based on the maturity of claims-made coverage for the higher rated specialty.¶

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Gynecology rate for claims-made year five,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

#### B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

#### C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

    Gynecology reporting endorsement premium for claims-made year two,  
    plus OB/GYN reporting endorsement premium for claims-made year five,  
    less OB/GYN reporting endorsement premium for claims-made year two.

#### D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

• **Risk Management Modification Plan**

	Total Credit/Debit
A. APPROVED PROGRAMS, INCLUDING SELF STUDY KITS OR SEMINARS	5 - 15%
- Evidence of completed seminar agenda or outline, completed within a reasonable timeframe	
- Complete approved self-study kit	
B. EXISTING RISK MANAGEMENT PROCEDURES IN PLACE	
Risk Management Survey	10-15%

Maximum modification based on A and B above is 25%.

NOTES:

- A. To receive credit for attending an approved Risk Management seminar:
1. It must have been attended within an acceptable timeframe of the inception date of the policy.
  2. It must be a seminar that is approved as a Risk Management Seminar, relating to Risk Management topics including, but not limited to, informed consent or medical records. Information, such as a brochure or flyer describing the seminar, is necessary to determine this.
  3. We must receive evidence of attendance, such as a certificate of completion.
  4. To receive credit for the self-study program, a test or other evidence of completion must be presented to PIC Wisconsin.
- B. To receive credit for procedures in place, the appropriate general, anesthesiology, radiology, or emergency medicine form must be completed. The categories of questions reviewed in these surveys include, in order of weighted importance: Medical Records (45% weight), Patient Management (15% weight), Informed Consent (15% weight), Patient Relations (15% weight), Employee Management (5.0% weight) and Regulatory Compliance (5% weight).

**Deleted: <#>Contractual Liability Coverage¶**

This optional coverage waives the contractual liability exclusion and will defend and indemnify our insured in the event our insured becomes legally obligated to defend and / or indemnify a third party, such as a hospital or managed care organization. However, we limit this to professional healthcare services provided by or on behalf of our insured (including employees). Coverage limits are as specified on the endorsement issue, at a rate of \$100 for each set of limits issued.¶

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36 Month Reporting Period  
 Claims reported within 36 months after the date the reporting endorsement is issued

D. Request Notification

The option to purchase the Extended Reporting Coverage must be exercised by the named insured by paying the minimum premium due for the Extended Reporting Coverage within thirty days after the cancellation or non-renewal of the policy.

F. Premiums

The charge for this coverage for Medical Professional Liability will be the **Expiring Annual Premium** of the policy multiplied by the appropriate Tail Factor shown below:

Physicians		Dentists	
<u>Claims Made Years</u>	<u>Tail Factor</u>	<u>Claims Made Years</u>	<u>Tail Factor</u>
1	4.7	1	2.048
2	4.25	2	1.738
3	2.5	3	1.568
4	2.5	4	1.499
5	2.526	5	1.439
6	2.461		
7	2.4		

For the purpose of this calculation, **Expiring Annual Premium** means the annual premium invoiced to the insured, plus any first or second year discounts that were deducted from the actual premium.

The premium for the optional reporting periods described above will be based on the charge shown above multiplied times the following factor:

Unlimited Reporting Period	1.00
12 Month Reporting Period	0.45
24 Month Reporting Period	0.75
36 Month Reporting Period	0.85

~~**XIII. Partnership, Professional Corporation or Professional Association Coverage (Healthcare and Dental Entities)**~~

~~The corporate coverage charge is 10% of premium, where premium includes all insured healthcare providers of the entity. The minimum premium charge for this coverage is \$100 for medical and \$50 for dental. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association. The premium charge for optional corporate tail coverage is based on the premium for the expiring corporate coverage (annual), multiplied by 2.4 for medical corporations and 1.439 for dental corporations.~~

**Neuman, Gayle**

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**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Wednesday, August 12, 2009 2:37 PM  
**To:** Neuman, Gayle  
**Subject:** RE: PIC Wisc. Filings

Hi Gayle.

Thank you for your email and voice message. Yes, you have the correct email address.

I checked my records and don't see that you ever asked us this question on these two filings. I was waiting on a response to your question and just received it today. ISO is the stat agent we use for all ProAssurance Companies.

I didn't realize until yesterday, after speaking with Murray, that we haven't received "official" approval or acknowledgement from your department on these filings. Is there something that you can send for our records?

Thanks.

LaQuita

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**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Tuesday, August 11, 2009 3:25 PM  
**To:** Goodwin, LaQuita  
**Subject:** PIC Wisc. Filings

Ms. Goodwin,

I apologize for the extended delay in the handling of the pending medical malpractice filings. On filings #PIC-MPL-1207 and #IL-DPL-0208, I requested information about 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? Unfortunately, I cannot find where an answer was provided in response.

Please forward this information as soon as possible. Thank you for your cooperation.

*Gayle Neuman*

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

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

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8/12/2009



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**Neuman, Gayle**

---

**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Wednesday, June 25, 2008 7:58 AM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207  
**Attachments:** Manual Page W.PDF

Ms. Neuman,

Pursuant to your request, I have amended the manual page. Please see attached.

If you have any other concerns, please let me know.

Thanks.

LaQuita B. Goodwin

---

**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Monday, June 16, 2008 8:11 AM  
**To:** Goodwin, LaQuita  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

We require the language stating "any nonpayment of these premiums will result in the Extended Reporting Coverage being voided" be deleted. If an insured pays the first installment (for the first year) but doesn't pay the second installment, the company could not void the coverage.

We request your prompt attention.

Gayle Neuman  
Division of Insurance

---

**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Thursday, June 05, 2008 1:03 PM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Neuman,

I have further amended Manual Page W to state that once the payment has been made, coverage cannot be cancelled. Also, I have submitted the form filing through SERFF.

Thanks.

LaQuita B. Goodwin  
Compliance Specialist  
Legal Department  
ProAssurance Professional Liability Group  
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN  
Woodbrook Casualty/Red Mountain Casualty

6/25/2008

Birmingham, Alabama  
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

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**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Tuesday, June 03, 2008 10:45 AM  
**To:** Goodwin, LaQuita  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

In response to your response dated May 21, 2008, please address the following:

1. In regard to the language for the cancellation of an extended reporting period, the wording should indicate once the entire premium is paid for the selected reporting period, the extended reporting period cannot be cancelled. This would apply for all situations including for example when the insured is purchasing a three year extended reporting period and three separate payments are due for such coverage.
2. You attached a copy of form PRA-HCP-606.IL 05 08. As this is a rate/rule filing, you would have to submit the form in a separate form filing.

We request receipt of your response by June 10, 2008.

Gayle Neuman  
Division of Insurance

---

**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Wednesday, May 21, 2008 10:06 AM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Good morning, Gayle.

Please see attached.

Thanks.



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6/25/2008

## ILLINOIS PROGRAMS

The following amends the preceding General Rules and Manual Pages and reflects programs that may be available for health care providers in Illinois.

### **GENERAL RULES**

#### **I. General Instructions**

The date indicated upon each page of the rules, classifications and rates in this manual do not necessarily reflect the effective date.

Coverage that is provided on or after the effective date (either by endorsement of outstanding policies or by the issuance of separate policies) will be written on the basis of the rates and rules in effect at the time of the change.

#### **VI. Policy Periods**

Policy periods will be consistent with requirements in 215 ILCS 5/143.13.

#### **XII. Extended Reporting Coverage (Tail Coverage) Applies to Claims-Made Policies**

##### **B. Scope of Coverage**

When coverage under the claims-made policy ends (for any reason) the Company will offer the insured an extension of coverage called Extended Reporting Coverage. If purchased, the Extended Reporting Coverage will extend the insured's coverage to include all valid claims that:

- (1) began on or after the retroactive date and prior to the cancellation or non-renewal date; and
- (2) are received by the insured and reported to the Company during the time period the Extended Reporting Coverage is in effect.

The Extended Reporting Coverage will be added to the policy by attaching the Extended Reporting Coverage Confirmation Endorsement.

In some instances, the insured may wish to limit the cost of their Extended Reporting Coverage by limiting the term of the endorsement.

##### Reporting Period Options:

###### Unlimited Reporting Period:

An unlimited extension of time is provided for reporting claims

###### 12 Month Reporting Period

Claims reported within 12 months after the date the reporting endorsement is issued

###### 24 Month Reporting Period

Claims reported within 24 months after the date the reporting endorsement is issued

###### 36 Month Reporting Period

Claims reported within 36 months after the date the reporting endorsement is issued

- C. Extended Reporting Coverage Payment Options: When coverage under this policy ends, an insured may purchase Extended Reporting Coverage using the annual or quarterly payment options. Exceptions may be considered on a case-by-case basis.

Any nonpayment of these premiums will result in the Extended Reporting Coverage being voided. Upon payment of premium due, the Extended Reporting Coverage cannot be cancelled.

**Neuman, Gayle**

---

**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Thursday, June 05, 2008 1:03 PM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207  
**Attachments:** Manual Page W.PDF

Ms. Neuman,

I have further amended Manual Page W to state that once the payment has been made, coverage cannot be cancelled. Also, I have submitted the form filing through SERFF.

Thanks.

LaQuita B. Goodwin  
Compliance Specialist  
Legal Department  
ProAssurance Professional Liability Group  
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN  
Woodbrook Casualty/Red Mountain Casualty  
Birmingham, Alabama  
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

---

**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Tuesday, June 03, 2008 10:45 AM  
**To:** Goodwin, LaQuita  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

In response to your response dated May 21, 2008, please address the following:

1. In regard to the language for the cancellation of an extended reporting period, the wording should indicate once the entire premium is paid for the selected reporting period, the extended reporting period cannot be cancelled. This would apply for all situations including for example when the insured is purchasing a three year extended reporting period and three separate payments are due for such coverage.
2. You attached a copy of form PRA-HCP-606.IL 05 08. As this is a rate/rule filing, you would have to submit the form in a separate form filing.

