Filing at a Glance

Company: ProAssurance Casualty Company
Product Name: Health Care Professional Liability Program
SERFF Tr Num: PCWA-127161288
State: Illinois
TOI: 11.2 Med Mal-Claims Made Only
SERFF Status: Closed-Filed
State Tr Num: PCWA-127161288
Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations
Co Tr Num: IL-CIPRPG-0711-RR
State Status:
Filing Type: Rate/Rule
Reviewer(s): Gayle Neuman
Author: LaQuita Goodwin
Disposition Date: 01/05/2012
Date Submitted: 05/11/2011
Disposition Status: Filed
Effective Date Requested (New): 07/01/2011
Effective Date (New): 07/01/2011
Effective Date Requested (Renewal): 07/01/2011
Effective Date (Renewal): 07/01/2011

State Filing Description:
*******FILING ROUTED 10/06/2011**********

General Information

Project Name: Central Illinois Physicians Risk Purchasing Group
Status of Filing in Domicile: Not Filed
Project Number:
Domicile Status Comments: None
Reference Organization: None
Reference Number:
Reference Title:
Advisory Org. Circular:
Filing Status Changed: 01/05/2012
State Status Changed:
Deemer Date:
Created By: LaQuita Goodwin
Submitted By: LaQuita Goodwin
Corresponding Filing Tracking Number:
Filing Description:
The Central Illinois Physicians Risk Purchasing Group is registered in Illinois and I am submitting for your review and approval the initial filing of the rates and rules that will be used for policies issued through this purchasing group, which is underwritten by ProAssurance Casualty Company. I request the effective date of July 1, 2011 for this filing submission.

The attached underwriting manual contains the rates and rules for physicians and surgeons and their paramedical employees written through this purchasing group. Other than the use of the form being submitted in a separate filing, it is our intention to use the policy forms, endorsements and applications currently filed and approved by your department

for ProAssurance Casualty Company.

Please note that any current or future rate and rule submissions for ProAssurance Casualty Company will also apply to this program, unless otherwise specified.

If you have any questions during the review process, please contact me.

Thank you.

Company and Contact

Filing Contact Information

LaQuita Goodwin, Compliance Specialist lgoodwin@proassurance.com
100 Brookwood Place 205-877-4426 [Phone]
Birmingham, AL 35209 205-414-2887 [FAX]

Filing Company Information

ProAssurance Casualty Company	CoCode: 38954	State of Domicile: Michigan
100 Brookwood Place	Group Code: 2698	Company Type: Property & Casualty
Birmingham, AL 35209	Group Name: ProAssurance	State ID Number: 12
(205) 877-4426 ext. [Phone]	FEIN Number: 38-2317569	

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ProAssurance Casualty Company	$0.00		

State Specific

Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm).: Acknowledged

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

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm: N/A

Medical Malpractice rates/rules may only be submitted in paper.: Per Gayle Neuman, med mal rates/rules can now be submitted through SERFF.

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

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

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	01/05/2012	01/05/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Gayle Neuman	12/22/2011	12/22/2011	LaQuita Goodwin	01/05/2012	01/05/2012
Pending Industry Response	Gayle Neuman	10/05/2011	10/05/2011	LaQuita Goodwin	10/05/2011	10/05/2011
Pending Industry Response	Gayle Neuman	10/03/2011	10/03/2011	LaQuita Goodwin	10/04/2011	10/04/2011
Pending Industry Response	Gayle Neuman	09/20/2011	09/20/2011	LaQuita Goodwin	10/03/2011	10/03/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
objection letter of 12/22/11	Note To Filer	Gayle Neuman	01/05/2012	01/05/2012
Effective Date of 7/1/2011	Note To Reviewer	LaQuita Goodwin	12/21/2011	12/21/2011

effective date	Note To Filer	Gayle Neuman	12/20/2011 12/20/2011

Disposition

Disposition Date: 01/05/2012

Effective Date (New): 07/01/2011

Effective Date (Renewal): 07/01/2011

Status: Filed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PCWA-127161288*	*State:*	*Illinois*
Filing Company:	*ProAssurance Casualty Company*	*State Tracking Number:*	*PCWA-127161288*
Company Tracking Number:	*IL-CIPRPG-0711-RR*		
TOI:	*11.2 Med Mal-Claims Made Only*	*Sub-TOI:*	*11.2000 Med Mal Sub-TOI Combinations*
Product Name:	*Health Care Professional Liability Program*		
Project Name/Number:	*Central Illinois Physicians Risk Purchasing Group/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document *(revised)*	Certification		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	marked manual pages		Yes
Rate *(revised)*	Underwriting Manual		Yes
Rate	Underwriting Manual		Yes
Rate	Revised Manual Pages		Yes
Rate	Underwriting Manual		Yes
Rate	Underwriting Manual		Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/22/2011
Submitted Date	12/22/2011
Respond By Date	12/29/2011

Dear LaQuita Goodwin,

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

Changes were made to pages 10 and 17 of the manual pursuant to your September 19, 2011 correspondence to Robert Walling at Pinnacle Actuarial Resources. These changes should be made to the manual on the SERFF filing, along with copies to show the change(s) made to pages 10 and 17.

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

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

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm

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

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

Sincerely,

Gayle Neuman

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/05/2012
Submitted Date	01/05/2012

Dear Gayle Neuman,

Comments:
Please find below the response to your 12/22/2011 objection.

Response 1

Comments: Pursuant to your request, please find marked pages 10 and 17 in regarding to the correspondence to Robert Walling at Pinnacle Actuarial Resources.

While comparing documents, I also noticed that the group deductibles on page 50 had to be revised as well to be identical to what is on file for ProAssurance Casualty's standard program and the OB-Gyn Risk Alliance program. A marked copy of the manual page is attached for your convenience.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: marked manual pages
Comment:

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #
Underwriting Manual	Entire Manual	New	
Previous Version			
Underwriting Manual	*Entire Manual*	*New*	
Revised Manual Pages	*Page 11 and 13*	*New*	
Underwriting Manual	*Entire Manual*	*New*	
Underwriting Manual	*Entire Manual*	*New*	

Please let me know if you have any other questions or concerns.

Thank you.

Sincerely,
LaQuita Goodwin

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/05/2011
Submitted Date	10/05/2011
Respond By Date	10/12/2011

Dear LaQuita Goodwin,

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

In regard to the Full -Time Equivalent Rating, what is the range of any debits/credits associated with this?

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

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

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm

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

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

Sincerely,

Gayle Neuman

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/05/2011
Submitted Date	10/05/2011

Dear Gayle Neuman,

Comments:
The response to your 10/5/11 objection follows below.

Response 1

Comments: Credits and debits would be applied in compliance with the existing rules in the Underwriting Manual. As such, the maximum credits, as detailed on Page 15 of the Underwriting Manual, would apply.

I realized that my last response contained only the revised manual pages and not the entire manual. This has been corrected.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #
Underwriting Manual	*Entire Manual*	*New*	
Previous Version			
Revised Manual Pages	*Page 11 and 13*	*New*	
Underwriting Manual	*Entire Manual*	*New*	
Underwriting Manual	*Entire Manual*	*New*	

Please let me know if you have any other questions or concerns.

Thank you.

Sincerely,

SERFF Tracking Number:	*PCWA-127161288*	*State:*	*Illinois*
Filing Company:	*ProAssurance Casualty Company*	*State Tracking Number:*	*PCWA-127161288*
Company Tracking Number:	*IL-CIPRPG-0711-RR*		
TOI:	*11.2 Med Mal-Claims Made Only*	*Sub-TOI:*	*11.2000 Med Mal Sub-TOI Combinations*
Product Name:	*Health Care Professional Liability Program*		
Project Name/Number:	*Central Illinois Physicians Risk Purchasing Group/*		

LaQuita Goodwin

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/03/2011
Submitted Date	10/03/2011
Respond By Date	10/10/2011

Dear LaQuita Goodwin,

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

I am still awaiting your response about the full-time equivalent rating issue.

On page 13 under Reporting Endorsements, please remove the reference to consent-to-rate issue.

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

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

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm

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

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

Sincerely,

Gayle Neuman

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/04/2011
Submitted Date	10/04/2011

Dear Gayle Neuman,

Comments:
Please find the response to your 10/3/2011 objection below.

Response 1

Comments: Please see the revised rule on page 11, which defines the parameters for the calculation of FTE.

I have revised paragraph B on page 13 as requested.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #
Revised Manual Pages	*Page 11 and 13*	*New*	
Previous Version			
Underwriting Manual	*Entire Manual*	*New*	
Underwriting Manual	*Entire Manual*	*New*	

Please let me know if you have any further questions or concerns.

Sincerely,
LaQuita Goodwin

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/20/2011
Submitted Date	09/20/2011
Respond By Date	09/27/2011

Dear LaQuita Goodwin,

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

1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

2. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This information is required in every rate/rule filing for medical malpractice.

3. Under I. Rates and Premium Calculations, paragraph B. - Please confirm that no insureds are currently written on an individual risk basis and that prior to issueing any such coverage such standards would be filed with the Department prior to implementation.

4. Under I. Rates and Premium Calculations, paragraph C. - Illinois does not allow insureds to be written on a consent-to-rate basis. This issue is again referenced under IX. Reporting Endorsement Premium Calculation.

5. Under II. Cancellations, paragraph C. should be removed or revised. Notice is required pursuant to the Illinois Insurance Code.

6. Based on the calculations for other debits and credits in this manual, why can't the company provide perimeters (such as classes, patient visits, etc.) for the Full-Time Equivalent Rating?

7. Please explain all other basis for the waiver of the Reporting Endorsement Premium beyond those in the coverage form/policy.

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

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

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm

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

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

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/03/2011
Submitted Date	10/03/2011

Dear Gayle Neuman,

Comments:
The responses to your 9/20/11 email is following below.

Response 1

Comments: 1. The Independent Statistical Service, Inc. (ISS) is our statistical reporting agency.

2. I have attached the certification.

3. This rule has been deleted. Please refer to page 4.

4. This rule has been deleted. Please refer to page 4.

5. This rule has been amended. Please refer to page 4.

6. I will respond to this question separately.

7. Other than the waiver of the reporting endorsement premium contained in the policy, there are no other basis for waiving the premium. I have amended Item B on Page 13.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: Certification
Comment:

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #

Underwriting Manual	*Entire Manual*	*New*

Previous Version

Underwriting Manual	*Entire Manual*	*New*

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

Thank you.

Sincerely,
LaQuita Goodwin

Note To Filer

Created By:

Gayle Neuman on 01/05/2012 09:02 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/05/2012 01:26 PM

Subject:

objection letter of 12/22/11

Comments:

I cannot close this filing until I get a response to my 12/22/11 objection letter along with the appropriate manual pages. Thank you for your prompt attention.

Note To Reviewer

Created By:

LaQuita Goodwin on 12/21/2011 01:56 PM

Last Edited By:

Gayle Neuman

Submitted On:

01/05/2012 01:26 PM

Subject:

Effective Date of 7/1/2011

Comments:

This filing was implemented on 7/1/2011. Yes, we would like to keep this same effective date. Thank you.

Note To Filer

Created By:
Gayle Neuman on 12/20/2011 01:42 PM
Last Edited By:
Gayle Neuman
Submitted On:
01/05/2012 01:26 PM
Subject:
effective date
Comments:
The Department of Insurance has now completed its review of this filing. Originally, ProAssurance Casualty requested the filing be effective July 1, 2011. Was the filing put in effect on July 1, 2011 or do you wish to have a different effective date?
Your prompt response is appreciated.

Rate/Rule Schedule

Schedule Item Status:	Exhibit Name:	Rule # or Page #:	Rate Action	Previous State Filing Number:	Attachments
	Underwriting Manual	Entire Manual	New		CIPRPG Manual eff 7-1-11.PDF

ILLINOIS MANUAL

HEALTHCARE PROFESSIONALS

UNDERWRITING RULES AND RATES

For Insureds of the
Central Illinois Physicians Risk Purchasing Group

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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance written through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

SPECIALTY CODES AND DESCRIPTIONS

* *

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**All Other Surgery**
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code: No Surgery	Industry Class Code: Minor Surgery	Industry Class Code: All Other Surgery
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code No Surgery	Minor Surgery	All Other Surgery
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)-basic procedures
	-	-	80475(C)-intermediate procedures
	-	-	80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Surgical Consultation – Office Only	80477(A)	80477(B)	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.
***See Internal Medicine – Minor Surgery.