We request receipt of your response by June 10, 2008.

Gayle Neuman  
Division of Insurance

---

**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Wednesday, May 21, 2008 10:06 AM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

6/5/2008

Good morning, Gayle.

Please see attached.

Thanks.



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6/5/2008

## ILLINOIS PROGRAMS

The following amends the preceding General Rules and Manual Pages and reflects programs that may be available for health care providers in Illinois.

### **GENERAL RULES**

#### **I. General Instructions**

The date indicated upon each page of the rules, classifications and rates in this manual do not necessarily reflect the effective date.

Coverage that is provided on or after the effective date (either by endorsement of outstanding policies or by the issuance of separate policies) will be written on the basis of the rates and rules in effect at the time of the change.

#### **VI. Policy Periods**

Policy periods will be consistent with requirements in 215 ILCS 5/143.13.

#### **XII. Extended Reporting Coverage (Tail Coverage) Applies to Claims-Made Policies**

##### **B. Scope of Coverage**

When coverage under the claims-made policy ends (for any reason) the Company will offer the insured an extension of coverage called Extended Reporting Coverage. If purchased, the Extended Reporting Coverage will extend the insured's coverage to include all valid claims that:

- (1) began on or after the retroactive date and prior to the cancellation or non-renewal date; and
- (2) are received by the insured and reported to the Company during the time period the Extended Reporting Coverage is in effect.

The Extended Reporting Coverage will be added to the policy by attaching the Extended Reporting Coverage Confirmation Endorsement.

In some instances, the insured may wish to limit the cost of their Extended Reporting Coverage by limiting the term of the endorsement.

##### Reporting Period Options:

##### Unlimited Reporting Period:

An unlimited extension of time is provided for reporting claims

##### 12 Month Reporting Period

Claims reported within 12 months after the date the reporting endorsement is issued

##### 24 Month Reporting Period

Claims reported within 24 months after the date the reporting endorsement is issued

##### 36 Month Reporting Period

Claims reported within 36 months after the date the reporting endorsement is issued

- C. Extended Reporting Coverage Payment Options: When coverage under this policy ends, an insured may purchase Extended Reporting Coverage using the annual or quarterly payment options. Exceptions may be considered on a case-by-case basis.

Any nonpayment of these premiums will result in the Extended Reporting Coverage being voided.

**Neuman, Gayle**

---

**From:** Neuman, Gayle  
**Sent:** Wednesday, June 04, 2008 9:45 AM  
**To:** 'Goodwin, LaQuita'  
**Subject:** FW: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Sorry - it was actually #2 on my 6/3/08 e-mail.

---

**From:** Neuman, Gayle  
**Sent:** Wednesday, June 04, 2008 9:43 AM  
**To:** 'Goodwin, LaQuita'  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

As indicated in #1 on my e-mail, this filing can only address the rate/rule manual. Changes to any forms will have to be submitted in a separate forms only filing.

Gayle Neuman  
Division of Insurance

---

**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Wednesday, June 04, 2008 9:41 AM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Gayle,

Are you referring to the cancellation in the manual or on the form? Please let me know so that I can correct. Thanks.

---

**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Tuesday, June 03, 2008 10:45 AM  
**To:** Goodwin, LaQuita  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

In response to your response dated May 21, 2008, please address the following:

1. In regard to the language for the cancellation of an extended reporting period, the wording should indicate once the entire premium is paid for the selected reporting period, the extended reporting period cannot be cancelled. This would apply for all situations including for example when the insured is purchasing a three year extended reporting period and three separate payments are due for such coverage.
2. You attached a copy of form PRA-HCP-606.IL 05 08. As this is a rate/rule filing, you would have to submit the form in a separate form filing.

We request receipt of your response by June 10, 2008.

Gayle Neuman  
Division of Insurance

6/4/2008

---

**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Wednesday, May 21, 2008 10:06 AM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Good morning, Gayle.

Please see attached.

Thanks.



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**Neuman, Gayle**

---

**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Wednesday, May 21, 2008 10:06 AM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207  
**Attachments:** Cover letter to 5-5-08 email.PDF; IL State Amendatory Endorsement.PDF; Final copy of PIC manual.pdf

Good morning, Gayle.

Please see attached.

Thanks.

---

**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Monday, May 05, 2008 2:51 PM  
**To:** Goodwin, LaQuita  
**Subject:** Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

We are in receipt of your responses dated 4/22/08, 4/24/08 and 5/1/2008. The second and third filings cancelled each other. Here are additional issues to be addressed:

1. It is our position that the extended reporting endorsement cannot be cancelled for non-payment of premium. In purchasing the extended reporting endorsement, if the insured's payment is dishonored, pursuant to 215 ILCS 5/143.13 the coverage (i.e. the extended reporting endorsement) is void and not subject to cancellation. Therefore, the second paragraph of section XII. C. should be deleted or it can be changed on Manual Page W or X.
2. 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 form 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 company must inform the insured of the extended reporting period premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the extended reporting period coverage to tell the insured what the premium will be or how the premium will be calculated. Therefore, please correct the paragraphs of section XII. F. or it can be changed on Manual Page W or X.
3. On Manual Page G, Risk Characteristic #8 indicates "illness or physical disability that impairs, or could impair, the healthcare provider's ability to practice his/her specialty". Are you surcharging a doctor with diabetes or epilepsy the same as you are surcharging a doctor with alcoholism? Please explain.
4. On Manual Page M, the maximum modification based on A and B above is +/- 25%.
5. On Manual Page X.2., for the \$1,000 deductible, how do you determine if the insured gets a 1.8% credit or a 2.2% credit? Please explain this range of credit for the entire chart.
6. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On page 7 under XVI. Experience Rating Plan, the wording "(NOT APPLICABLE IN NEVADA)" was removed. Please address.

5/21/2008

7. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On Manual Pages G and H, numbering was changed (actually it was corrected) but the change was not disclosed.

We request receipt of your response by no later than May 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.

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[Gayle.Neuman@illinois.gov](mailto:Gayle.Neuman@illinois.gov)



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5/21/2008

May 21, 2008

Ms. Gayle Neuman  
Illinois Department of Insurance  
320 West Washington Street  
Springfield, IL 62767

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400  
A ProAssurance Company  
Line of Business – Medical Malpractice – Class 2 Clause (c)  
Medical Professional Liability  
Company Filing #PIC-MPL-1207

Dear Ms. Neuman:

Please find the following responses to your email dated May 5, 2008:

Item 1

It is our position that the extended reporting endorsement cannot be cancelled for non-payment of premium. In purchasing the extended reporting endorsement, if the insured's payment is dishonored, pursuant to 215 ILCS 5/143.13 the coverage (i.e. the extended reporting endorsement) is void and not subject to cancellation. Therefore, the second paragraph of section XII. C. should be deleted or it can be changed on Manual Page W or X.

Answer 1

We acknowledge that extended reporting endorsements cannot be cancelled for nonpayment of premium. I have amended the second paragraph of Section XII. C. You can locate this correction on Illinois Program Page W.

Item 2

2. 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 form 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 company must inform the insured of the extended reporting period premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the extended reporting period coverage to tell the insured what the premium will be or how the premium will be calculated. Therefore, please correct the paragraphs of section XII. F. or it can be changed on Manual Page W or X.

Ms. Gayle Neuman  
Illinois Department of Insurance  
May 21, 2008  
Page 2 of 3

Answer 2

On Manual Page X, Item XII. F. has been further amended to comply with the extended reporting period (tail coverage) requirement. The Illinois State Amendatory Endorsement has also been amended and will inform the insured of the extended reporting period premium at policy issuance. Please see attached.

Item 3

3. On Manual Page G, Risk Characteristic #8 indicates "illness or physical disability that impairs, or could impair, the healthcare provider's ability to practice his/her specialty". Are you surcharging a doctor with diabetes or epilepsy the same as you are surcharging a doctor with alcoholism? Please explain.

Answer 3

Upon further review, we have revised this risk characteristic for clarity. Please refer to the revised Manual Page G. We have never surcharged a physician for a medical condition, other than alcoholism or drug abuse. It is not Company practice to ask if a physician has diabetes or epilepsy, so we would not surcharge someone if they do have these diseases.

Item 4

4. On Manual Page M, the maximum modification based on A and B above is +/- 25%.

Answer 4

I have amended the maximum debit/credit to reflect +/-25%.

Item 5

5. On Manual Page X.2., for the \$1,000 deductible, how do you determine if the insured gets a 1.8% credit or a 2.2% credit? Please explain this range of credit for the entire chart.

Answer 5

Revisions have been made to this entire chart by designating a specific amount instead of a range. Due to the installment plans being added to the manual, please refer to Manual Page X.2.

Item 6

6. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On page 7 under XVI. Experience Rating Plan, the wording "(NOT APPLICABLE IN NEVADA)" was removed. Please address.

Answer 6

This language was unnecessary as the Nevada Program pages contained an Experience Rating Section which overrides the general section for that state. However, we cannot

Ms. Gayle Neuman  
Illinois Department of Insurance  
May 21, 2008  
Page 3 of 3

find documentation as to when the words were omitted. Since the words conflict with the state program section, I am requesting that you accept the page with these words omitted.

Item 7

7. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On Manual Pages G and H, numbering was changed (actually it was corrected) but the change was not disclosed.

Answer 7

I cannot locate when or how this numbering was corrected; however, I am requesting that you accept the page with the correct numbering.