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:
   a) First year resident - 25% of the appropriate specialty classification rate
   b) Second year resident - 50% of the appropriate specialty classification rate
   c) Third year resident - 75% of the appropriate specialty classification rate
   d) Fellows and interns - 85% of the appropriate specialty classification rate

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).

C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

Classification	Rating Criteria:
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

TYPE	Class	Average Weekly Practice Hours <20 hours
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty (2,080 hours of work per FTE) or the average number of patient contacts/visits in a 12 month period (4,000 visits per FTE). A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. 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:

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.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 40% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor discounts: up to 50%. Deductible credits may be combined with the New Doctor discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing $100,000 or more annualized premium

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credits, up to a maximum of 12%.

A. Individual Risk Management Activities: Individual insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

		Activity	Credit
1.		Successful completion of an approved fee-for-service office analysis and education program. Positive response to recommendations made shall result in the application of this credit for up to three policy years. Applicable only to accounts generating $250,000 or more in annual premium.	5%
2.	a.	A Company sponsored Loss Prevention or other approved risk management seminar carrying at least two CME credits (annual); or,	5%

	b.	(i) A Company-produced online Loss Prevention seminar.	2.5%
3.		Company-produced Supplemental Online Modules (up to four).	0.5% for each module completed (up to a maximum of 2.0%)
4.	a.	An approved closed claim review (annual); and/or	5%
	b.	Successful completion of an approved risk management correspondence course carrying at least two CME credits (annual).	5%
5.		Demonstrated regular use of an approved patient information system or program.	5%

Educational activities must qualify for Continuing Medical Education credit (where applicable) to be acceptable for risk management credits. The applicant must provide proof (Certificate) of CME credits earned at the time of application. Activities submitted for risk management credits must have been completed within twelve months prior to application.

B. In addition to the above, any physician or surgeon whose practice benefits from the risk management activities of an employed practice administrator or risk manager may receive one of the following credits:
   1. If the practice employs a full-time, qualified, professional risk manager primarily engaged in risk management and loss prevention activities, each insured shall receive a 5% credit.
   2. If the practice administrator or office manager participates in a Company-sponsored Loss Prevention or other risk management seminar, each insured shall receive a 2% credit. Certain requirements apply:
      a. The seminar must be designated by the Company as eligible for practice administrator credit.
      b. Attendance must occur within the twelve months prior to the effective date of the policy being rated.
      c. At least 75% of the insureds in the practice must qualify for risk management credit as a result of individual risk management activities under the terms of Section III(A)(2), above.
      d. The practice administrator or office manager must actively manage the practice for thirty or more hours per week. In the case of shared practice management, determination of eligibility will rest with the Company.

C. Any risk management credit will be revoked or withheld for any of the following reasons:
   1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
   2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company,
   3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
   4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and*
12. Insured group maintains differing limits of liability on members.*

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

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

A. Individual Deductibles

See State Rates and Exceptions.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

See State Rates and Exceptions.

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. New Doctor Discount or other resident or part-time, semi-retired discount;
3. Risk Management Discount and Scheduled Rating (apply the net credit or debit); and

Example: Class 1, $1M/$3M, 1st year new doctor, Risk Management Seminar within 12 months. $25,000 deductible. Assume manual rate $7,500.

$7,500	Manual Rate for $1M/$3M
x .91	Less 9% (Deductible Credit)
6825	
x .50	Less 50% (New Doctor)
3,413	Applicable Net Premium
x .85	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. 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.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. 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 Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians and dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to participants in the Program at no additional charge. There is a premium charge for those insureds that elect expanded coverage with higher limits.

Limits are in excess of $50,000 primary coverage.

# of Physicians	$1M Limit
1 Physician	$ 1,125
2 Physicians	$ 1,500
3-5 Physicians	$ 2,063
6-10 Physicians	$ 2,813
10-15 Physicians	$ 3,750
16-20 Physicians	$ 5,100
21-25 Physicians	$ 6,375
26-30 Physicians	$ 7,650

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.132	0.400	0.120
Surgeon's Assistant (SA)	0.132	0.400	0.120
Certified Nurse Practitioner (CNP)	0.132	0.400	0.120
Psychologist	0.040	0.111	0.033
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.025	0.050	0.015

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.400
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physiotherapist	80938	0.018
Psychologist	80912	0.111
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.122
Social Worker	80911	0.045
Sonographer	80754	0.018
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	Factors
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under $500 are not eligible for the step-rating factors.

SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND PODIATRISTS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes					
1	80102(A)	80179	80235	80240	80256(A)	80620
	80178	80231	80236	80254	80265	
2	80233	80249	80256(B)	80267	80621	
	80238	80252	80263	80474		
3	80102(B)	80244	80257	80268	80420	80477(A)
	80145(A)	80245	80260	80282	80431	
	80222(A)	80255	80266	80289	80473	
4	80114	80151	80241	80253	80269	
	80145(B)	80222(B)	80246	80261	80421(A)	
5	80145(C)	80280	80286	80291	80360	80425
	80274	80283	80287	80293	80421(B)	80477(B)
	80278	80284	80288	80294	80424(F)	
6	80102(C)	80159	80277	80421(C)		
	80117(A)	80167	80281(A)	80472		
7	80115	80117(B)	80281(B)	80475(A)		
8	80117(C)	80155	80169			
9	80143	80154(A)	80156			
10	80146	80150				
11	80144	80154(B)	80171	80475(B)		
12	80153					
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	5,011	8,177	10,288	11,344	12,399
2	6,594	11,344	14,510	16,094	17,677
3	8,177	14,510	18,732	20,844	22,955
4	9,760	17,677	22,955	25,593	28,232
5	11,344	20,844	27,177	30,343	33,510
6	13,244	24,643	32,243	36,043	39,843
7	14,510	27,177	35,621	39,843	44,065
8	17,677	33,510	44,065	49,343	54,621
9	20,844	39,843	52,509	58,843	65,176
10	24,010	46,176	60,954	68,342	75,731
11	27,177	52,509	69,398	77,842	86,287
12	30,343	58,843	77,842	87,342	96,842
13	33,510	65,176	86,287	96,842	107,397
14	43,010	84,175	111,619	125,341	139,063
15	46,176	90,509	120,064	134,841	149,619

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,061	6,277	7,755	8,494	9,233
2	5,169	8,494	10,710	11,819	12,927
3	6,277	10,710	13,666	15,144	16,621
4	7,385	12,927	16,621	18,469	20,316
5	8,494	15,144	19,577	21,793	24,010
6	9,824	17,804	23,123	25,783	28,443
7	10,710	19,577	25,488	28,443	31,399
8	12,927	24,010	31,399	35,093	38,788
9	15,144	28,443	37,310	41,743	46,176
10	17,360	32,877	43,221	48,393	53,565
11	19,577	37,310	49,132	55,043	60,954
12	21,793	41,743	55,043	61,693	68,342
13	24,010	46,176	60,954	68,342	75,731
14	30,660	59,476	78,687	88,292	97,897
15	32,877	63,909	84,598	94,942	105,286

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	3,617	5,391	6,573	7,164	7,755
2	4,504	7,164	8,937	9,824	10,710
3	5,391	8,937	11,301	12,484	13,666
4	6,277	10,710	13,666	15,144	16,621
5	7,164	12,484	16,030	17,804	19,577
6	8,228	14,612	18,868	20,996	23,123
7	8,937	16,030	20,759	23,123	25,488
8	10,710	19,577	25,488	28,443	31,399
9	12,484	23,123	30,217	33,763	37,310
10	14,257	26,670	34,945	39,083	43,221
11	16,030	30,217	39,674	44,403	49,132
12	17,804	33,763	44,403	49,723	55,043
13	19,577	37,310	49,132	55,043	60,954
14	24,897	47,950	63,318	71,002	78,687
15	26,670	51,496	68,047	76,322	84,598

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,536	7,227	9,022	9,919	10,816
2	5,881	9,919	12,610	13,956	15,302
3	7,227	12,610	16,199	17,994	19,788
4	8,573	15,302	19,788	22,031	24,274
5	9,919	17,994	23,377	26,068	28,760
6	11,534	21,223	27,683	30,913	34,143
7	12,610	23,377	30,554	34,143	37,732
8	15,302	28,760	37,732	42,218	46,704
9	17,994	34,143	44,910	50,293	55,676
10	20,685	39,526	52,087	58,368	64,648
11	23,377	44,910	59,265	66,443	73,620
12	26,068	50,293	66,443	74,517	82,592
13	28,760	55,676	73,620	82,592	91,564
14	36,835	71,826	95,153	106,817	118,480
15	39,526	77,209	102,331	114,891	127,452

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,694	7,544	9,444	10,394	11,344
2	6,119	10,394	13,244	14,669	16,094
3	7,544	13,244	17,044	18,944	20,844
4	8,969	16,094	20,844	23,218	25,593
5	10,394	18,944	24,643	27,493	30,343
6	12,104	22,363	29,203	32,623	36,043
7	13,244	24,643	32,243	36,043	39,843
8	16,094	30,343	39,843	44,593	49,343
9	18,944	36,043	47,443	53,143	58,843
10	21,793	41,743	55,043	61,693	68,342
11	24,643	47,443	62,643	70,242	77,842
12	27,493	53,143	70,242	78,792	87,342
13	30,343	58,843	77,842	87,342	96,842
14	38,893	75,942	100,642	112,992	125,341
15	41,743	81,642	108,242	121,541	134,841

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	6,374	10,905	13,925	15,435	16,945
2	8,640	15,435	19,966	22,231	24,496
3	10,905	19,966	26,006	29,026	32,047
4	13,170	24,496	32,047	35,822	39,597
5	15,435	29,026	38,087	42,618	47,148
6	18,153	34,463	45,336	50,772	56,209
7	19,966	38,087	50,168	56,209	62,249
8	24,496	47,148	62,249	69,800	77,351
9	29,026	56,209	74,330	83,391	92,452
10	33,557	65,270	86,411	96,982	107,553
11	38,087	74,330	98,492	110,574	122,655
12	42,618	83,391	110,574	124,165	137,756
13	47,148	92,452	122,655	137,756	152,857
14	60,739	119,634	158,898	178,530	198,161
15	65,270	128,695	170,979	192,121	213,263

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,015	8,186	10,301	11,358	12,415
2	6,601	11,358	14,529	16,115	17,700
3	8,186	14,529	18,757	20,872	22,986
4	9,772	17,700	22,986	25,629	28,271
5	11,358	20,872	27,214	30,385	33,557
6	13,261	24,677	32,288	36,094	39,899
7	14,529	27,214	35,671	39,899	44,128
8	17,700	33,557	44,128	49,413	54,699
9	20,872	39,899	52,584	58,927	65,270
10	24,043	46,242	61,041	68,441	75,840
11	27,214	52,584	69,498	77,955	86,411
12	30,385	58,927	77,955	87,469	96,982
13	33,557	65,270	86,411	96,982	107,553
14	43,071	84,297	111,782	125,524	139,266
15	46,242	90,640	120,238	135,038	149,837

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	4,381	6,918	8,609	9,455	10,301
2	5,649	9,455	11,992	13,261	14,529
3	6,918	11,992	15,375	17,066	18,757
4	8,186	14,529	18,757	20,872	22,986
5	9,455	17,066	22,140	24,677	27,214
6	10,977	20,110	26,199	29,244	32,288
7	11,992	22,140	28,906	32,288	35,671
8	14,529	27,214	35,671	39,899	44,128
9	17,066	32,288	42,436	47,510	52,584
10	19,603	37,362	49,202	55,121	61,041
11	22,140	42,436	55,967	62,733	69,498
12	24,677	47,510	62,733	70,344	77,955
13	27,214	52,584	69,498	77,955	86,411
14	34,825	67,807	89,794	100,788	111,782
15	37,362	72,881	96,560	108,399	120,238

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,695	9,546	12,113	13,396	14,680
2	7,620	13,396	17,247	19,173	21,098
3	9,546	17,247	22,382	24,949	27,516
4	11,471	21,098	27,516	30,725	33,934
5	13,396	24,949	32,651	36,501	40,352
6	15,707	29,570	38,812	43,433	48,054
7	17,247	32,651	42,920	48,054	53,188
8	21,098	40,352	53,188	59,607	66,025
9	24,949	48,054	63,457	71,159	78,861
10	28,800	55,756	73,726	82,712	91,697
11	32,651	63,457	83,995	94,264	104,533
12	36,501	71,159	94,264	105,817	117,369
13	40,352	78,861	104,533	117,369	130,205
14	51,905	101,966	135,340	152,027	168,714
15	55,756	109,667	145,609	163,579	181,550

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,921	9,999	12,717	14,076	15,435
2	7,960	14,076	18,153	20,192	22,231
3	9,999	18,153	23,590	26,308	29,026
4	12,037	22,231	29,026	32,424	35,822
5	14,076	26,308	34,463	38,540	42,618
6	16,522	31,201	40,987	45,879	50,772
7	18,153	34,463	45,336	50,772	56,209
8	22,231	42,618	56,209	63,004	69,800
9	26,308	50,772	67,082	75,236	83,391
10	30,385	58,927	77,955	87,469	96,982
11	34,463	67,082	88,828	99,701	110,574
12	38,540	75,236	99,701	111,933	124,165
13	42,618	83,391	110,574	124,165	137,756
14	54,850	107,855	143,192	160,861	178,530
15	58,927	116,010	154,065	173,093	192,121

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,697	13,550	17,453	19,404	21,355
2	10,624	19,404	25,257	28,183	31,110
3	13,550	25,257	33,061	36,963	40,865
4	16,477	31,110	40,865	45,743	50,621
5	19,404	36,963	48,670	54,523	60,376
6	22,916	43,987	58,035	65,059	72,083
7	25,257	48,670	64,278	72,083	79,887
8	31,110	60,376	79,887	89,642	99,398
9	36,963	72,083	95,496	107,202	118,909
10	42,817	83,789	111,104	124,762	138,419
11	48,670	95,496	126,713	142,321	157,930
12	54,523	107,202	142,321	159,881	177,441
13	60,376	118,909	157,930	177,441	196,952
14	77,936	154,028	204,756	230,120	255,484
15	83,789	165,734	220,365	247,680	274,995

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,941	10,038	12,770	14,136	15,501
2	7,990	14,136	18,233	20,282	22,330
3	10,038	18,233	23,696	26,427	29,159
4	12,087	22,330	29,159	32,573	35,988
5	14,136	26,427	34,622	38,719	42,817
6	16,594	31,344	41,178	46,094	51,011
7	18,233	34,622	45,548	51,011	56,474
8	22,330	42,817	56,474	63,303	70,132
9	26,427	51,011	67,400	75,595	83,789
10	30,525	59,206	78,326	87,886	97,447
11	34,622	67,400	89,252	100,178	111,104
12	38,719	75,595	100,178	112,470	124,762
13	42,817	83,789	111,104	124,762	138,419
14	55,108	108,373	143,882	161,637	179,392
15	59,206	116,567	154,808	173,929	193,049

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,122	8,400	10,585	11,677	12,770
2	6,761	11,677	14,955	16,594	18,233
3	8,400	14,955	19,326	21,511	23,696
4	10,038	18,233	23,696	26,427	29,159
5	11,677	21,511	28,066	31,344	34,622
6	13,644	25,444	33,311	37,244	41,178
7	14,955	28,066	36,807	41,178	45,548
8	18,233	34,622	45,548	51,011	56,474
9	21,511	41,178	54,289	60,844	67,400
10	24,789	47,733	63,030	70,678	78,326
11	28,066	54,289	71,771	80,511	89,252
12	31,344	60,844	80,511	90,345	100,178
13	34,622	67,400	89,252	100,178	111,104
14	44,455	87,067	115,475	129,678	143,882
15	47,733	93,623	124,215	139,512	154,808

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	6,819	11,794	15,111	16,770	18,428
2	9,307	16,770	21,745	24,233	26,720
3	11,794	21,745	28,379	31,695	35,012
4	14,282	26,720	35,012	39,158	43,304
5	16,770	31,695	41,646	46,621	51,596
6	19,755	37,666	49,606	55,577	61,547
7	21,745	41,646	54,913	61,547	68,181
8	26,720	51,596	68,181	76,473	84,765
9	31,695	61,547	81,448	91,398	101,349
10	36,671	71,497	94,715	106,324	117,933
11	41,646	81,448	107,983	121,250	134,517
12	46,621	91,398	121,250	136,176	151,101
13	51,596	101,349	134,517	151,101	167,685
14	66,522	131,200	174,319	195,879	217,438
15	71,497	141,151	187,586	210,804	234,022

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,112	12,380	15,892	17,648	19,404
2	9,746	17,648	22,916	25,550	28,183
3	12,380	22,916	29,939	33,451	36,963
4	15,014	28,183	36,963	41,353	45,743
5	17,648	33,451	43,987	49,255	54,523
6	20,808	39,773	52,416	58,737	65,059
7	22,916	43,987	58,035	65,059	72,083
8	28,183	54,523	72,083	80,863	89,642
9	33,451	65,059	86,130	96,666	107,202
10	38,719	75,595	100,178	112,470	124,762
11	43,987	86,130	114,226	128,274	142,321
12	49,255	96,666	128,274	144,077	159,881
13	54,523	107,202	142,321	159,881	177,441
14	70,327	138,810	184,465	207,292	230,120
15	75,595	149,345	198,513	223,096	247,680

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago	0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago	0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago	0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago	0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago	0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago	0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago	0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago	0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	2.088	2.136	2.172	2.196	2.208
1+ to 2 yrs. ago	1.416	1.452	1.476	1.488	1.488
2+ to 3 yrs. ago	0.912	0.936	0.948	0.948	0.948
3+ to 4 yrs. ago	0.576	0.588	0.588	0.588	0.588
4+ to 5 yrs. ago	0.408	0.408	0.408	0.408	0.408
5+ to 6 yrs. ago	0.288	0.288	0.288	0.288	0.288
6+ to 7 yrs. ago	0.192	0.192	0.192	0.192	0.192
7+ to 8 yrs. ago	0.120	0.120	0.120	0.120	0.120
8+ to 9 yrs. ago	0.072	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago	0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago	0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago	0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago	0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago	0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago	0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**Major Surgery**
Endocrinology	80238	-	-
Infectious Disease	80246		-

2. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

CLARIFICATION OF SPECIALTY CODES

Code	Specialty Description
80102(A)	Emergency Medicine – Moonlighting - no surgery
80102(B)	Emergency Medicine – Moonlighting - minor surgery
80102(C)	Emergency Medicine – clinic/hosp. primarily
80117(A)	Family/General Practice, No OB – major surgery
80117(B)	Family/General Practice, Limited OB – major surgery
80117(C)	Family/General Practice, Significant OB – major surgery
80145(A)	Urology – no surgery
80145(B)	Urology – minor surgery
80145(C)	Urology – major surgery
80154(A)	Orthopedic (No Spines) – major surgery
80154(B)	Orthopedic (Spines) – major surgery
80222(A)	Hospitalist – Hosp. Employed/ Single Hospital Affiliation
80222(B)	Hospitalist – Non-Hosp. Employed/Multiple Hospital Affiliations
80256(A)	Dermatology – no surgery
80256(B)	Dermatology – no surgery (specified procedures)
80281(A)	Cardiovascular Dis. – minor surgery
80281(B)	Cardiovascular Dis. – minor surgery, specified procedures
80421(A)	FP or GP – assist in major surgery - own patients only (no minor)
80421(B)	FP or GP – minor surgery & assist in major surgery- own patients
80421(C)	FP or GP – assist in major surgery
80424(F)	Urgent Care – no surgery
80424(V)	Urgent Care – no surgery, rated on a per-visit basis
80475(A)	Pain Management – no major surgery
80475(B)	Pain Management – basic procedures
80475(C)	Pain Management – intermediate procedures
80475(D)	Pain Management – advanced procedures
80116(A)	Physician Assistant
80116(B)	Surgeon Assistant
80960(D)	Nurse Anesthetist – Dental
80960(M)	Nurse Anesthetist – Medical

3. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

5. Item V, Scheduled Rating Program, of Section 4, Professional Liability Discounts, is amended as follows:

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

6. Item VI, Deductibles, of Section 4, Professional Liability Discounts, is hereby replaced by the following:

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

Per Claim/Aggregate		Per Claim/Aggregate	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 12,750
10/30	.038	.035	.030	.024	25,500
25/75	.084	.079	.070	.058	63,750
50/150	.145	.139	.127	.109	127,500
100/300	.234	.228	.216	.196	255,000
200/600	.348	.346	.338	.321	510,000
250/750	.385	.385	.381	.368	637,500

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

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. 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.

B. Rules

1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.

   A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date.

Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

   With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

SECTION 8

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.

2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard rating factors.

Claims-made Rate Per 100 Patient Visits $1,000,000 / $3,000,000						
Class	**Code**	**Territory 1**	**Territory 2**	**Territory 3**	**Territory 4**	**Territory 5**
Emergency Room	80429	$2,287	$1,613	$1,298	$1,950	$2,062
Urgent Care	80424(V)	$1,725	$1,220	$984	$1,472	$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 7, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
c. Determine the remaining optional separate limit premium, if applicable.
d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

SECTION 9

STATE RATES AND EXCEPTIONS – PHYSICIAN EXTENDER, PARAMEDICAL

AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

4. Item I of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.026	0.080	0.025
Surgeon's Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041
Psychologist	0.018	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.500	0.149

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.022	0.045	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

5. Item II of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.128
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse – Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.080
Physiotherapist	80938	0.018
Psychologist	80912	0.054
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.125
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80151)
Nurse Anesthetist – Medical	80960(M)	0.350
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

Health Care Professional NOC	80301	Refer to Company

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

C. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

II. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Explanatory Memorandum
Comments:
Attachment:
Filing Memorandum.PDF

Item Status: **Status Date:**

Bypassed - Item: Form RF3 - (Summary Sheet)
Bypass Reason: N/A - Initial Filing - no rate change
Comments:

Item Status: **Status Date:**

Satisfied - Item: Certification
Comments:
Attachment:
Certification.PDF

Item Status: **Status Date:**

Bypassed - Item: Manual
Bypass Reason: Complete up to date manual is located on the rate/rule schedule tab.
Comments:

Item Status: **Status Date:**

Satisfied - Item: marked manual pages
Comments:
Attachments:
Revised Page 10-marked.PDF

Revised Page 17-marked.PDF

Revised page 50-group deductibles-marked.PDF

Central Illinois Physicians Risk Purchasing Group
Filing Memorandum

The purchasing group's only purpose is the purchasing of medical professional liability insurance on a purchasing group basis from ProAssurance Casualty Company for its physician members and to meet their mutual need to acquire reasonably priced insurance coverage.

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

Kathryn A. Neville

_____ 9/27/11

Kathryn A. Neville, Secretary
Signature and Title of Authorized Insurance Company Officer — Date

_____ 9/27/11

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

Insurance Company FEIN 39-1567580 Filing Number IL-CIPRPG-0711-RR
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

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. ~~The rate shall generally be 50% of the appropriate specialty classification, but may vary from 25% to 75% depending upon the clinical exposure of each individual rated.~~ For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:

a) First year resident – 25% of the appropriate specialty classification rate
b) Second year resident – 50% of the appropriate specialty classification rate
c) Third year resident – 75% of the appropriate specialty classification rate
d) Fellows and interns – 85% of the appropriate specialty classification rate

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).