I have carefully reviewed the entire manual that was filed with your department that was effective December 1, 2004 and compared it to the marked copy of the manual and the final manual that I submitted to your department to be effective December 15, 2007. Other than what is in the marked manual and the two corrections listed in Items 6 and 7 above, there are no other changes to disclose. I am enclosing a copy of the manual, with all corrections, for your approval.

I believe you will find everything in order. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at [lgoodwin@proassurance.com](mailto:lgoodwin@proassurance.com).

Sincerely,



LaQuita B. Goodwin  
Compliance Specialist

Enclosures

---

***General Rule and Rating Manual***

**Healthcare Providers Professional Liability**

*General Rules*

---

**I. *General Instructions***

This manual contains the rules, classifications and rates governing the underwriting of healthcare providers' professional liability claims-made and occurrence insurance. The rules, classifications and rates in this manual become effective as of the date indicated upon each page.

Coverage that is provided on or after the effective dates of any changes in this manual (either by endorsement of outstanding policies or by the issuance of separate policies) will be written on the basis of the rates and rules in effect at the time the policy is effective.

The following requirements must be observed in the preparation of policies for insurance covered by this manual:

- Appropriate wording identifying the classifications applicable for each risk will be specified on the policy Declarations or Coverage Summary, including the appropriate code number.
- Any language in classification phraseology or footnotes affecting the scope of the classification applicable or assigned to operations to be insured will be incorporated on the Declarations or Coverage Summary of the policy.
- For each classification, the proper premium will be calculated either as actual or as an adequate estimate subject to audit, dependent on the case.

**II. *Scope of Coverage***

Each professional liability policy provides the details of the coverage and exclusions that are incorporated into the terms of the policy.

**III. *Persons Insured***

The persons or entities insured under the policy are specified on the Declarations or Coverage Summary of each professional liability policy, or are described in the language of the policy form.

**IV. *Definitions***

The definitions of the key terms used in the policy are provided in an introductory section of the professional liability policy.

**V. *Limits of Liability***

- A. **Statutory Requirements:** The limits of liability for some healthcare providers (as defined by the appropriate state statute) are statutorily specified. Accordingly, all primary insurance coverage for these healthcare providers must provide the minimum level of limits, as specified in the applicable statutes. In other states where limits of liability are *not* statutorily specified, refer to filed rate pages for per professional healthcare incident and annual aggregate limits of liability.

For individual professional liability, the limits of liability apply separately to each individual insured. For entity, partnership, association or corporation professional liability coverage, the inclusion of more than one insured does not increase the limits of liability. Employees (as defined in the policy or endorsements to the policy) of individuals, entities, partnerships, associations or corporations share in their employer's limit of liability, unless separate limits of liability are purchased, if available.

- B. **Deductibles:** Deductibles are a method of coverage under which the insured agrees to reimburse us for damages and/or expenses we pay on the insured's behalf. The amount of reimbursement will be the amount of the deductible or the damages and/or expenses paid on the insured's behalf, whichever is less. As appropriate, the insured receives a premium credit in exchange for his or her acceptance of additional risk, except in cases in which a mandatory deductible applies.

**VI. *Policy Periods***

Policies may be written for any period of less than one year, up to and including one year, or more than one year, at the discretion of the Company.

**VII. Rates and Premium Calculation**

- A. Rates, as presented in this manual and/or the applicable rate filings, apply on an annual basis to each individual insured or entity.
- B. Additional Charges: The additional charges provided under the classifications in this manual measure the liability of the insured for increased levels of exposure. Additional charges shall be obtained only where coverage for such exposures is provided.
- C. Calculation of Premium: One-Year Policies: The premium shall be determined on the basis of the units of exposure existing at policy inception.
- D. Calculation of Premium: Short-Term Policies: The premium on policies written for a period of less than one year shall be computed on an annual basis, and the pro rata premium will be charged for the policy period.

**VIII. Cancellations**

- A. By the Insuring Company: The earned premium shall be determined on a pro rata basis by multiplying the number of units of exposure for the period the policy was in force by the applicable rates but shall not be less than the pro rata amount of the minimum premium.
- B. By the Insured: Return premium will be computed on a pro rata basis, except as follows. If the insured cancels their policy midterm to obtain coverage from another carrier, while continuing to practice in the same state, their premium will be calculated on a short rate basis.

**IX. Additional Interests**

All additional interests shall be submitted to Underwriting for rating.

**X. Underwriting Procedure: Coverage Options**

Professional liability policies may be written to include (1) individual coverage, (2) entity, partnership, association or corporation coverage, or (3) both coverage types.

**XI. Classification Procedure**

- A. For classification assignment purposes, the following phraseology is defined:
1. The term "*no surgery*" applies to general practitioners and primary care specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia) and who do not ordinarily assist in surgical procedures.
  2. The term "*minor surgery*" applies to general practitioners and primary care specialists who perform minor surgery (including obstetrical procedures not constituting major surgery) or who assist in major surgery on their own patients.
  3. The term "*major surgery*" includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen or pelvis. Major surgery also includes any other operation that because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the removal of any gland organ, plastic surgery, and any operation done using general anesthesia.
  4. Dentists' classifications are based on the types of procedures that the dentist performs, as well as the location in which the dentist performs those procedures. The Dentist Class Pages provide a description of the classification assignment for dental procedures by location and sedation methodology.
  5. Other ancillary healthcare professional classifications are based on the type of professional services being provided. This includes, but is not limited to, nurses, podiatrists, chiropractors, optometrists, psychologists, etc. See Rate Pages for appropriate description of ancillary healthcare professionals.

NOTE: The Classification Pages provide the classification procedures for the various specialties.

- B. When two or more classifications are applicable to a general practitioner or specialist, the rate for the highest-rated classification shall apply.
- C. Healthcare Providers in active United States military service: The classification section in this manual does not apply to healthcare providers in active United States military services.
- D. Healthcare Providers employed full time by the Federal Government but not in active United States military service: The classification section in this manual does not apply to healthcare providers employed full time by the Federal Government (not military service).

**XII. *Extended Reporting Coverage (Tail Coverage) -- Applies To Claims-Made Policies Only***

- A. General Instructions: When coverage under this policy ends (whether by nonrenewal or cancellation), the insured has the right to purchase an optional extension of coverage called an Extended Reporting Coverage. The Extended Reporting Coverage will be added to the policy by attaching the appropriate endorsement to the insured's policy.
- B. Scope of Coverage: The Extended Reporting Coverage will extend the insured's coverage to include all valid claims that: (1) began on or after the retroactive date and prior to the cancellation or non-renewal date; and (2) are reported to the Company during the time period the Extended Reporting Coverage is in effect.
- C. Extended Reporting Coverage Payment Options: When coverage under this policy ends, an insured may purchase Extended Reporting Coverage using the annual or quarterly payment options. Exceptions may be considered on a case-by-case basis.

Any nonpayment of these premiums will result in the Extended Reporting Coverage being canceled, and we will not provide further coverage.

- D. Request Notification: The option to purchase the Extended Reporting Coverage must be exercised by the named insured by written notice to the Company within thirty (30) days after termination of the policy. Subsequent premium payments must be made by the premium due date of the endorsement, or the endorsement will terminate. There is no grace period built into the premium due dates.
- E. Limits of Liability: The limits of liability that apply to the extended reporting period will be the same as, and included in, the limits in effect on the expiring policy. The limits of liability cannot be increased from those on the canceled or nonrenewed policy.

The aggregate limit stated on the Extended Reporting Coverage is the most we will pay for all claims first received by the insured and reported to the Company during the period of the endorsement. In states where limits of liability are statutorily specified, if the period of the endorsement is for more than one year, the total limit applies separately to each annual period, as required by state statute, beginning with the date the endorsement takes effect. In other states where limits of liability are *not* statutorily specified, if not required by state statute, the total limit may apply to the entire extended reporting period shown on the endorsement.

- F. Premiums: The premiums for the extended reporting period will be set by the Company in accordance with the rules, limits and rating plans in effect on the date the coverage is to be effective.

To determine the appropriate charge for Extended Reporting Coverage, we must determine the appropriate specialty and risk classification, calculate the period of time during which coverage existed under the claims-made policy, and apply these factors to our rating model to determine the appropriate premiums.

**Neuman, Gayle**

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**From:** Neuman, Gayle  
**Sent:** Wednesday, May 14, 2008 8:33 AM  
**To:** 'Goodwin, LaQuita'  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

LaQuita,

I copied language I had used before. Unfortunately, I didn't catch that the wording mentioned "form". As this is a rate/rule filing, I am only making the criticism for the filing under review.

Gayle Neuman  
Division of Insurance

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**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Tuesday, May 13, 2008 4:03 PM  
**To:** Neuman, Gayle  
**Subject:** RE: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Gayle,

I need clarification on Item 2 of your May 5 email regarding the captioned filing. The second sentence states that "The form must list the factor(s)...or it can be changed on Manual Page W or X." I'm unclear as to what you mean by the "form." Please explain. Is it something that needs to go to the insured? Or is this information only to be added to the manual page?

Thanks.

2. 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 form 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 company must inform the insured of the extended reporting period premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the extended reporting period coverage to tell the insured what the premium will be or how the premium will be calculated. Therefore, please correct the paragraphs of section XII. F. or it can be changed on Manual Page W or X.



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5/14/2008

## Neuman, Gayle

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**From:** Neuman, Gayle  
**Sent:** Wednesday, May 14, 2008 8:21 AM  
**To:** 'Goodwin, LaQuita'  
**Subject:** RE: Request for extension to respond to filings

I will extend the due date until May 23, 2008.