C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

Classification	Rating Criteria:
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of ~~up to~~ 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and*
12. Insured group maintains differing limits of liability on members.*

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 12~~0~~,750~~0~~
10/30	.038	.035	.030	.024	25~~1~~,~~0~~500
25/75	.084	.079	.070	.058	~~52~~63,750~~0~~
50/150	.145	.139	.127	.109	127~~05~~,~~0~~500
100/300	.234	.228	.216	.196	255~~10~~,000
200/600	.348	.346	.338	.321	~~42~~510,000
250/750	.385	.385	.381	.368	~~525~~637,~~0~~500

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

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/09/2011	Supporting Document	Certification	10/03/2011	
10/05/2011	Rate and Rule	Underwriting Manual	01/05/2012	CIPRPG Manual eff 7-1-11.PDF (Superceded)
10/04/2011	Rate and Rule	Revised Manual Pages	10/05/2011	Revised Pages 11 and 13.PDF (Superceded)
10/03/2011	Rate and Rule	Underwriting Manual	10/04/2011	CIPRPG Manual eff 7-1-11.PDF (Superceded)
05/10/2011	Rate and Rule	Underwriting Manual	10/03/2011	CIPRPG Manual eff 7-1-11.PDF (Superceded)

ILLINOIS MANUAL

HEALTHCARE PROFESSIONALS

UNDERWRITING RULES AND RATES

For Insureds of the
Central Illinois Physicians Risk Purchasing Group

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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance written through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

SPECIALTY CODES AND DESCRIPTIONS

* *

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**All Other Surgery**
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code: No Surgery	Industry Class Code: Minor Surgery	Industry Class Code: All Other Surgery
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code No Surgery	Minor Surgery	All Other Surgery
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)-basic procedures
	-	-	80475(C)-intermediate procedures
	-	-	80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Surgical Consultation – Office Only	80477(A)	80477(B)	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.
***See Internal Medicine – Minor Surgery.

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:
   a) First year resident - 25% of the appropriate specialty classification rate
   b) Second year resident - 50% of the appropriate specialty classification rate
   c) Third year resident - 75% of the appropriate specialty classification rate
   d) Fellows and interns - 85% of the appropriate specialty classification rate

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).

C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

Classification	Rating Criteria:
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

TYPE	Class	Average Weekly Practice Hours <20 hours
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty (2,080 hours of work per FTE) or the average number of patient contacts/visits in a 12 month period (4,000 visits per FTE). A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. 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:

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.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 40% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor discounts: up to 50%. Deductible credits may be combined with the New Doctor discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing $100,000 or more annualized premium

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credits, up to a maximum of 12%.

A. Individual Risk Management Activities: Individual insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

		Activity	Credit
1.		Successful completion of an approved fee-for-service office analysis and education program. Positive response to recommendations made shall result in the application of this credit for up to three policy years. Applicable only to accounts generating $250,000 or more in annual premium.	5%
2.	a.	A Company sponsored Loss Prevention or other approved risk management seminar carrying at least two CME credits (annual); or,	5%

	b.	(i) A Company-produced online Loss Prevention seminar.	2.5%
3.		Company-produced Supplemental Online Modules (up to four).	0.5% for each module completed (up to a maximum of 2.0%)
4.	a.	An approved closed claim review (annual); and/or	5%
	b.	Successful completion of an approved risk management correspondence course carrying at least two CME credits (annual).	5%
5.		Demonstrated regular use of an approved patient information system or program.	5%

Educational activities must qualify for Continuing Medical Education credit (where applicable) to be acceptable for risk management credits. The applicant must provide proof (Certificate) of CME credits earned at the time of application. Activities submitted for risk management credits must have been completed within twelve months prior to application.

B. In addition to the above, any physician or surgeon whose practice benefits from the risk management activities of an employed practice administrator or risk manager may receive one of the following credits:
   1. If the practice employs a full-time, qualified, professional risk manager primarily engaged in risk management and loss prevention activities, each insured shall receive a 5% credit.
   2. If the practice administrator or office manager participates in a Company-sponsored Loss Prevention or other risk management seminar, each insured shall receive a 2% credit. Certain requirements apply:
      a. The seminar must be designated by the Company as eligible for practice administrator credit.
      b. Attendance must occur within the twelve months prior to the effective date of the policy being rated.
      c. At least 75% of the insureds in the practice must qualify for risk management credit as a result of individual risk management activities under the terms of Section III(A)(2), above.
      d. The practice administrator or office manager must actively manage the practice for thirty or more hours per week. In the case of shared practice management, determination of eligibility will rest with the Company.

C. Any risk management credit will be revoked or withheld for any of the following reasons:
   1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
   2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company,
   3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
   4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and*
12. Insured group maintains differing limits of liability on members.*

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

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

A. Individual Deductibles

See State Rates and Exceptions.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

See State Rates and Exceptions.

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. New Doctor Discount or other resident or part-time, semi-retired discount;
3. Risk Management Discount and Scheduled Rating (apply the net credit or debit); and

Example: Class 1, $1M/$3M, 1st year new doctor, Risk Management Seminar within 12 months. $25,000 deductible. Assume manual rate $7,500.

$7,500	Manual Rate for $1M/$3M
x .91	Less 9% (Deductible Credit)
6825	
x .50	Less 50% (New Doctor)
3,413	Applicable Net Premium
x .85	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. 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.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. 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 Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians and dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to participants in the Program at no additional charge. There is a premium charge for those insureds that elect expanded coverage with higher limits.

Limits are in excess of $50,000 primary coverage.

# of Physicians	$1M Limit
1 Physician	$ 1,125
2 Physicians	$ 1,500
3-5 Physicians	$ 2,063
6-10 Physicians	$ 2,813
10-15 Physicians	$ 3,750
16-20 Physicians	$ 5,100
21-25 Physicians	$ 6,375
26-30 Physicians	$ 7,650

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.132	0.400	0.120
Surgeon's Assistant (SA)	0.132	0.400	0.120
Certified Nurse Practitioner (CNP)	0.132	0.400	0.120
Psychologist	0.040	0.111	0.033
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.025	0.050	0.015

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.400
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physiotherapist	80938	0.018
Psychologist	80912	0.111
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.122
Social Worker	80911	0.045
Sonographer	80754	0.018
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	Factors
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under $500 are not eligible for the step-rating factors.

SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND PODIATRISTS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes					
1	80102(A)	80179	80235	80240	80256(A)	80620
	80178	80231	80236	80254	80265	
2	80233	80249	80256(B)	80267	80621	
	80238	80252	80263	80474		
3	80102(B)	80244	80257	80268	80420	80477(A)
	80145(A)	80245	80260	80282	80431	
	80222(A)	80255	80266	80289	80473	
4	80114	80151	80241	80253	80269	
	80145(B)	80222(B)	80246	80261	80421(A)	
5	80145(C)	80280	80286	80291	80360	80425
	80274	80283	80287	80293	80421(B)	80477(B)
	80278	80284	80288	80294	80424(F)	
6	80102(C)	80159	80277	80421(C)		
	80117(A)	80167	80281(A)	80472		
7	80115	80117(B)	80281(B)	80475(A)		
8	80117(C)	80155	80169			
9	80143	80154(A)	80156			
10	80146	80150				
11	80144	80154(B)	80171	80475(B)		
12	80153					
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	5,011	8,177	10,288	11,344	12,399
2	6,594	11,344	14,510	16,094	17,677
3	8,177	14,510	18,732	20,844	22,955
4	9,760	17,677	22,955	25,593	28,232
5	11,344	20,844	27,177	30,343	33,510
6	13,244	24,643	32,243	36,043	39,843
7	14,510	27,177	35,621	39,843	44,065
8	17,677	33,510	44,065	49,343	54,621
9	20,844	39,843	52,509	58,843	65,176
10	24,010	46,176	60,954	68,342	75,731
11	27,177	52,509	69,398	77,842	86,287
12	30,343	58,843	77,842	87,342	96,842
13	33,510	65,176	86,287	96,842	107,397
14	43,010	84,175	111,619	125,341	139,063
15	46,176	90,509	120,064	134,841	149,619

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,061	6,277	7,755	8,494	9,233
2	5,169	8,494	10,710	11,819	12,927
3	6,277	10,710	13,666	15,144	16,621
4	7,385	12,927	16,621	18,469	20,316
5	8,494	15,144	19,577	21,793	24,010
6	9,824	17,804	23,123	25,783	28,443
7	10,710	19,577	25,488	28,443	31,399
8	12,927	24,010	31,399	35,093	38,788
9	15,144	28,443	37,310	41,743	46,176
10	17,360	32,877	43,221	48,393	53,565
11	19,577	37,310	49,132	55,043	60,954
12	21,793	41,743	55,043	61,693	68,342
13	24,010	46,176	60,954	68,342	75,731
14	30,660	59,476	78,687	88,292	97,897
15	32,877	63,909	84,598	94,942	105,286

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	3,617	5,391	6,573	7,164	7,755
2	4,504	7,164	8,937	9,824	10,710
3	5,391	8,937	11,301	12,484	13,666
4	6,277	10,710	13,666	15,144	16,621
5	7,164	12,484	16,030	17,804	19,577
6	8,228	14,612	18,868	20,996	23,123
7	8,937	16,030	20,759	23,123	25,488
8	10,710	19,577	25,488	28,443	31,399
9	12,484	23,123	30,217	33,763	37,310
10	14,257	26,670	34,945	39,083	43,221
11	16,030	30,217	39,674	44,403	49,132
12	17,804	33,763	44,403	49,723	55,043
13	19,577	37,310	49,132	55,043	60,954
14	24,897	47,950	63,318	71,002	78,687
15	26,670	51,496	68,047	76,322	84,598

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,536	7,227	9,022	9,919	10,816
2	5,881	9,919	12,610	13,956	15,302
3	7,227	12,610	16,199	17,994	19,788
4	8,573	15,302	19,788	22,031	24,274
5	9,919	17,994	23,377	26,068	28,760
6	11,534	21,223	27,683	30,913	34,143
7	12,610	23,377	30,554	34,143	37,732
8	15,302	28,760	37,732	42,218	46,704
9	17,994	34,143	44,910	50,293	55,676
10	20,685	39,526	52,087	58,368	64,648
11	23,377	44,910	59,265	66,443	73,620
12	26,068	50,293	66,443	74,517	82,592
13	28,760	55,676	73,620	82,592	91,564
14	36,835	71,826	95,153	106,817	118,480
15	39,526	77,209	102,331	114,891	127,452

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,694	7,544	9,444	10,394	11,344
2	6,119	10,394	13,244	14,669	16,094
3	7,544	13,244	17,044	18,944	20,844
4	8,969	16,094	20,844	23,218	25,593
5	10,394	18,944	24,643	27,493	30,343
6	12,104	22,363	29,203	32,623	36,043
7	13,244	24,643	32,243	36,043	39,843
8	16,094	30,343	39,843	44,593	49,343
9	18,944	36,043	47,443	53,143	58,843
10	21,793	41,743	55,043	61,693	68,342
11	24,643	47,443	62,643	70,242	77,842
12	27,493	53,143	70,242	78,792	87,342
13	30,343	58,843	77,842	87,342	96,842
14	38,893	75,942	100,642	112,992	125,341
15	41,743	81,642	108,242	121,541	134,841

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	6,374	10,905	13,925	15,435	16,945
2	8,640	15,435	19,966	22,231	24,496
3	10,905	19,966	26,006	29,026	32,047
4	13,170	24,496	32,047	35,822	39,597
5	15,435	29,026	38,087	42,618	47,148
6	18,153	34,463	45,336	50,772	56,209
7	19,966	38,087	50,168	56,209	62,249
8	24,496	47,148	62,249	69,800	77,351
9	29,026	56,209	74,330	83,391	92,452
10	33,557	65,270	86,411	96,982	107,553
11	38,087	74,330	98,492	110,574	122,655
12	42,618	83,391	110,574	124,165	137,756
13	47,148	92,452	122,655	137,756	152,857
14	60,739	119,634	158,898	178,530	198,161
15	65,270	128,695	170,979	192,121	213,263

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,015	8,186	10,301	11,358	12,415
2	6,601	11,358	14,529	16,115	17,700
3	8,186	14,529	18,757	20,872	22,986
4	9,772	17,700	22,986	25,629	28,271
5	11,358	20,872	27,214	30,385	33,557
6	13,261	24,677	32,288	36,094	39,899
7	14,529	27,214	35,671	39,899	44,128
8	17,700	33,557	44,128	49,413	54,699
9	20,872	39,899	52,584	58,927	65,270
10	24,043	46,242	61,041	68,441	75,840
11	27,214	52,584	69,498	77,955	86,411
12	30,385	58,927	77,955	87,469	96,982
13	33,557	65,270	86,411	96,982	107,553
14	43,071	84,297	111,782	125,524	139,266
15	46,242	90,640	120,238	135,038	149,837