Gayle Neuman  
Division of Insurance

-----Original Message-----

**From:** Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]  
**Sent:** Wednesday, May 14, 2008 8:04 AM  
**To:** Neuman, Gayle  
**Subject:** Request for extension to respond to filings

RE: Company Filing Numbers PIC-MPL-1207, IL-DPL-0208 and PIC0608

Good morning, Gayle.

You asked that we respond to your concerns on the aforementioned filings by May 15. I would like to respectfully request an additional week to respond. The Senior Underwriter will not return to the office until May 16. Please confirm extension by replying.

Thank you for your immediate attention to this matter.

LaQuita B. Goodwin  
Compliance Specialist  
Legal Department  
ProAssurance Professional Liability Group  
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN  
Woodbrook Casualty/Red Mountain Casualty  
Birmingham, Alabama  
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

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**Neuman, Gayle**

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**From:** Neuman, Gayle  
**Sent:** Monday, May 05, 2008 2:51 PM  
**To:** 'Goodwin, LaQuita'  
**Subject:** Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

We are in receipt of your responses dated 4/22/08, 4/24/08 and 5/1/2008. The second and third filings cancelled each other. Here are additional issues to be addressed:

1. It is our position that the extended reporting endorsement cannot be cancelled for non-payment of premium. In purchasing the extended reporting endorsement, if the insured's payment is dishonored, pursuant to 215 ILCS 5/143.13 the coverage (i.e. the extended reporting endorsement) is void and not subject to cancellation. Therefore, the second paragraph of section XII. C. should be deleted or it can be changed on Manual Page W or X.
2. 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 form 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 company must inform the insured of the extended reporting period premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the extended reporting period coverage to tell the insured what the premium will be or how the premium will be calculated. Therefore, please correct the paragraphs of section XII. F. or it can be changed on Manual Page W or X.
3. On Manual Page G, Risk Characteristic #8 indicates "illness or physical disability that impairs, or could impair, the healthcare provider's ability to practice his/her specialty". Are you surcharging a doctor with diabetes or epilepsy the same as you are surcharging a doctor with alcoholism? Please explain.
4. On Manual Page M, the maximum modification based on A and B above is +/- 25%.
5. On Manual Page X.2., for the \$1,000 deductible, how do you determine if the insured gets a 1.8% credit or a 2.2% credit? Please explain this range of credit for the entire chart.
6. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On page 7 under XVI. Experience Rating Plan, the wording "(NOT APPLICABLE IN NEVADA)" was removed. Please address.
7. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On Manual Pages G and H, numbering was changed (actually it was corrected) but the change was not disclosed.

We request receipt of your response by no later than May 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.

5/5/2008

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**Neuman, Gayle**

---

**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Thursday, May 01, 2008 11:22 AM  
**To:** Neuman, Gayle  
**Subject:** FW: Medical Malpractice - Rate/Rule Filing #PIC-MPL-1207  
**Attachments:** Manual Page X-minimum prem for corps.PDF; marked Manual Page X-minimum prem for corps.PDF

Gayle,

First, I want to begin by apologizing but I need to amend this filing by removing the attached Manual Page X. I will submit a separate filing for this minimum premium for corporation and partnerships for a later effective date.

Because this minimum premium rule was not in the manual when the underwriters were issuing policies effective 12/15/07 and after, many corporations and partnerships received a minimum premium less than \$50. Because the policies have already been issued, we can't retroactively go back. We want to fully comply with our filing, so I'm asking that this revision that I sent you on April 24 be withdrawn and that you continue to use the submission that I forwarded on April 22. You should receive a new, separate filing for this minimum premium rule to be effective June 15 shortly.

If you have any questions, please let me know.

Thanks.

LaQuita

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**From:** Goodwin, LaQuita  
**Sent:** Thursday, April 24, 2008 12:58 PM  
**To:** 'Neuman, Gayle'  
**Subject:** FW: Medical Malpractice - Rate/Rule Filing #PIC-MPL-1207

Good afternoon, Gayle.

After reviewing the corporation language further, I realized that two sentences were inadvertently omitted from the marked copy of the manual and the final copy of the manual that were forwarded to you on Tuesday. Please replace these pages and continue your review. I apologize for the inconvenience.

Thanks.

LaQuita

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**From:** Goodwin, LaQuita  
**Sent:** Tuesday, April 22, 2008 2:04 PM  
**To:** 'Neuman, Gayle'  
**Subject:** RE: Medical Malpractice - Rate/Rule Filing #PIC-MPL-1207

Ms. Neuman,

I've attached the information needed to respond to your concerns. If you require a hard copy of this information, please let me know. Also, if you have any other concerns, please let me know as well.

Thank you for your immediate attention to this matter.

5/1/2008

LaQuita B. Goodwin  
Compliance Specialist  
Legal Department  
ProAssurance Professional Liability Group  
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN  
Woodbrook Casualty/Red Mountain Casualty  
Birmingham, Alabama  
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

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**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Thursday, April 17, 2008 11:28 AM  
**To:** Goodwin, LaQuita  
**Subject:** Medical Malpractice - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

We are in receipt of the above referenced filing submitted by your letter dated December 6, 2007.

The filing memorandum references "Physicians and Surgeons". However, the pages being changed (that were previously filed effective 12/1/04) are labeled as "Health Care Providers". It seems they should all be under one title.

There is a huge problem in this submission with page numbering and text. Here is the first example. On the previous page D, there is a paragraph continued from page C on Limited Practice. It was not a part of the new edition of page D. The text on the previous page F has been replaced - yet it was not removed so it seems the text should now push back text on pages G through M. This happens more times on subsequent pages.

New text on page W was not disclosed in this filing as being added. Pursuant to 50 Ill. Adm. Code 754.10, identification of all changes in all superseding filings, as well as identification of all superseded filings is required. Additionally, we require you certify that nothing else has changed from what was previously filed except for the changes brought to our attention in this filing.

We additionally require that you submit all pages in the manual section - which of course will be required to make the changes requested above.

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?

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.

We request receipt of your response by no later than April 30, 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.

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[Gayle.Neuman@illinois.gov](mailto:Gayle.Neuman@illinois.gov)



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5/1/2008

D. Request Notification

The option to purchase the Extended Reporting Coverage must be exercised by the named insured by paying the minimum premium due for the Extended Reporting Coverage within thirty days after the cancellation or non-renewal of the policy.

F. Premiums

The charge for this coverage for Medical Professional Liability will be the **Expiring Annual Premium** of the policy multiplied by the appropriate Tail Factor shown below:

Physicians		Dentists	
<u>Claims Made Years</u>	<u>Tail Factor</u>	<u>Claims Made Years</u>	<u>Tail Factor</u>
1	4.7	1	2.048
2	4.25	2	1.738
3	2.5	3	1.568
4	2.5	4	1.499
5	2.526	5	1.439
6	2.461		
7	2.4		

For the purpose of this calculation, **Expiring Annual Premium** means the annual premium invoiced to the insured, plus any first or second year discounts that were deducted from the actual premium.

The premium for the optional reporting periods described above will be based on the charge shown above multiplied times the following factor:

Unlimited Reporting Period	1.00
12 Month Reporting Period	0.45
24 Month Reporting Period	0.75
36 Month Reporting Period	0.85

**XIII. Partnership - Corporation - Professional Association Coverage**

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. The minimum premium charge for this coverage is \$100 for medical and \$50 for dental. However, his minimum premium may be waived for a specific market or program applying to eligible members of an association. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians, or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

# of Insureds	\$1M/\$3M Charge			\$500K/\$1.5M			\$200K/\$600K		
	PRA	IL Prop.		PRA	IL Prop.		PRA	IL Prop.	
	<u>Std.</u>	<u>Phys</u>	<u>Dental</u>	<u>Std.</u>	<u>Phys</u>	<u>Dental</u>	<u>Std.</u>	<u>Phys</u>	<u>Dental</u>
1	N/A	N/A	5.0%	N/A	N/A	N/A	N/A	N/A	N/A
2 - 5	15.0%	N/A	5.0%	18.0%	N/A	18.0%	23.0%	N/A	23.0%
6 - 9	12.0%	N/A	5.0%	17.0%	N/A	17.0%	21.0%	N/A	21.0%
10 - 19	9.0%	N/A	5.0%	13.0%	N/A	13.0%	17.0%	N/A	17.0%
20 - 49	7.0%	N/A	5.0%	9.0%	N/A	9.0%	13.0%	N/A	13.0%
50 or more	5.0%	N/A	5.0%	7.5%	N/A	7.5%	10.0%	N/A	10.0%

**XIII. Partnership - Corporation - Professional Association Coverage**

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. The minimum premium charge for this coverage is \$100 for medical and \$50 for dental. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians, or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

# of Insureds	\$1M/\$3M Charge			\$500K/\$1.5M			\$200K/\$600K		
	PRA		IL Prop.	PRA		IL Prop.	PRA		IL Prop.
	Std.	Phys	Dental	Std.	Phys	Dental	Std.	Phys	Dental
1	N/A	N/A	5.0%	N/A	N/A	N/A	N/A	N/A	N/A
2 - 5	15.0%	N/A	5.0%	18.0%	N/A	18.0%	23.0%	N/A	23.0%
6 - 9	12.0%	N/A	5.0%	17.0%	N/A	17.0%	21.0%	N/A	21.0%
10 - 19	9.0%	N/A	5.0%	13.0%	N/A	13.0%	17.0%	N/A	17.0%
20 - 49	7.0%	N/A	5.0%	9.0%	N/A	9.0%	13.0%	N/A	13.0%
50 or more	5.0%	N/A	5.0%	7.5%	N/A	7.5%	10.0%	N/A	10.0%

**• Partnership - Corporation - Professional Association Extended Reporting Endorsement Coverage**

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in the Paragraph above.