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	4,381	6,918	8,609	9,455	10,301
2	5,649	9,455	11,992	13,261	14,529
3	6,918	11,992	15,375	17,066	18,757
4	8,186	14,529	18,757	20,872	22,986
5	9,455	17,066	22,140	24,677	27,214
6	10,977	20,110	26,199	29,244	32,288
7	11,992	22,140	28,906	32,288	35,671
8	14,529	27,214	35,671	39,899	44,128
9	17,066	32,288	42,436	47,510	52,584
10	19,603	37,362	49,202	55,121	61,041
11	22,140	42,436	55,967	62,733	69,498
12	24,677	47,510	62,733	70,344	77,955
13	27,214	52,584	69,498	77,955	86,411
14	34,825	67,807	89,794	100,788	111,782
15	37,362	72,881	96,560	108,399	120,238

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,695	9,546	12,113	13,396	14,680
2	7,620	13,396	17,247	19,173	21,098
3	9,546	17,247	22,382	24,949	27,516
4	11,471	21,098	27,516	30,725	33,934
5	13,396	24,949	32,651	36,501	40,352
6	15,707	29,570	38,812	43,433	48,054
7	17,247	32,651	42,920	48,054	53,188
8	21,098	40,352	53,188	59,607	66,025
9	24,949	48,054	63,457	71,159	78,861
10	28,800	55,756	73,726	82,712	91,697
11	32,651	63,457	83,995	94,264	104,533
12	36,501	71,159	94,264	105,817	117,369
13	40,352	78,861	104,533	117,369	130,205
14	51,905	101,966	135,340	152,027	168,714
15	55,756	109,667	145,609	163,579	181,550

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,921	9,999	12,717	14,076	15,435
2	7,960	14,076	18,153	20,192	22,231
3	9,999	18,153	23,590	26,308	29,026
4	12,037	22,231	29,026	32,424	35,822
5	14,076	26,308	34,463	38,540	42,618
6	16,522	31,201	40,987	45,879	50,772
7	18,153	34,463	45,336	50,772	56,209
8	22,231	42,618	56,209	63,004	69,800
9	26,308	50,772	67,082	75,236	83,391
10	30,385	58,927	77,955	87,469	96,982
11	34,463	67,082	88,828	99,701	110,574
12	38,540	75,236	99,701	111,933	124,165
13	42,618	83,391	110,574	124,165	137,756
14	54,850	107,855	143,192	160,861	178,530
15	58,927	116,010	154,065	173,093	192,121

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,697	13,550	17,453	19,404	21,355
2	10,624	19,404	25,257	28,183	31,110
3	13,550	25,257	33,061	36,963	40,865
4	16,477	31,110	40,865	45,743	50,621
5	19,404	36,963	48,670	54,523	60,376
6	22,916	43,987	58,035	65,059	72,083
7	25,257	48,670	64,278	72,083	79,887
8	31,110	60,376	79,887	89,642	99,398
9	36,963	72,083	95,496	107,202	118,909
10	42,817	83,789	111,104	124,762	138,419
11	48,670	95,496	126,713	142,321	157,930
12	54,523	107,202	142,321	159,881	177,441
13	60,376	118,909	157,930	177,441	196,952
14	77,936	154,028	204,756	230,120	255,484
15	83,789	165,734	220,365	247,680	274,995

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,941	10,038	12,770	14,136	15,501
2	7,990	14,136	18,233	20,282	22,330
3	10,038	18,233	23,696	26,427	29,159
4	12,087	22,330	29,159	32,573	35,988
5	14,136	26,427	34,622	38,719	42,817
6	16,594	31,344	41,178	46,094	51,011
7	18,233	34,622	45,548	51,011	56,474
8	22,330	42,817	56,474	63,303	70,132
9	26,427	51,011	67,400	75,595	83,789
10	30,525	59,206	78,326	87,886	97,447
11	34,622	67,400	89,252	100,178	111,104
12	38,719	75,595	100,178	112,470	124,762
13	42,817	83,789	111,104	124,762	138,419
14	55,108	108,373	143,882	161,637	179,392
15	59,206	116,567	154,808	173,929	193,049

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,122	8,400	10,585	11,677	12,770
2	6,761	11,677	14,955	16,594	18,233
3	8,400	14,955	19,326	21,511	23,696
4	10,038	18,233	23,696	26,427	29,159
5	11,677	21,511	28,066	31,344	34,622
6	13,644	25,444	33,311	37,244	41,178
7	14,955	28,066	36,807	41,178	45,548
8	18,233	34,622	45,548	51,011	56,474
9	21,511	41,178	54,289	60,844	67,400
10	24,789	47,733	63,030	70,678	78,326
11	28,066	54,289	71,771	80,511	89,252
12	31,344	60,844	80,511	90,345	100,178
13	34,622	67,400	89,252	100,178	111,104
14	44,455	87,067	115,475	129,678	143,882
15	47,733	93,623	124,215	139,512	154,808

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	6,819	11,794	15,111	16,770	18,428
2	9,307	16,770	21,745	24,233	26,720
3	11,794	21,745	28,379	31,695	35,012
4	14,282	26,720	35,012	39,158	43,304
5	16,770	31,695	41,646	46,621	51,596
6	19,755	37,666	49,606	55,577	61,547
7	21,745	41,646	54,913	61,547	68,181
8	26,720	51,596	68,181	76,473	84,765
9	31,695	61,547	81,448	91,398	101,349
10	36,671	71,497	94,715	106,324	117,933
11	41,646	81,448	107,983	121,250	134,517
12	46,621	91,398	121,250	136,176	151,101
13	51,596	101,349	134,517	151,101	167,685
14	66,522	131,200	174,319	195,879	217,438
15	71,497	141,151	187,586	210,804	234,022

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,112	12,380	15,892	17,648	19,404
2	9,746	17,648	22,916	25,550	28,183
3	12,380	22,916	29,939	33,451	36,963
4	15,014	28,183	36,963	41,353	45,743
5	17,648	33,451	43,987	49,255	54,523
6	20,808	39,773	52,416	58,737	65,059
7	22,916	43,987	58,035	65,059	72,083
8	28,183	54,523	72,083	80,863	89,642
9	33,451	65,059	86,130	96,666	107,202
10	38,719	75,595	100,178	112,470	124,762
11	43,987	86,130	114,226	128,274	142,321
12	49,255	96,666	128,274	144,077	159,881
13	54,523	107,202	142,321	159,881	177,441
14	70,327	138,810	184,465	207,292	230,120
15	75,595	149,345	198,513	223,096	247,680

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago	0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago	0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago	0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago	0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago	0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago	0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago	0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago	0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	2.088	2.136	2.172	2.196	2.208
1+ to 2 yrs. ago	1.416	1.452	1.476	1.488	1.488
2+ to 3 yrs. ago	0.912	0.936	0.948	0.948	0.948
3+ to 4 yrs. ago	0.576	0.588	0.588	0.588	0.588
4+ to 5 yrs. ago	0.408	0.408	0.408	0.408	0.408
5+ to 6 yrs. ago	0.288	0.288	0.288	0.288	0.288
6+ to 7 yrs. ago	0.192	0.192	0.192	0.192	0.192
7+ to 8 yrs. ago	0.120	0.120	0.120	0.120	0.120
8+ to 9 yrs. ago	0.072	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago	0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago	0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago	0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago	0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago	0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago	0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**Major Surgery**
Endocrinology	80238	-	-
Infectious Disease	80246		-

2. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

CLARIFICATION OF SPECIALTY CODES

Code	Specialty Description
80102(A)	Emergency Medicine – Moonlighting - no surgery
80102(B)	Emergency Medicine – Moonlighting - minor surgery
80102(C)	Emergency Medicine – clinic/hosp. primarily
80117(A)	Family/General Practice, No OB – major surgery
80117(B)	Family/General Practice, Limited OB – major surgery
80117(C)	Family/General Practice, Significant OB – major surgery
80145(A)	Urology – no surgery
80145(B)	Urology – minor surgery
80145(C)	Urology – major surgery
80154(A)	Orthopedic (No Spines) – major surgery
80154(B)	Orthopedic (Spines) – major surgery
80222(A)	Hospitalist – Hosp. Employed/ Single Hospital Affiliation
80222(B)	Hospitalist – Non-Hosp. Employed/Multiple Hospital Affiliations
80256(A)	Dermatology – no surgery
80256(B)	Dermatology – no surgery (specified procedures)
80281(A)	Cardiovascular Dis. – minor surgery
80281(B)	Cardiovascular Dis. – minor surgery, specified procedures
80421(A)	FP or GP – assist in major surgery - own patients only (no minor)
80421(B)	FP or GP – minor surgery & assist in major surgery- own patients
80421(C)	FP or GP – assist in major surgery
80424(F)	Urgent Care – no surgery
80424(V)	Urgent Care – no surgery, rated on a per-visit basis
80475(A)	Pain Management – no major surgery
80475(B)	Pain Management – basic procedures
80475(C)	Pain Management – intermediate procedures
80475(D)	Pain Management – advanced procedures
80116(A)	Physician Assistant
80116(B)	Surgeon Assistant
80960(D)	Nurse Anesthetist – Dental
80960(M)	Nurse Anesthetist – Medical

3. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

5. Item V, Scheduled Rating Program, of Section 4, Professional Liability Discounts, is amended as follows:

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

6. Item VI, Deductibles, of Section 4, Professional Liability Discounts, is hereby replaced by the following:

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

Per Claim/Aggregate		Per Claim/Aggregate	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

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

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. 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.

B. Rules

1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.

   A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date.

Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

   With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

SECTION 8

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.

2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard rating factors.

Claims-made Rate Per 100 Patient Visits $1,000,000 / $3,000,000						
Class	**Code**	**Territory 1**	**Territory 2**	**Territory 3**	**Territory 4**	**Territory 5**
Emergency Room	80429	$2,287	$1,613	$1,298	$1,950	$2,062
Urgent Care	80424(V)	$1,725	$1,220	$984	$1,472	$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 7, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
c. Determine the remaining optional separate limit premium, if applicable.
d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

SECTION 9

STATE RATES AND EXCEPTIONS – PHYSICIAN EXTENDER, PARAMEDICAL

AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

4. Item I of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.026	0.080	0.025
Surgeon's Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041
Psychologist	0.018	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.500	0.149

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.022	0.045	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

5. Item II of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.128
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse – Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.080
Physiotherapist	80938	0.018
Psychologist	80912	0.054
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.125
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80151)
Nurse Anesthetist – Medical	80960(M)	0.350
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

Health Care Professional NOC	80301	Refer to Company

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

C. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

II. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

TYPE	Class	Average Weekly Practice Hours <20 hours
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty (2,080 hours of work per FTE) or the average number of patient contacts/visits in a 12 month period (4,000 visits per FTE). A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

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.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

ILLINOIS MANUAL

HEALTHCARE PROFESSIONALS

UNDERWRITING RULES AND RATES

For Insureds of the
Central Illinois Physicians Risk Purchasing Group

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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance written through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

SPECIALTY CODES AND DESCRIPTIONS

* *

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**All Other Surgery**
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code: No Surgery	Industry Class Code: Minor Surgery	Industry Class Code: All Other Surgery
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code No Surgery	Minor Surgery	All Other Surgery
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)-basic procedures
	-	-	80475(C)-intermediate procedures
	-	-	80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Surgical Consultation – Office Only	80477(A)	80477(B)	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.
***See Internal Medicine – Minor Surgery.

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:
   a) First year resident - 25% of the appropriate specialty classification rate
   b) Second year resident - 50% of the appropriate specialty classification rate
   c) Third year resident - 75% of the appropriate specialty classification rate
   d) Fellows and interns - 85% of the appropriate specialty classification rate

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).

C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

Classification	Rating Criteria:
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

TYPE	Class	Average Weekly Practice Hours <20 hours
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period. A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. 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:

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.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 40% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor discounts: up to 50%. Deductible credits may be combined with the New Doctor discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing $100,000 or more annualized premium

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credits, up to a maximum of 12%.

A. Individual Risk Management Activities: Individual insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

		Activity	Credit
1.		Successful completion of an approved fee-for-service office analysis and education program. Positive response to recommendations made shall result in the application of this credit for up to three policy years. Applicable only to accounts generating $250,000 or more in annual premium.	5%
2.	a.	A Company sponsored Loss Prevention or other approved risk management seminar carrying at least two CME credits (annual); or,	5%

	b.	(i) A Company-produced online Loss Prevention seminar.	2.5%
3.		Company-produced Supplemental Online Modules (up to four).	0.5% for each module completed (up to a maximum of 2.0%)
4.	a.	An approved closed claim review (annual); and/or	5%
	b.	Successful completion of an approved risk management correspondence course carrying at least two CME credits (annual).	5%
5.		Demonstrated regular use of an approved patient information system or program.	5%

Educational activities must qualify for Continuing Medical Education credit (where applicable) to be acceptable for risk management credits. The applicant must provide proof (Certificate) of CME credits earned at the time of application. Activities submitted for risk management credits must have been completed within twelve months prior to application.

B. In addition to the above, any physician or surgeon whose practice benefits from the risk management activities of an employed practice administrator or risk manager may receive one of the following credits:
   1. If the practice employs a full-time, qualified, professional risk manager primarily engaged in risk management and loss prevention activities, each insured shall receive a 5% credit.
   2. If the practice administrator or office manager participates in a Company-sponsored Loss Prevention or other risk management seminar, each insured shall receive a 2% credit. Certain requirements apply:
      a. The seminar must be designated by the Company as eligible for practice administrator credit.
      b. Attendance must occur within the twelve months prior to the effective date of the policy being rated.
      c. At least 75% of the insureds in the practice must qualify for risk management credit as a result of individual risk management activities under the terms of Section III(A)(2), above.
      d. The practice administrator or office manager must actively manage the practice for thirty or more hours per week. In the case of shared practice management, determination of eligibility will rest with the Company.

C. Any risk management credit will be revoked or withheld for any of the following reasons:
   1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
   2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company,
   3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
   4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and*
12. Insured group maintains differing limits of liability on members.*

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

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

A. Individual Deductibles

See State Rates and Exceptions.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

See State Rates and Exceptions.

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. New Doctor Discount or other resident or part-time, semi-retired discount;
3. Risk Management Discount and Scheduled Rating (apply the net credit or debit); and

Example: Class 1, $1M/$3M, 1st year new doctor, Risk Management Seminar within 12 months. $25,000 deductible. Assume manual rate $7,500.

$7,500	Manual Rate for $1M/$3M
x .91	Less 9% (Deductible Credit)
6825	
x .50	Less 50% (New Doctor)
3,413	Applicable Net Premium
x .85	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. 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.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. 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 Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians and dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to participants in the Program at no additional charge. There is a premium charge for those insureds that elect expanded coverage with higher limits.

Limits are in excess of $50,000 primary coverage.

# of Physicians	$1M Limit
1 Physician	$ 1,125
2 Physicians	$ 1,500
3-5 Physicians	$ 2,063
6-10 Physicians	$ 2,813
10-15 Physicians	$ 3,750
16-20 Physicians	$ 5,100
21-25 Physicians	$ 6,375
26-30 Physicians	$ 7,650

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.132	0.400	0.120
Surgeon's Assistant (SA)	0.132	0.400	0.120
Certified Nurse Practitioner (CNP)	0.132	0.400	0.120
Psychologist	0.040	0.111	0.033
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.025	0.050	0.015

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.400
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physiotherapist	80938	0.018
Psychologist	80912	0.111
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.122
Social Worker	80911	0.045
Sonographer	80754	0.018
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	Factors
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under $500 are not eligible for the step-rating factors.

SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND PODIATRISTS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes					
1	80102(A)	80179	80235	80240	80256(A)	80620
	80178	80231	80236	80254	80265	
2	80233	80249	80256(B)	80267	80621	
	80238	80252	80263	80474		
3	80102(B)	80244	80257	80268	80420	80477(A)
	80145(A)	80245	80260	80282	80431	
	80222(A)	80255	80266	80289	80473	
4	80114	80151	80241	80253	80269	
	80145(B)	80222(B)	80246	80261	80421(A)	
5	80145(C)	80280	80286	80291	80360	80425
	80274	80283	80287	80293	80421(B)	80477(B)
	80278	80284	80288	80294	80424(F)	
6	80102(C)	80159	80277	80421(C)		
	80117(A)	80167	80281(A)	80472		
7	80115	80117(B)	80281(B)	80475(A)		
8	80117(C)	80155	80169			
9	80143	80154(A)	80156			
10	80146	80150				
11	80144	80154(B)	80171	80475(B)		
12	80153					
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	5,011	8,177	10,288	11,344	12,399
2	6,594	11,344	14,510	16,094	17,677
3	8,177	14,510	18,732	20,844	22,955
4	9,760	17,677	22,955	25,593	28,232
5	11,344	20,844	27,177	30,343	33,510
6	13,244	24,643	32,243	36,043	39,843
7	14,510	27,177	35,621	39,843	44,065
8	17,677	33,510	44,065	49,343	54,621
9	20,844	39,843	52,509	58,843	65,176
10	24,010	46,176	60,954	68,342	75,731
11	27,177	52,509	69,398	77,842	86,287
12	30,343	58,843	77,842	87,342	96,842
13	33,510	65,176	86,287	96,842	107,397
14	43,010	84,175	111,619	125,341	139,063
15	46,176	90,509	120,064	134,841	149,619

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,061	6,277	7,755	8,494	9,233
2	5,169	8,494	10,710	11,819	12,927
3	6,277	10,710	13,666	15,144	16,621
4	7,385	12,927	16,621	18,469	20,316
5	8,494	15,144	19,577	21,793	24,010
6	9,824	17,804	23,123	25,783	28,443
7	10,710	19,577	25,488	28,443	31,399
8	12,927	24,010	31,399	35,093	38,788
9	15,144	28,443	37,310	41,743	46,176
10	17,360	32,877	43,221	48,393	53,565
11	19,577	37,310	49,132	55,043	60,954
12	21,793	41,743	55,043	61,693	68,342
13	24,010	46,176	60,954	68,342	75,731
14	30,660	59,476	78,687	88,292	97,897
15	32,877	63,909	84,598	94,942	105,286

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	3,617	5,391	6,573	7,164	7,755
2	4,504	7,164	8,937	9,824	10,710
3	5,391	8,937	11,301	12,484	13,666
4	6,277	10,710	13,666	15,144	16,621
5	7,164	12,484	16,030	17,804	19,577
6	8,228	14,612	18,868	20,996	23,123
7	8,937	16,030	20,759	23,123	25,488
8	10,710	19,577	25,488	28,443	31,399
9	12,484	23,123	30,217	33,763	37,310
10	14,257	26,670	34,945	39,083	43,221
11	16,030	30,217	39,674	44,403	49,132
12	17,804	33,763	44,403	49,723	55,043
13	19,577	37,310	49,132	55,043	60,954
14	24,897	47,950	63,318	71,002	78,687
15	26,670	51,496	68,047	76,322	84,598

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,536	7,227	9,022	9,919	10,816
2	5,881	9,919	12,610	13,956	15,302
3	7,227	12,610	16,199	17,994	19,788
4	8,573	15,302	19,788	22,031	24,274
5	9,919	17,994	23,377	26,068	28,760
6	11,534	21,223	27,683	30,913	34,143
7	12,610	23,377	30,554	34,143	37,732
8	15,302	28,760	37,732	42,218	46,704
9	17,994	34,143	44,910	50,293	55,676
10	20,685	39,526	52,087	58,368	64,648
11	23,377	44,910	59,265	66,443	73,620
12	26,068	50,293	66,443	74,517	82,592
13	28,760	55,676	73,620	82,592	91,564
14	36,835	71,826	95,153	106,817	118,480
15	39,526	77,209	102,331	114,891	127,452

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,694	7,544	9,444	10,394	11,344
2	6,119	10,394	13,244	14,669	16,094
3	7,544	13,244	17,044	18,944	20,844
4	8,969	16,094	20,844	23,218	25,593
5	10,394	18,944	24,643	27,493	30,343
6	12,104	22,363	29,203	32,623	36,043
7	13,244	24,643	32,243	36,043	39,843
8	16,094	30,343	39,843	44,593	49,343
9	18,944	36,043	47,443	53,143	58,843
10	21,793	41,743	55,043	61,693	68,342
11	24,643	47,443	62,643	70,242	77,842
12	27,493	53,143	70,242	78,792	87,342
13	30,343	58,843	77,842	87,342	96,842
14	38,893	75,942	100,642	112,992	125,341
15	41,743	81,642	108,242	121,541	134,841

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	6,374	10,905	13,925	15,435	16,945
2	8,640	15,435	19,966	22,231	24,496
3	10,905	19,966	26,006	29,026	32,047
4	13,170	24,496	32,047	35,822	39,597
5	15,435	29,026	38,087	42,618	47,148
6	18,153	34,463	45,336	50,772	56,209
7	19,966	38,087	50,168	56,209	62,249
8	24,496	47,148	62,249	69,800	77,351
9	29,026	56,209	74,330	83,391	92,452
10	33,557	65,270	86,411	96,982	107,553
11	38,087	74,330	98,492	110,574	122,655
12	42,618	83,391	110,574	124,165	137,756
13	47,148	92,452	122,655	137,756	152,857
14	60,739	119,634	158,898	178,530	198,161
15	65,270	128,695	170,979	192,121	213,263

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,015	8,186	10,301	11,358	12,415
2	6,601	11,358	14,529	16,115	17,700
3	8,186	14,529	18,757	20,872	22,986
4	9,772	17,700	22,986	25,629	28,271
5	11,358	20,872	27,214	30,385	33,557
6	13,261	24,677	32,288	36,094	39,899
7	14,529	27,214	35,671	39,899	44,128
8	17,700	33,557	44,128	49,413	54,699
9	20,872	39,899	52,584	58,927	65,270
10	24,043	46,242	61,041	68,441	75,840
11	27,214	52,584	69,498	77,955	86,411
12	30,385	58,927	77,955	87,469	96,982
13	33,557	65,270	86,411	96,982	107,553
14	43,071	84,297	111,782	125,524	139,266
15	46,242	90,640	120,238	135,038	149,837

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	4,381	6,918	8,609	9,455	10,301
2	5,649	9,455	11,992	13,261	14,529
3	6,918	11,992	15,375	17,066	18,757
4	8,186	14,529	18,757	20,872	22,986
5	9,455	17,066	22,140	24,677	27,214
6	10,977	20,110	26,199	29,244	32,288
7	11,992	22,140	28,906	32,288	35,671
8	14,529	27,214	35,671	39,899	44,128
9	17,066	32,288	42,436	47,510	52,584
10	19,603	37,362	49,202	55,121	61,041
11	22,140	42,436	55,967	62,733	69,498
12	24,677	47,510	62,733	70,344	77,955
13	27,214	52,584	69,498	77,955	86,411
14	34,825	67,807	89,794	100,788	111,782
15	37,362	72,881	96,560	108,399	120,238

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,695	9,546	12,113	13,396	14,680
2	7,620	13,396	17,247	19,173	21,098
3	9,546	17,247	22,382	24,949	27,516
4	11,471	21,098	27,516	30,725	33,934
5	13,396	24,949	32,651	36,501	40,352
6	15,707	29,570	38,812	43,433	48,054
7	17,247	32,651	42,920	48,054	53,188
8	21,098	40,352	53,188	59,607	66,025
9	24,949	48,054	63,457	71,159	78,861
10	28,800	55,756	73,726	82,712	91,697
11	32,651	63,457	83,995	94,264	104,533
12	36,501	71,159	94,264	105,817	117,369
13	40,352	78,861	104,533	117,369	130,205
14	51,905	101,966	135,340	152,027	168,714
15	55,756	109,667	145,609	163,579	181,550

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,921	9,999	12,717	14,076	15,435
2	7,960	14,076	18,153	20,192	22,231
3	9,999	18,153	23,590	26,308	29,026
4	12,037	22,231	29,026	32,424	35,822
5	14,076	26,308	34,463	38,540	42,618
6	16,522	31,201	40,987	45,879	50,772
7	18,153	34,463	45,336	50,772	56,209
8	22,231	42,618	56,209	63,004	69,800
9	26,308	50,772	67,082	75,236	83,391
10	30,385	58,927	77,955	87,469	96,982
11	34,463	67,082	88,828	99,701	110,574
12	38,540	75,236	99,701	111,933	124,165
13	42,618	83,391	110,574	124,165	137,756
14	54,850	107,855	143,192	160,861	178,530
15	58,927	116,010	154,065	173,093	192,121