**XIX. Voluntary Deductibles**

**Medical Professional Liability Deductible Credits**

Deductible credits assume the following:

1. Aggregate deductible of 3 times the per occurrence deductible
2. Deductible is for damages only, not for damages and defense
3. Deductible applies per incident, not per certificate holder
4. Factor is applied to gross PL premium at \$1M/\$3M limits
5. Excess pricing for deductible accounts is based on premium prior to application of deductible factor

Deductible	Credit % of \$1,000,000/\$3,000,000 Gross PL Premium
\$1,000	1.8% - 2.2%

## Neuman, Gayle

---

**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Tuesday, April 22, 2008 2:04 PM  
**To:** Neuman, Gayle  
**Subject:** RE: Medical Malpractice - Rate/Rule Filing #PIC-MPL-1207  
**Attachments:** Cover Letter & info.pdf; PIC manual with marked revisions.pdf; Final copy of PIC manual.pdf

Ms. Neuman,

I've attached the information needed to respond to your concerns. If you require a hard copy of this information, please let me know. Also, if you have any other concerns, please let me know as well.

Thank you for your immediate attention to this matter.

LaQuita B. Goodwin  
Compliance Specialist  
Legal Department  
ProAssurance Professional Liability Group  
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN  
Woodbrook Casualty/Red Mountain Casualty  
Birmingham, Alabama  
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

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**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Thursday, April 17, 2008 11:28 AM  
**To:** Goodwin, LaQuita  
**Subject:** Medical Malpractice - Rate/Rule Filing #PIC-MPL-1207

Ms. Goodwin,

We are in receipt of the above referenced filing submitted by your letter dated December 6, 2007.

The filing memorandum references "Physicians and Surgeons". However, the pages being changed (that were previously filed effective 12/1/04) are labeled as "Health Care Providers". It seems they should all be under one title.

There is a huge problem in this submission with page numbering and text. Here is the first example. On the previous page D, there is a paragraph continued from page C on Limited Practice. It was not a part of the new edition of page D. The text on the previous page F has been replaced - yet it was not removed so it seems the text should now push back text on pages G through M. This happens more times on subsequent pages.

New text on page W was not disclosed in this filing as being added. Pursuant to 50 Ill. Adm. Code 754.10, identification of all changes in all superseding filings, as well as identification of all superseded filings is required. Additionally, we require you certify that nothing else has changed from what was previously filed except for the changes brought to our attention in this filing.

We additionally require that you submit all pages in the manual section - which of course will be required to make the changes requested above.

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?

4/22/2008

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.

We request receipt of your response by no later than April 30, 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.

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[Gayle.Neuman@illinois.gov](mailto:Gayle.Neuman@illinois.gov)



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April 22, 2008

Ms. Gayle Neuman  
Illinois Department of Insurance  
320 West Washington Street  
Springfield, IL 62767

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400  
A ProAssurance Company  
Line of Business – Medical Malpractice – Class 2 Clause (c)  
Medical Professional Liability  
Company Filing #PIC-MPL-1207

Dear Ms. Neuman:

Please find the following responses to your email dated April 17, 2008:

Please find enclosed a revised Filing Memorandum which states that this particular filing is for Healthcare Providers Professional Liability, which includes several specialties.

In the original submission dated December 6, 2007, I only included the manual pages that changed, final and marked copies. However, there was one additional item, Item XIII on the Illinois Program pages, that I failed to disclose as new. Please find enclosed a marked copy and a final copy of the entire General Rule and Rating Manual.

Please note that the statistical agency that we utilize for ProAssurance Group is ISO.

I believe you will find everything in order. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at [lgoodwin@proassurance.com](mailto:lgoodwin@proassurance.com).

Sincerely,



LaQuita B. Goodwin  
Compliance Specialist

Enclosures

G. Fully Paid-Up Tail Benefit: If the insured meets any of the following conditions, he or she will receive the Death, Disability and Retirement (DDR) Extended Reporting Coverage at no additional cost:

1. Death:
2. Permanent and total disability that renders the insured completely unable to continue his or her practice;
3. Full retirement from practice (any specialty) and completion of at least five (5) continuous years coverage with us, ending on the date of retirement.

Before we issue such an Extended Reporting Coverage, we will require proof of eligibility from the insured.

The DDR Extended Reporting Coverage will become effective at the end of the policy period during which the insured meets one of the preceding conditions and will provide a new set of coverage limits and an unlimited extended reporting period.

H. Resumption of Practice: If at any time in the future the insured resumes his or her practice to any extent, any Extended Reporting Coverage issued pursuant to Sections XII.G or XII.H will terminate as of the time the insured resumes his or her practice.

The insured will then have the right to purchase Extended Reporting Coverage upon payment of the proper premiums, in accordance with the terms of our policy.

I. Eligibility: Any healthcare provider or entity insured under a primary policy issued by the Company is eligible for and entitled to purchase Extended Reporting Coverage.

**FILED**

DEC 15 2007

**XIII. *Partnership, Professional Corporation or Professional Association Coverage***

Partnerships, professional corporations (including solo corporations), or professional associations may receive a primary insurance policy at the option of the insured (unless required by law) at a charge that is based on the net premium charge for the individual healthcare providers of the entity, provided that the Company insures all principals as individuals. (See Manual Page A) Exceptions to this "all-or-none" rule may be made at the Company's discretion. The minimum premium charge for this coverage is \$100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

**XIV. *Employee Professional Liability Coverage***

- A. Definitions: Employees (other than a physician or resident) are covered under an insured's policy if they are employed by the named insured and are acting within the scope of their duties as such. Refer to the policy for the definition of employees.
- B. Limits of Liability: Such employees share in the limits of liability with their employer. They do not receive their own individual limits of liability. In some cases, individual limits of liability are available for employees at an additional charge. See Rate Pages.

All other manual rates are applicable.

**XV. *Prior Acts Coverage -- Applies To Claims-Made Policies Only***

For insureds who have been covered under a claims-made policy with another insurance carrier, we can offer Prior Acts Coverage, subject to underwriting approval. Prior Acts Coverage will recognize the insured's retroactive date under the previous policy. However, special rules for claims apply to Prior Acts Coverage, as specified in the most current policy form.

Prior Acts Coverage is limited to activities in those states where PIC Wisconsin is licensed to write professional liability coverage, or where we are legally allowed to and have agreed to do so. If we are unable to provide Prior Acts Coverage due to licensing or underwriting restrictions, the insured must obtain Extended Reporting Coverage for that exposure from their previous carrier. Rating for Prior Acts Coverage is based on the same criteria as the insured's base coverage, including retroactive date, specialty classification and other applicable factors as described throughout this Rule and Rating Manual.

**XVI. *Experience Rating Plan***

The experience rating plan provides an adjustment to a policyholder's current premium, based on the loss history of that particular policyholder.

The experience modification factor is applied to the rate developed from the rates and rules in our standard filing. The experience modification factor is derived from a formula-based credibility factor. The credibility factor is the result of the expected claim count of the policyholder, as developed from past claims history.

For purposes of determining the experience modification factor, the following definitions apply:

- **Expected Claim Count**                      Calculated as the expected losses divided by the average severity.
- **Expected Losses**                              Extrapolation of current loss history into the future, using reporting patterns derived from the Company's rate filings.
- **Average Severity**                              Expected losses divided by an actuarially determined average loss cost.
- **Credibility**                                      The square root of: the expected claim count/683 (full credibility standard).
- **Experience Modification Factor**                      The actual-to-expected loss ratio times the credibility factor, plus 1.0 minus the credibility factor.

The experience modification factor is principally guided by the developed credibility factor, where credibility increases with the number of exposures involved. Thus, the larger the group of healthcare providers, the higher the credibility.

The program is intended to be applied only to groups of significant size (35 healthcare providers or greater) and will not be utilized in conjunction with any other loss-ratio based group rating/credit mechanism.

**XVII. Reunderwriting Rating Mechanisms: Rules and Risk Characteristics**

Through an automated process, individuals who fall into the following categories will be identified for a reunderwriting review:

- **Claims Severity:** Any claim that is \$50,000 or higher (reserve or indemnity paid) for physicians or surgeons, and \$10,000 or higher for other healthcare providers or practitioners.
- **Claims Frequency:** (1) Two claims with paid indemnity (or open with reserves established) within a three-year period, or (2) five claims of any kind within a five-year period.

On the basis of Underwriting's review, the individual may be subject to a risk management advisory letter, a surcharge or practice limitation, a mandatory deductible or, if necessary, nonrenewal.

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A. Surcharge and/or Coverage Exclusion

The surcharge mechanism will be used to account for claim severity, although it could be used for claim frequency, as identified through a review of the insured's claim file, through discussions with the claim examiner and evaluation of expert medical reviews. This surcharge system involves the assessment of a predetermined surcharge scale. (See Manual Pages.)

The five-year evaluation period is calculated on a calendar-year basis, retroactive from January 1 of the policy year in which the review is being conducted.

B. Mandatory Deductible

The deductible mechanism may be applicable when a policyholder exhibits a pattern of claim frequency that exceeds the average for his/her specialty. In the consideration of a deductible assessment, severity is usually not an issue.

Deductibles may be imposed in amounts from \$1,000 to \$250,000 per claim. There is no corresponding premium discount, and there are no aggregate limits on mandatory deductibles.

An amendatory deductible endorsement will be added to the policy at renewal and will be maintained for no less than one year. The policy will be subject to an annual review thereafter for consideration of a revised sanction.

**XVIII. Rate Adjustments for Changes in Exposure – Claims-made, Retroactive and Reporting Endorsement Coverage**

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

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For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

**B. Prior Acts Coverage**

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

**C. Reporting Endorsement Coverage**

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

Gynecology reporting endorsement premium for claims-made year two,  
plus OB/GYN reporting endorsement premium for claims-made year five,  
less OB/GYN reporting endorsement premium for claims-made year two.

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**D. Occurrence Coverage**

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

**XIX. *Voluntary Deductibles***

In exchange for a reduction in their premium, some insureds opt to accept a portion of the risk. The Company maintains responsibility for making indemnity payments on the insured's behalf, up to the limits defined in the policy. However, the insureds who select a deductible option agree to reimburse us up to the deductible amount specified on their Declarations, Coverage Summary or any Deductible Endorsement.

Refer to the state programs section of the manual for the applicable deductible credits.

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**HEALTHCARE PROVIDERS  
PROFESSIONAL LIABILITY  
MANUAL PAGES**

• ***Healthcare Entities, Partnership, Professional Corporation or Professional Association Coverage***

Healthcare entities, professional corporations, associations or partnerships (including solo corporations) may receive a primary policy at the option of the insured (unless required by law) at a 0 - 10 percent charge, unless specified in the State Program pages, that is based on the net premium charge for the individual insured healthcare providers of the entity, provided that the Company insures all principals and employed healthcare providers as individuals. The covered entity will receive a separate set of limits for the 0 - 25 percent charge, unless where specified in the State Exceptions pages. The minimum premium charge for this coverage is \$100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

• ***Employee Professional Liability***

Professional employees (other than nurse anesthetists, certified nurse midwives, physicians, residents, surgeons or dentists) of a partnership, professional corporation, professional association or an individual practitioner may be included under policies issued to their employers at no additional charge. The employees' limits of liability will be shared with the named insured, unless separate limits of liability are purchased. These employees may also receive their own individual policy with separate limits of liability, dependent on the scope of their practice.

**Additional Professional Employee Charges**

If the professional employee shares in the limits of liability with their employer, the following additional charges will be added to the named insured's policy, as appropriate.

- **Physician or Surgeon Assistant:** 80116  
No Additional Charge.

- **Certified Nurse Midwives:**  
Refer to rate page for Ancillary Coverages.

- **Advanced Practice Nurse Prescribers:**  
No Additional Charge.

- **Vicarious Liability for Contract Healthcare Providers:**

The rate for vicarious liability for contract healthcare providers will be 10% of the mature claims-made rate, regardless of maturation, or 10% of occurrence, depending on the policy, for the self-employed healthcare provider. The additional charge does not apply if the employer/ full-time contractor is also insured by our Company.

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• Vicarious Liability

Any employer may be vicariously liable for the acts of an employee. In the case of a health care provider not insured by PIC Wisconsin due to underwriting reasons (failure to cooperate with risk management, claims history, etc.), the employer will be charged 10% of the rate applicable for that health care provider. That is 10% of the mature claims-made rate, regardless of maturation, or 10% of the occurrence rate, depending on the policy. Exceptions can be made and the charge waived if:

- A health care provider is eligible for coverage with PIC but elects to obtain coverage from another carrier; or
- A health care provider is close to retirement and would receive an Extended Reporting Coverage at no charge from another carrier.

If the professional employee received his or her own policy and separate limits of liability, the following rates will be added to their own policy:

• Physician or Surgeon Assistant: 80116

See Ancillary Coverage Charges, as filed with the Department of Insurance. The rate per physician or surgeon assistant will be 15 % of the mature Class I rate or the rate shown on the rate page, as filed with the Department of Insurance.

• Certified Nurse Midwives:

See Ancillary Coverage Charges, as filed with the Department of Insurance. The rate per certified nurse midwife will be based on the Class I rate, as filed with the Department of Insurance.

• Advanced Practice Nurse Prescribers:

See Ancillary Coverage Charges, as filed with the Department of Insurance. The rate per advanced practice nurse prescriber will be 15 % of the mature Class I rate or the rate shown on the rate page, as filed with the Department of Insurance.

• ***Emergency Medicine Part-Time***

Physicians working in the emergency room to supplement their income or as a requirement for hospital privileges may work a maximum of 15% of their practice time without increasing their classification to Emergency Medicine.

Any physician working 16 % or more of his or her scheduled practice time in the Emergency Room will be classified as Emergency Medicine (Code 80102), unless the physician also practices in a specialty that is in a higher rated classification than Emergency Medicine, then the premium will be based on the rates for the higher classification.

• ***Moonlighting Residents***

Residents who work part-time for a corporation, a clinic or another healthcare provider will be assigned the appropriate classification code, in accordance with our underwriting guidelines. Refer to rate page for Ancillary Coverages.

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• **Locum Tenens Coverage**

Coverage for temporary substitute health care providers may be provided through the issuance of an Additional Insured endorsement or the Locum Tenens Endorsement. In states not requiring a separate set of limits for the substitute, the Locum Tenens health care providers will be added to the insured's policy as an additional insured, sharing in the insured health care provider's limits. In states requiring separate limits for each health care provider, a Locum Tenens endorsement will be added to the insured health care provider's policy, providing a separate set of temporary limits to the Locum Tenens. Locum tenens coverage should not exceed a period of 90 days.

To cover the processing and administrative costs involved, a \$50 minimum premium charge per Locum Tenens endorsement may be applied. At underwriter's discretion, the processing charge may be waived if the Locum Tenens physician has been covered within the previous 30 days.

• **First- and Second-Year Practitioner Credit**

Any healthcare provider just entering private practice who has finished his/her formal education within the preceding year may be classified and rated in accordance with his/her specialty with the following credits:

<u>Description</u>	<u>Modification Factor</u>
1 <sup>st</sup> -year New Healthcare Provider	0.50 times the appropriate first-year claims-made rate
2 <sup>nd</sup> -year New Healthcare Provider	0.75 times the appropriate second-year claims-made rate

Note that these discounts do not apply to occurrence rates. Please note State Exceptions pages for specific state rules.

• **Teaching Credit**

A healthcare provider who spends a minimum of 40 percent of his/her practice time teaching (non-clinical) will be classified and rated by the following method:

<u>Description</u>	<u>Modification Factor</u>
Use appropriate specialty code description	0.75 times the appropriate claims-made rate

• **Limited Practice (Not available in Nebraska)**

The rate for healthcare providers who are eligible for the Limited Practice benefit (practicing an average of 20 hours per week or less) will be 50% of the applicable claims-made premium that corresponds to the period of time during which the healthcare provider practices on a limited basis. Refer to Underwriting for eligible specialties. The healthcare provider's premium will still account for any previous exposure that the healthcare provider faced, in accordance with our rating model. For occurrence policies, the 50% discount applies to the pro rata premium from the date Limited Practice is added through the expiration date, if added mid-term. For occurrence policy renewals or new business or other policies with Limited Practice from inception to expiration, the premium is reduced by 50%. Please note State Exceptions pages for specific state rules.

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• *Suspension of Coverage (Not available in Nebraska)*

The rate for healthcare providers who are eligible for the Suspension of Coverage benefit will be 0 percent of the applicable claims-made premium that corresponds to the period of time during which the healthcare provider suspends coverage. The healthcare provider's premium will still account for any previous exposure that the healthcare provider faced.

The Suspension of Coverage provision in the Exposure Reduction Endorsement will indicate the date on which the healthcare provider anticipates to return to practice. For rating purposes, this date will serve as the ending date of the suspension of coverage period. However, if the healthcare provider actually returns to active practice on a date that differs from this indicated date, we will adjust the premium to reflect the actual ending date of the suspension period. Upon returning to practice, the healthcare provider will receive an Amendatory Endorsement that will clearly specify the period of suspension of coverage. Please note State Exceptions pages for specific state rules.

• *Anesthesiologist's Program*

Anesthesiologists and certified registered nurse anesthetists (CRNAs) who indicate that they utilize a pulse oximeter and an end-tidal CO<sub>2</sub> analyzer in the administration of anesthesia will be rated at 60 percent of the applicable claims-made premium. It is assumed that this equipment is being utilized, and the credit is built into the manual rate. If the equipment is not used, a surcharge will be applied to the premium for the insured that does not utilize this equipment.

• *Schedule Credit / Debit Program*

To recognize the unique risk characteristics of our insureds, we may apply debits or credits that reflect the nature of a particular insured's practice. The maximum deviation available under this program varies by state. See unique state program pages per state.

Credits for insureds will be determined on the basis of our evaluation of each insured's risk profile. This assessment may consider such characteristics as loss experience, management, employees, patient medical records, quality assurance, facilities and billing procedures, and other criteria, as appropriate. This program only applies if a schedule rating plan is shown in this manual for the applicable market.

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**• Rate Adjustments for Changes in Exposure – Claims-Made, Retroactive and Reporting Endorsement Coverage**

**A. Claims-Made Coverage**

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

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Gynecology rate for claims-made year five,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

**B. Prior Acts Coverage**

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

**C. Reporting Endorsement Coverage**

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

Gynecology reporting endorsement premium for claims-made year two,  
plus OB/GYN reporting endorsement premium for claims-made year five,  
less OB/GYN reporting endorsement premium for claims-made year two.

**D. Occurrence Coverage**

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

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• **Surcharge and/or Procedure Exclusion Criteria**

This surcharge system assesses each type of adverse risk that the underwriter identifies. The following table defines the surcharge percentage that can be applied to the healthcare provider's standard rate, based on the applicable class designation and policy maturity.