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,697	13,550	17,453	19,404	21,355
2	10,624	19,404	25,257	28,183	31,110
3	13,550	25,257	33,061	36,963	40,865
4	16,477	31,110	40,865	45,743	50,621
5	19,404	36,963	48,670	54,523	60,376
6	22,916	43,987	58,035	65,059	72,083
7	25,257	48,670	64,278	72,083	79,887
8	31,110	60,376	79,887	89,642	99,398
9	36,963	72,083	95,496	107,202	118,909
10	42,817	83,789	111,104	124,762	138,419
11	48,670	95,496	126,713	142,321	157,930
12	54,523	107,202	142,321	159,881	177,441
13	60,376	118,909	157,930	177,441	196,952
14	77,936	154,028	204,756	230,120	255,484
15	83,789	165,734	220,365	247,680	274,995

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,941	10,038	12,770	14,136	15,501
2	7,990	14,136	18,233	20,282	22,330
3	10,038	18,233	23,696	26,427	29,159
4	12,087	22,330	29,159	32,573	35,988
5	14,136	26,427	34,622	38,719	42,817
6	16,594	31,344	41,178	46,094	51,011
7	18,233	34,622	45,548	51,011	56,474
8	22,330	42,817	56,474	63,303	70,132
9	26,427	51,011	67,400	75,595	83,789
10	30,525	59,206	78,326	87,886	97,447
11	34,622	67,400	89,252	100,178	111,104
12	38,719	75,595	100,178	112,470	124,762
13	42,817	83,789	111,104	124,762	138,419
14	55,108	108,373	143,882	161,637	179,392
15	59,206	116,567	154,808	173,929	193,049

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,122	8,400	10,585	11,677	12,770
2	6,761	11,677	14,955	16,594	18,233
3	8,400	14,955	19,326	21,511	23,696
4	10,038	18,233	23,696	26,427	29,159
5	11,677	21,511	28,066	31,344	34,622
6	13,644	25,444	33,311	37,244	41,178
7	14,955	28,066	36,807	41,178	45,548
8	18,233	34,622	45,548	51,011	56,474
9	21,511	41,178	54,289	60,844	67,400
10	24,789	47,733	63,030	70,678	78,326
11	28,066	54,289	71,771	80,511	89,252
12	31,344	60,844	80,511	90,345	100,178
13	34,622	67,400	89,252	100,178	111,104
14	44,455	87,067	115,475	129,678	143,882
15	47,733	93,623	124,215	139,512	154,808

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	6,819	11,794	15,111	16,770	18,428
2	9,307	16,770	21,745	24,233	26,720
3	11,794	21,745	28,379	31,695	35,012
4	14,282	26,720	35,012	39,158	43,304
5	16,770	31,695	41,646	46,621	51,596
6	19,755	37,666	49,606	55,577	61,547
7	21,745	41,646	54,913	61,547	68,181
8	26,720	51,596	68,181	76,473	84,765
9	31,695	61,547	81,448	91,398	101,349
10	36,671	71,497	94,715	106,324	117,933
11	41,646	81,448	107,983	121,250	134,517
12	46,621	91,398	121,250	136,176	151,101
13	51,596	101,349	134,517	151,101	167,685
14	66,522	131,200	174,319	195,879	217,438
15	71,497	141,151	187,586	210,804	234,022

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,112	12,380	15,892	17,648	19,404
2	9,746	17,648	22,916	25,550	28,183
3	12,380	22,916	29,939	33,451	36,963
4	15,014	28,183	36,963	41,353	45,743
5	17,648	33,451	43,987	49,255	54,523
6	20,808	39,773	52,416	58,737	65,059
7	22,916	43,987	58,035	65,059	72,083
8	28,183	54,523	72,083	80,863	89,642
9	33,451	65,059	86,130	96,666	107,202
10	38,719	75,595	100,178	112,470	124,762
11	43,987	86,130	114,226	128,274	142,321
12	49,255	96,666	128,274	144,077	159,881
13	54,523	107,202	142,321	159,881	177,441
14	70,327	138,810	184,465	207,292	230,120
15	75,595	149,345	198,513	223,096	247,680

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago	0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago	0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago	0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago	0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago	0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago	0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago	0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago	0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	2.088	2.136	2.172	2.196	2.208
1+ to 2 yrs. ago	1.416	1.452	1.476	1.488	1.488
2+ to 3 yrs. ago	0.912	0.936	0.948	0.948	0.948
3+ to 4 yrs. ago	0.576	0.588	0.588	0.588	0.588
4+ to 5 yrs. ago	0.408	0.408	0.408	0.408	0.408
5+ to 6 yrs. ago	0.288	0.288	0.288	0.288	0.288
6+ to 7 yrs. ago	0.192	0.192	0.192	0.192	0.192
7+ to 8 yrs. ago	0.120	0.120	0.120	0.120	0.120
8+ to 9 yrs. ago	0.072	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago	0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago	0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago	0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago	0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago	0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago	0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**Major Surgery**
Endocrinology	80238	-	-
Infectious Disease	80246		-

2. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

CLARIFICATION OF SPECIALTY CODES

Code	Specialty Description
80102(A)	Emergency Medicine – Moonlighting - no surgery
80102(B)	Emergency Medicine – Moonlighting - minor surgery
80102(C)	Emergency Medicine – clinic/hosp. primarily
80117(A)	Family/General Practice, No OB – major surgery
80117(B)	Family/General Practice, Limited OB – major surgery
80117(C)	Family/General Practice, Significant OB – major surgery
80145(A)	Urology – no surgery
80145(B)	Urology – minor surgery
80145(C)	Urology – major surgery
80154(A)	Orthopedic (No Spines) – major surgery
80154(B)	Orthopedic (Spines) – major surgery
80222(A)	Hospitalist – Hosp. Employed/ Single Hospital Affiliation
80222(B)	Hospitalist – Non-Hosp. Employed/Multiple Hospital Affiliations
80256(A)	Dermatology – no surgery
80256(B)	Dermatology – no surgery (specified procedures)
80281(A)	Cardiovascular Dis. – minor surgery
80281(B)	Cardiovascular Dis. – minor surgery, specified procedures
80421(A)	FP or GP – assist in major surgery - own patients only (no minor)
80421(B)	FP or GP – minor surgery & assist in major surgery- own patients
80421(C)	FP or GP – assist in major surgery
80424(F)	Urgent Care – no surgery
80424(V)	Urgent Care – no surgery, rated on a per-visit basis
80475(A)	Pain Management – no major surgery
80475(B)	Pain Management – basic procedures
80475(C)	Pain Management – intermediate procedures
80475(D)	Pain Management – advanced procedures
80116(A)	Physician Assistant
80116(B)	Surgeon Assistant
80960(D)	Nurse Anesthetist – Dental
80960(M)	Nurse Anesthetist – Medical

3. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

5. Item V, Scheduled Rating Program, of Section 4, Professional Liability Discounts, is amended as follows:

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

6. Item VI, Deductibles, of Section 4, Professional Liability Discounts, is hereby replaced by the following:

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

Per Claim/Aggregate		Per Claim/Aggregate	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

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

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. 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.

B. Rules

1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.

   A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date.

Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

   With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

SECTION 8

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.

2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard rating factors.

Claims-made Rate Per 100 Patient Visits $1,000,000 / $3,000,000						
Class	**Code**	**Territory 1**	**Territory 2**	**Territory 3**	**Territory 4**	**Territory 5**
Emergency Room	80429	$2,287	$1,613	$1,298	$1,950	$2,062
Urgent Care	80424(V)	$1,725	$1,220	$984	$1,472	$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 7, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
c. Determine the remaining optional separate limit premium, if applicable.
d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

SECTION 9

STATE RATES AND EXCEPTIONS – PHYSICIAN EXTENDER, PARAMEDICAL

AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

4. Item I of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.026	0.080	0.025
Surgeon's Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041
Psychologist	0.018	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.500	0.149

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.022	0.045	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

5. Item II of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.128
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse – Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.080
Physiotherapist	80938	0.018
Psychologist	80912	0.054
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.125
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80151)
Nurse Anesthetist – Medical	80960(M)	0.350
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

Health Care Professional NOC	80301	Refer to Company

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

C. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

II. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

ILLINOIS MANUAL

HEALTH CARE PROFESSIONALS

UNDERWRITING RULES AND RATES

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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance written through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of $100,000 or more for basic limits for individual (a) rating.

C. Non-Standard Risks: Individuals rejected for standard coverage by the Company may be individually considered for coverage at an additional premium charge or other applicable coverage conditions and limitations on an individually agreed, consent-to-rate basis.

D. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, regardless of whether notice has been given by the insured.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

SPECIALTY CODES AND DESCRIPTIONS

* *

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**All Other Surgery**
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code: No Surgery	Industry Class Code: Minor Surgery	Industry Class Code: All Other Surgery
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code No Surgery	Minor Surgery	All Other Surgery
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)-basic procedures
	-	-	80475(C)-intermediate procedures
	-	-	80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Surgical Consultation – Office Only	80477(A)	80477(B)	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.
***See Internal Medicine – Minor Surgery.

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. The rate shall generally be 50% of the appropriate specialty classification, but may vary from 25% to 75% depending upon the clinical exposure of each individual rated.

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).

C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

Classification	Rating Criteria:
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

TYPE	Class	Average Weekly Practice Hours <20 hours
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period. A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. 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:

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.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force or at the discretion of the Company.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 40% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor discounts: up to 50%. Deductible credits may be combined with the New Doctor discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing $100,000 or more annualized premium

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credits, up to a maximum of 12%.

A. Individual Risk Management Activities: Individual insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

		Activity	Credit
1.		Successful completion of an approved fee-for-service office analysis and education program. Positive response to recommendations made shall result in the application of this credit for up to three policy years. Applicable only to accounts generating $250,000 or more in annual premium.	5%
2.	a.	A Company sponsored Loss Prevention or other approved risk management seminar carrying at least two CME credits (annual); or,	5%

	b.	(i) A Company-produced online Loss Prevention seminar.	2.5%
3.		Company-produced Supplemental Online Modules (up to four).	0.5% for each module completed (up to a maximum of 2.0%)
4.	a.	An approved closed claim review (annual); and/or	5%
	b.	Successful completion of an approved risk management correspondence course carrying at least two CME credits (annual).	5%
5.		Demonstrated regular use of an approved patient information system or program.	5%

Educational activities must qualify for Continuing Medical Education credit (where applicable) to be acceptable for risk management credits. The applicant must provide proof (Certificate) of CME credits earned at the time of application. Activities submitted for risk management credits must have been completed within twelve months prior to application.

B. In addition to the above, any physician or surgeon whose practice benefits from the risk management activities of an employed practice administrator or risk manager may receive one of the following credits:
   1. If the practice employs a full-time, qualified, professional risk manager primarily engaged in risk management and loss prevention activities, each insured shall receive a 5% credit.
   2. If the practice administrator or office manager participates in a Company-sponsored Loss Prevention or other risk management seminar, each insured shall receive a 2% credit. Certain requirements apply:
      a. The seminar must be designated by the Company as eligible for practice administrator credit.
      b. Attendance must occur within the twelve months prior to the effective date of the policy being rated.
      c. At least 75% of the insureds in the practice must qualify for risk management credit as a result of individual risk management activities under the terms of Section III(A)(2), above.
      d. The practice administrator or office manager must actively manage the practice for thirty or more hours per week. In the case of shared practice management, determination of eligibility will rest with the Company.

C. Any risk management credit will be revoked or withheld for any of the following reasons:
   1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
   2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company,
   3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
   4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of up to 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and*
12. Insured group maintains differing limits of liability on members.*

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

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

A. Individual Deductibles

See State Rates and Exceptions.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

See State Rates and Exceptions.

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. New Doctor Discount or other resident or part-time, semi-retired discount;
3. Risk Management Discount and Scheduled Rating (apply the net credit or debit); and

Example: Class 1, $1M/$3M, 1st year new doctor, Risk Management Seminar within 12 months. $25,000 deductible. Assume manual rate $7,500.

$7,500	Manual Rate for $1M/$3M
x .91	Less 9% (Deductible Credit)
6825	
x .50	Less 50% (New Doctor)
3,413	Applicable Net Premium
x .85	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. 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.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. 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 Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians and dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to participants in the Program at no additional charge. There is a premium charge for those insureds that elect expanded coverage with higher limits.