Risk Characteristics:

Within the past 5 years:

	<u>Surcharge</u>
1. Claim or suit involving questionable procedure or judgment.	10%
2. Claim or suit involving <u>significant</u> questionable procedure or judgment.	25%
3. Claim or suit involving practicing in area that is questionably beyond training or competence.	20%
4. Claim or suit involving practicing in an area that is <u>significantly</u> beyond training or competence.	30%
5. Claim or suit involving negligence.	100%
6. Three or more <u>medically culpable</u> claims, regardless of disposition.	150%
7. Two or more claims or suits (or any combination thereof) arising out of the same procedure treatment.	20%
8. Alcoholism, mental illness or drug addiction that impairs, or could impair, the healthcare provider's ability to practice his/her specialty.	100%
9. A healthcare provider who has had an application for hospital staff privileges denied or restricted for professional reasons, and/or who has had his/her hospital privileges revoked, nonrenewed, modified, restricted, or subject to probation and/or disciplinary action (except suspension of hospital privileges for delinquent medical records).	40%

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Within the past 10 years:

10. Healthcare Provider who has been subject to a licensing board disciplinary procedure due to impropriety or incompetence in medical practice or in prescribing, resulting in medical or DEA license having been:
  - a. denied, revoked or voluntarily surrendered; 75%
  - b. suspended or subject to probation. 50%
  
11. Healthcare Provider who has been adjudged guilty of: 200%
  - a. a crime of moral turpitude;
  - b. a crime medically related to ethical or professional conduct.
  
12. Any other circumstances represented on the healthcare provider's application or obtained through other sources that merit a point assessment and/or exclusion, termination or declination. 50%

The surcharge will remain in effect in accordance with the following table.

<u>Surcharge Percentage</u>	<u>Duration</u>
5 - 25 percent	12 months
30 - 50 percent	24 months
75 - 200 percent	24 months minimum, subject to reevaluation at the end of 12 and 24 months.

Any procedure exclusion imposed will continue for an indefinite time period. A policyholder may request consideration for the removal of the exclusion only after it has been in effect for one year and then only after he/she has furnished satisfactory evidence of retraining or other appropriate evidence.

The five- or ten-year evaluation period is calculated on a calendar-year basis, retroactive from January 1 of the policy year in which the review is being conducted.

• **Group Practice Modification Plan (not available in Nebraska)**

Credits for groups will be determined annually on the basis of our evaluation of each individual group's risk profile, which assesses such characteristics as changes in maturity, number of healthcare providers, specialty composition, management, employees, patient records, quality assurance, facilities, billing procedures and loss history. See Unique State Programs pages for specific debit and credit allowance.

**Group Practice Eligibility**

1. a. For a group of physician healthcare providers, five or more permanently licensed, practicing physicians, or two or more physicians that generate a combined premium of \$50,000 annually after all other premium modifications have been applied (but prior to the application of the "group practice modification plan.")
- b. For a group of dental healthcare providers, two or more permanently licensed, practicing dentists.
- c. Other markets are not eligible for group practice (entity) policies or rating, unless specifically addressed in this manual.
2. Group must be a corporation, partnership, joint venture, or limited partnership association.
3. Primary location where both professional services are rendered and administrative functions (billing, patient records) are undertaken.
4. Satellites are acceptable to the extent they are controlled and are practicing as part of the primary location.
5. The entity must be organized for the purpose of delivering professional services to patients.
6. The applicant should have a favorable loss history over the preceding five-year period. Evaluation will be based on the size of the group, the number of paid and pending losses and the severity of the losses.

**Group Practice Primary Evaluation Criteria**

1. Length of time entity has operated as a group.
2. Degree of specialization within the group.
3. Stability of members and locations.
4. Reputation and standard within the community served.
5. Promotional materials, advertising, sign on the door.
6. Hospitals where healthcare provider(s) has admitting privileges.

**Group Practice Risk Profile**

This risk profile should ascertain the level of the group's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort clinics use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas;
2. Augment a defensible position;
3. Increase awareness of potential areas of risk;
4. Improve the standard of care;
5. Provide a mechanism for patient advocacy.

**Group Practice Claims History Evaluation**

This evaluation ascertains the level of the group's prior claims and loss history and to obtain the appropriate claim information and assess the liability, if any, of a healthcare provider. To make the assessment, identify the following factors:

1. Did the healthcare provider depart from the accepted standard of care? Did that departure result in injury, loss, or damage to the patient?
2. What was the opinion of the peer review committee, if any, or experts who reviewed the case as to the standard of care rendered?
3. Are there any patterns or trends noted in the healthcare provider's practice which could give rise to subsequent professional incidents, such as the same surgical procedure improperly performed, inadequate patient histories or workups, lack of informed consent, improper record keeping and documentation, etc.?
4. Assess the number of claims which have occurred from inception of the healthcare provider's practice. Evaluate those that have occurred against the nature of the insured's specialty. For example, an emergency room physician is exposed more frequently due to the nature of that specialty – treatment of trauma injuries.
5. If a renewal, review the claim representative's case summary, trial review or other evaluation report for their assessment of the merits of the case. Often the Litigation Specialist is in contact with the healthcare provider and is the most knowledgeable of the facts in the case. Did the healthcare provider cooperate with the Litigation Specialist and the Company in preparing the defense?

Upon evaluation of these factors, either a decision or a recommendation for coverage will be formed by the Underwriter. If necessary, the case will then be reviewed by the appropriate peer review committee or Underwriting Advisory Committee for acceptability based on adherence to the standard of care.

**Non-Group Primary Evaluation Criteria**

1. Length of time healthcare provider(s) has practiced;
2. Stability of practice;
3. Reputation and standing within the community served;
4. Hospitals where healthcare provider(s) has admitting privileges;

**Non-Group Risk Profile**

This risk profile should ascertain the level of the healthcare provider's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort healthcare providers use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas;
2. Augment a defensible position;
3. Increase awareness of potential areas of risk;
4. Improve the standard of care;
5. Provide a mechanism for patient advocacy.

• ***Independent Medical Exams (IMEs)***

Physicians performing the IMEs are generally retired and face a limited amount of exposure from IMEs. Accordingly this "per IME" rating methodology more appropriately reflects the actual risk that these physicians face.

Following is the calculation process for rates per independent medical examination:

Number of IMEs X 2 hours per IME / 2304 (the hours worked to be considered full time)= Number of full time equivalents. The number of full time equivalents is multiplied by the occurrence rate for legal medicine to determine the total premium based on full time physicians. This premium is divided by the number of IMEs to determine the rate per IME. The average number of IMEs performed by those in the program is multiplied by the rate per IME to get the premium per physician in the program, subject to the minimum premium of \$550 / physician.

The insured has the option of making this program audited (based on the actual number of IMEs performed, subject to the minimum premium per physician) or non-audited.

The total premium will be computed by multiplying the number of annual IMEs by this derived rate. The total premium value is also subject to a minimum premium of \$550 per physician. Likewise, the corporate premium -- which is based on 2% of the mature Class I-A rate multiplied by the total Full-Time Equivalents -- is subject to the minimum premium of \$500.

• ***Loss Free Discount Program***

Loss-Free Credit: Healthcare providers who have not experienced losses may be able to receive premium credits in accordance with our established guidelines. Loss-free credits are earned in annual increments as shown on the state pages.

Definition of a Meritorious Claim: If any one claim results in an indemnity payment of more than \$10,000 for physicians, or \$3,000 for all other healthcare providers, the premium for the healthcare provider will revert to the base level. Otherwise, loss-free credits will continue to apply and accumulate, subject to the maximum available credit, as well as Underwriting review.

If a Loss (As Defined) Occurs After Enrollment Into the Program: In this situation, the rates upon renewal revert back to the 100 percent level until the health care provider has been loss free for a full policy year, at which time credits again begin to accumulate.

- ***Affinity Group Discount Program***

An affinity group is a group of people who are within the same geographic community or the same specialty, or both. This program is a form of participation credit for insureds who have a common relationship – the same specialty or the same geographic region, using the same purchasing agent or broker. If more members in the purchasing group or specialty group participate in the Company's programs, they may qualify to receive a higher affinity discount percentage.

An affinity group is similar to a credit union, a cooperative organization that provides special benefits or discounts to its members, who all share some unique characteristic to be eligible for membership. An example of this in the medical malpractice insurance world would be a group of 25 anesthesiologists practicing as individual physicians but use the same purchaser or broker for billing services or insurance purchasing power, forming an insurance purchasing group. Another example would be members of the State Medical Society as the affinity group, and a ten-member group practice would be a subgroup with that larger affinity group.

Affinity groups must have at least 2 or more independent practices/customers (solo or multiple as part of the same corporation) and consist of at least 25 total insureds. Each member continues to have their own policy and individual premium components, but can receive the affinity discount due to their common relationship as a part of such an affinity group.

Participation discounts would be based on the number of physicians in the "group" and the specific composition of that "group". The participation discount for all members of the affinity group will be determined at one time during the year, and will remain at that level until the anniversary date the following year. All changes are based on the discount in effect on the renewal/anniversary date. The new discount is applied to participating members at renewal. All other participating members will receive the discount on their own individual renewal/anniversary date.

A customer that is in multiple affinity groups can only purchase his/her PIC WISCONSIN Medical Professional Liability through one affinity group at a time, receiving only one affinity discount.

Refer to state program manual pages for participation discounts, based on the number of members.

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• **Risk Management Modification Plan**

	Total Credit/Debit
A. APPROVED PROGRAMS, INCLUDING SELF STUDY KITS OR SEMINARS - Evidence of completed seminar agenda or outline, completed within a reasonable timeframe - Complete approved self-study kit	5 - 15%
B. EXISTING RISK MANAGEMENT PROCEDURES IN PLACE Risk Management Survey	10-15%

Maximum modification based on A and B above is +/-25%.

NOTES:

- A. To receive credit for attending an approved Risk Management seminar:
1. It must have been attended within an acceptable timeframe of the inception date of the policy.
  2. It must be a seminar that is approved as a Risk Management Seminar, relating to Risk Management topics including, but not limited to, informed consent or medical records. Information, such as a brochure or flyer describing the seminar, is necessary to determine this.
  3. We must receive evidence of attendance, such as a certificate of completion.
  4. To receive credit for the self-study program, a test or other evidence of completion must be presented to PIC Wisconsin.
- B. To receive credit for procedures in place, the appropriate general, anesthesiology, radiology, or emergency medicine form must be completed. The categories of questions reviewed in these surveys include, in order of weighted importance: Medical Records (45% weight), Patient Management (15% weight), Informed Consent (15% weight), Patient Relations (15% weight), Employee Management (5.0% weight) and Regulatory Compliance (5% weight).

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STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
SPRINGFIELD, ILLINOIS

PIC WISCONSIN

**Summary of Credits Available for All Markets, All States**

Please refer to State Programs Pages for each individual state's credit listings.

all states 10/01/04

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STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
SPRINGFIELD, ILLINOIS

## ILLINOIS PROGRAMS

The following amends the preceding General Rules and Manual Pages and reflects programs that may be available for health care providers in Illinois.

### **GENERAL RULES**

#### **I. General Instructions**

The date indicated upon each page of the rules, classifications and rates in this manual do not necessarily reflect the effective date.

Coverage that is provided on or after the effective date (either by endorsement of outstanding policies or by the issuance of separate policies) will be written on the basis of the rates and rules in effect at the time of the change.

#### **VI. Policy Periods**

Policy periods will be consistent with requirements in 215 ILCS 5/143.13.

#### **XII. Extended Reporting Coverage (Tail Coverage) Applies to Claims-Made Policies**

##### **B. Scope of Coverage**

When coverage under the claims-made policy ends (for any reason) the Company will offer the insured an extension of coverage called Extended Reporting Coverage. If purchased, the Extended Reporting Coverage will extend the insured's coverage to include all valid claims that:

- (1) began on or after the retroactive date and prior to the cancellation or non-renewal date; and
- (2) are received by the insured and reported to the Company during the time period the Extended Reporting Coverage is in effect.

The Extended Reporting Coverage will be added to the policy by attaching the Extended Reporting Coverage Confirmation Endorsement.

In some instances, the insured may wish to limit the cost of their Extended Reporting Coverage by limiting the term of the endorsement.

##### Reporting Period Options:

###### Unlimited Reporting Period:

An unlimited extension of time is provided for reporting claims

###### 12 Month Reporting Period

Claims reported within 12 months after the date the reporting endorsement is issued

###### 24 Month Reporting Period

Claims reported within 24 months after the date the reporting endorsement is issued

###### 36 Month Reporting Period

Claims reported within 36 months after the date the reporting endorsement is issued

- ##### **C. Extended Reporting Coverage Payment Options:** When coverage under this policy ends, an insured may purchase Extended Reporting Coverage using the annual or quarterly payment options. Exceptions may be considered on a case-by-case basis.

Upon payment of premium due, the Extended Reporting Coverage cannot be canceled.

D. Request Notification

The option to purchase the Extended Reporting Coverage must be exercised by the named insured by paying the minimum premium due for the Extended Reporting Coverage within thirty days after the cancellation or non-renewal of the policy.

F. Premiums

The charge for this coverage for Medical Professional Liability will be the **Expiring Annual Premium** of the policy multiplied by the appropriate Tail Factor shown below:

Physicians		Dentists	
<u>Claims Made Years</u>	<u>Tail Factor</u>	<u>Claims Made Years</u>	<u>Tail Factor</u>
1	4.7	1	2.048
2	4.25	2	1.738
3	2.5	3	1.568
4	2.5	4	1.499
5	2.526	5	1.439
6	2.461		
7	2.4		

For the purpose of this calculation, **Expiring Annual Premium** means the annual premium invoiced to the insured, plus any first or second year discounts that were deducted from the actual premium.

The premium for the optional reporting periods described above will be based on the charge shown above multiplied times the following factor:

Unlimited Reporting Period	1.00
12 Month Reporting Period	0.45
24 Month Reporting Period	0.75
36 Month Reporting Period	0.85

The Company will notify insureds of the cost of the Reporting Endorsement (tail coverage) at the time the last policy is issued pursuant to Illinois law.

**XIII. Partnership - Corporation - Professional Association Coverage**

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians, or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

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# of Insureds	\$1M/\$3M Charge			\$500K/\$1.5M			\$200K/\$600K		
	PRA	IL Prop.		PRA	IL Prop.		PRA	IL Prop.	
	Std.	Phys	Dental	Std.	Phys	Dental	Std.	Phys	Dental
1	N/A	N/A	5.0%	N/A	N/A	N/A	N/A	N/A	N/A
2 - 5	15.0%	N/A	5.0%	18.0%	N/A	18.0%	23.0%	N/A	23.0%
6 - 9	12.0%	N/A	5.0%	17.0%	N/A	17.0%	21.0%	N/A	21.0%
10 - 19	9.0%	N/A	5.0%	13.0%	N/A	13.0%	17.0%	N/A	17.0%
20 - 49	7.0%	N/A	5.0%	9.0%	N/A	9.0%	13.0%	N/A	13.0%
50 or more	5.0%	N/A	5.0%	7.5%	N/A	7.5%	10.0%	N/A	10.0%

• **Partnership - Corporation - Professional Association Extended Reporting Endorsement Coverage**

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in the Paragraph above.

• **Quarterly Installment Options**

1. Quarterly Installment Option One
  - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
  - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. 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 the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
  
2. Quarterly Installment Option Two – (35/25/25/15)
  - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
  - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. 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 the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

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**XIX. Voluntary Deductibles**

**Medical Professional Liability Deductible Credits**

Deductible credits assume the following:

1. Aggregate deductible of 3 times the per occurrence deductible
2. Deductible is for damages only, not for damages and defense
3. Deductible applies per incident, not per certificate holder
4. Factor is applied to gross PL premium at \$1M/\$3M limits
5. Excess pricing for deductible accounts is based on premium prior to application of deductible factor

<b>Deductible</b>	<b>Credit % of \$1,000,000/\$3,000,000 Gross PL Premium</b>
\$1,000	2.0%
\$2,000	4.0%
\$5,000	7.0%
\$10,000	9.0%
\$25,000	14.0%
\$50,000	18.0%
\$75,000	23.0%
\$100,000	28.0%
\$150,000	34.0%
\$250,000	40.0%
\$400,000	44.0%
\$500,000	50.0%

Note: For full limits deductibles, refer to Company

Additional options, multiply times the following factors:

Aggregate 4 times the per occurrence	1.050
Aggregate 5 times the per occurrence	1.075
No Aggregate	1.100
Damages and Defense deductible	1.10 - 1.25
Deductible per certificate holder	1.100

Effective 12/15/07

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STATE OF ILLINOIS  
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**MANUAL PAGES**

• **Schedule Credit/Debit Program**

The maximum deviation available under this program in Illinois is 75% for physicians and dentists.

• **Loss Free Discount Program (Physicians)**

<u># Of Loss-Free Years</u>	<u>Annual Credit</u>	<u>Accumulated Credit</u>
1	3.33%	3.33%
2	3.33%	6.66%
3	3.34%	10.00%

New Business: Physicians who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 10 percent. Physicians who have been loss-free for two years will receive a 6.66 percent credit, while physicians with one year of loss-free experience will receive a 3.33 percent credit.

• **Loss Free Discount Program (Dentists)**

<u># Of Loss-Free Years</u>	<u>Annual Credit</u>	<u>Accumulated Credit</u>
1	5%	5%
2	10%	10%
3	15%	15%

New Business: Dentists who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 15 percent. Dentists who have been loss-free for two years will receive a 10 percent credit, while dentists with one year of loss-free experience will receive a 5 percent credit.

• **Affinity Group Discount Program**

Participation discounts, based on the number of members would be:

0 - 25% Participation	1% Discount
26 - 49% Participation	2% Discount
50 - 99 Participation	3% Discount
100% Participation	5% Discount

• **Group Practice Modification Plan**

The maximum credit or debit is 75 percent for physicians and dentists, based on the eligibility, primary evaluation criteria, risk profile and loss ratio evaluation, as described in the rules pages.

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STATE OF ILLINOIS  
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SPRINGFIELD, ILLINOIS

**Maximum Credit / Debit Modifications**

The maximums available under these programs in Illinois are as follows:

	<u>Group Providers</u>	<u>Individuals</u>
Schedule Credit / Debit Program	NA	75%
Loss Free Discount (physicians)	NA	10% Credit
Loss Free Discount (dentists)	NA	15% Credit
Risk Management Credit/Debit	included in Group Practice Modification Plan	10%
Affinity Group Discount	5% Credit	5% Credit
Group Practice Modification Plan	75%	NA

***• Dental Board Examination Coverage:***

Dental students taking their licensing examinations will be offered annual occurrence coverage for their exposure while taking a dental licensing board examination. Coverage will be provided at limits of \$1,000,000 per incident, \$3,000,000 aggregate. The policy definition of Professional Health Care Services referred to in the policy are limited to only those services rendered by the insured during a dental board examination.

A \$15 charge per examinee will be charged to cover the exposure for these dental candidates. In addition, if the examinee obtains professional liability coverage with the Company after obtaining his/her license to practice dentistry, the Company will apply this fee as a reduction to the insured's first-year premium. The dentist's first professional policy to insure his/her full-time dental practice must be purchased from the Company in order to receive that \$15 reduction.

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