Limits are in excess of $50,000 primary coverage.

# of Physicians	$1M Limit
1 Physician	$ 1,125
2 Physicians	$ 1,500
3-5 Physicians	$ 2,063
6-10 Physicians	$ 2,813
10-15 Physicians	$ 3,750
16-20 Physicians	$ 5,100
21-25 Physicians	$ 6,375
26-30 Physicians	$ 7,650

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.132	0.400	0.120
Surgeon's Assistant (SA)	0.132	0.400	0.120
Certified Nurse Practitioner (CNP)	0.132	0.400	0.120
Psychologist	0.040	0.111	0.033
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.025	0.050	0.015

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.400
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physiotherapist	80938	0.018
Psychologist	80912	0.111
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.122
Social Worker	80911	0.045
Sonographer	80754	0.018
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	Factors
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under $500 are not eligible for the step-rating factors.

SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND PODIATRISTS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes					
1	80102(A)	80179	80235	80240	80256(A)	80620
	80178	80231	80236	80254	80265	
2	80233	80249	80256(B)	80267	80621	
	80238	80252	80263	80474		
3	80102(B)	80244	80257	80268	80420	80477(A)
	80145(A)	80245	80260	80282	80431	
	80222(A)	80255	80266	80289	80473	
4	80114	80151	80241	80253	80269	
	80145(B)	80222(B)	80246	80261	80421(A)	
5	80145(C)	80280	80286	80291	80360	80425
	80274	80283	80287	80293	80421(B)	80477(B)
	80278	80284	80288	80294	80424(F)	
6	80102(C)	80159	80277	80421(C)		
	80117(A)	80167	80281(A)	80472		
7	80115	80117(B)	80281(B)	80475(A)		
8	80117(C)	80155	80169			
9	80143	80154(A)	80156			
10	80146	80150				
11	80144	80154(B)	80171	80475(B)		
12	80153					
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	5,011	8,177	10,288	11,344	12,399
2	6,594	11,344	14,510	16,094	17,677
3	8,177	14,510	18,732	20,844	22,955
4	9,760	17,677	22,955	25,593	28,232
5	11,344	20,844	27,177	30,343	33,510
6	13,244	24,643	32,243	36,043	39,843
7	14,510	27,177	35,621	39,843	44,065
8	17,677	33,510	44,065	49,343	54,621
9	20,844	39,843	52,509	58,843	65,176
10	24,010	46,176	60,954	68,342	75,731
11	27,177	52,509	69,398	77,842	86,287
12	30,343	58,843	77,842	87,342	96,842
13	33,510	65,176	86,287	96,842	107,397
14	43,010	84,175	111,619	125,341	139,063
15	46,176	90,509	120,064	134,841	149,619

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,061	6,277	7,755	8,494	9,233
2	5,169	8,494	10,710	11,819	12,927
3	6,277	10,710	13,666	15,144	16,621
4	7,385	12,927	16,621	18,469	20,316
5	8,494	15,144	19,577	21,793	24,010
6	9,824	17,804	23,123	25,783	28,443
7	10,710	19,577	25,488	28,443	31,399
8	12,927	24,010	31,399	35,093	38,788
9	15,144	28,443	37,310	41,743	46,176
10	17,360	32,877	43,221	48,393	53,565
11	19,577	37,310	49,132	55,043	60,954
12	21,793	41,743	55,043	61,693	68,342
13	24,010	46,176	60,954	68,342	75,731
14	30,660	59,476	78,687	88,292	97,897
15	32,877	63,909	84,598	94,942	105,286

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	3,617	5,391	6,573	7,164	7,755
2	4,504	7,164	8,937	9,824	10,710
3	5,391	8,937	11,301	12,484	13,666
4	6,277	10,710	13,666	15,144	16,621
5	7,164	12,484	16,030	17,804	19,577
6	8,228	14,612	18,868	20,996	23,123
7	8,937	16,030	20,759	23,123	25,488
8	10,710	19,577	25,488	28,443	31,399
9	12,484	23,123	30,217	33,763	37,310
10	14,257	26,670	34,945	39,083	43,221
11	16,030	30,217	39,674	44,403	49,132
12	17,804	33,763	44,403	49,723	55,043
13	19,577	37,310	49,132	55,043	60,954
14	24,897	47,950	63,318	71,002	78,687
15	26,670	51,496	68,047	76,322	84,598

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,536	7,227	9,022	9,919	10,816
2	5,881	9,919	12,610	13,956	15,302
3	7,227	12,610	16,199	17,994	19,788
4	8,573	15,302	19,788	22,031	24,274
5	9,919	17,994	23,377	26,068	28,760
6	11,534	21,223	27,683	30,913	34,143
7	12,610	23,377	30,554	34,143	37,732
8	15,302	28,760	37,732	42,218	46,704
9	17,994	34,143	44,910	50,293	55,676
10	20,685	39,526	52,087	58,368	64,648
11	23,377	44,910	59,265	66,443	73,620
12	26,068	50,293	66,443	74,517	82,592
13	28,760	55,676	73,620	82,592	91,564
14	36,835	71,826	95,153	106,817	118,480
15	39,526	77,209	102,331	114,891	127,452

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,694	7,544	9,444	10,394	11,344
2	6,119	10,394	13,244	14,669	16,094
3	7,544	13,244	17,044	18,944	20,844
4	8,969	16,094	20,844	23,218	25,593
5	10,394	18,944	24,643	27,493	30,343
6	12,104	22,363	29,203	32,623	36,043
7	13,244	24,643	32,243	36,043	39,843
8	16,094	30,343	39,843	44,593	49,343
9	18,944	36,043	47,443	53,143	58,843
10	21,793	41,743	55,043	61,693	68,342
11	24,643	47,443	62,643	70,242	77,842
12	27,493	53,143	70,242	78,792	87,342
13	30,343	58,843	77,842	87,342	96,842
14	38,893	75,942	100,642	112,992	125,341
15	41,743	81,642	108,242	121,541	134,841

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	6,374	10,905	13,925	15,435	16,945
2	8,640	15,435	19,966	22,231	24,496
3	10,905	19,966	26,006	29,026	32,047
4	13,170	24,496	32,047	35,822	39,597
5	15,435	29,026	38,087	42,618	47,148
6	18,153	34,463	45,336	50,772	56,209
7	19,966	38,087	50,168	56,209	62,249
8	24,496	47,148	62,249	69,800	77,351
9	29,026	56,209	74,330	83,391	92,452
10	33,557	65,270	86,411	96,982	107,553
11	38,087	74,330	98,492	110,574	122,655
12	42,618	83,391	110,574	124,165	137,756
13	47,148	92,452	122,655	137,756	152,857
14	60,739	119,634	158,898	178,530	198,161
15	65,270	128,695	170,979	192,121	213,263

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,015	8,186	10,301	11,358	12,415
2	6,601	11,358	14,529	16,115	17,700
3	8,186	14,529	18,757	20,872	22,986
4	9,772	17,700	22,986	25,629	28,271
5	11,358	20,872	27,214	30,385	33,557
6	13,261	24,677	32,288	36,094	39,899
7	14,529	27,214	35,671	39,899	44,128
8	17,700	33,557	44,128	49,413	54,699
9	20,872	39,899	52,584	58,927	65,270
10	24,043	46,242	61,041	68,441	75,840
11	27,214	52,584	69,498	77,955	86,411
12	30,385	58,927	77,955	87,469	96,982
13	33,557	65,270	86,411	96,982	107,553
14	43,071	84,297	111,782	125,524	139,266
15	46,242	90,640	120,238	135,038	149,837

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	4,381	6,918	8,609	9,455	10,301
2	5,649	9,455	11,992	13,261	14,529
3	6,918	11,992	15,375	17,066	18,757
4	8,186	14,529	18,757	20,872	22,986
5	9,455	17,066	22,140	24,677	27,214
6	10,977	20,110	26,199	29,244	32,288
7	11,992	22,140	28,906	32,288	35,671
8	14,529	27,214	35,671	39,899	44,128
9	17,066	32,288	42,436	47,510	52,584
10	19,603	37,362	49,202	55,121	61,041
11	22,140	42,436	55,967	62,733	69,498
12	24,677	47,510	62,733	70,344	77,955
13	27,214	52,584	69,498	77,955	86,411
14	34,825	67,807	89,794	100,788	111,782
15	37,362	72,881	96,560	108,399	120,238

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,695	9,546	12,113	13,396	14,680
2	7,620	13,396	17,247	19,173	21,098
3	9,546	17,247	22,382	24,949	27,516
4	11,471	21,098	27,516	30,725	33,934
5	13,396	24,949	32,651	36,501	40,352
6	15,707	29,570	38,812	43,433	48,054
7	17,247	32,651	42,920	48,054	53,188
8	21,098	40,352	53,188	59,607	66,025
9	24,949	48,054	63,457	71,159	78,861
10	28,800	55,756	73,726	82,712	91,697
11	32,651	63,457	83,995	94,264	104,533
12	36,501	71,159	94,264	105,817	117,369
13	40,352	78,861	104,533	117,369	130,205
14	51,905	101,966	135,340	152,027	168,714
15	55,756	109,667	145,609	163,579	181,550

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,921	9,999	12,717	14,076	15,435
2	7,960	14,076	18,153	20,192	22,231
3	9,999	18,153	23,590	26,308	29,026
4	12,037	22,231	29,026	32,424	35,822
5	14,076	26,308	34,463	38,540	42,618
6	16,522	31,201	40,987	45,879	50,772
7	18,153	34,463	45,336	50,772	56,209
8	22,231	42,618	56,209	63,004	69,800
9	26,308	50,772	67,082	75,236	83,391
10	30,385	58,927	77,955	87,469	96,982
11	34,463	67,082	88,828	99,701	110,574
12	38,540	75,236	99,701	111,933	124,165
13	42,618	83,391	110,574	124,165	137,756
14	54,850	107,855	143,192	160,861	178,530
15	58,927	116,010	154,065	173,093	192,121

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,697	13,550	17,453	19,404	21,355
2	10,624	19,404	25,257	28,183	31,110
3	13,550	25,257	33,061	36,963	40,865
4	16,477	31,110	40,865	45,743	50,621
5	19,404	36,963	48,670	54,523	60,376
6	22,916	43,987	58,035	65,059	72,083
7	25,257	48,670	64,278	72,083	79,887
8	31,110	60,376	79,887	89,642	99,398
9	36,963	72,083	95,496	107,202	118,909
10	42,817	83,789	111,104	124,762	138,419
11	48,670	95,496	126,713	142,321	157,930
12	54,523	107,202	142,321	159,881	177,441
13	60,376	118,909	157,930	177,441	196,952
14	77,936	154,028	204,756	230,120	255,484
15	83,789	165,734	220,365	247,680	274,995

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,941	10,038	12,770	14,136	15,501
2	7,990	14,136	18,233	20,282	22,330
3	10,038	18,233	23,696	26,427	29,159
4	12,087	22,330	29,159	32,573	35,988
5	14,136	26,427	34,622	38,719	42,817
6	16,594	31,344	41,178	46,094	51,011
7	18,233	34,622	45,548	51,011	56,474
8	22,330	42,817	56,474	63,303	70,132
9	26,427	51,011	67,400	75,595	83,789
10	30,525	59,206	78,326	87,886	97,447
11	34,622	67,400	89,252	100,178	111,104
12	38,719	75,595	100,178	112,470	124,762
13	42,817	83,789	111,104	124,762	138,419
14	55,108	108,373	143,882	161,637	179,392
15	59,206	116,567	154,808	173,929	193,049

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,122	8,400	10,585	11,677	12,770
2	6,761	11,677	14,955	16,594	18,233
3	8,400	14,955	19,326	21,511	23,696
4	10,038	18,233	23,696	26,427	29,159
5	11,677	21,511	28,066	31,344	34,622
6	13,644	25,444	33,311	37,244	41,178
7	14,955	28,066	36,807	41,178	45,548
8	18,233	34,622	45,548	51,011	56,474
9	21,511	41,178	54,289	60,844	67,400
10	24,789	47,733	63,030	70,678	78,326
11	28,066	54,289	71,771	80,511	89,252
12	31,344	60,844	80,511	90,345	100,178
13	34,622	67,400	89,252	100,178	111,104
14	44,455	87,067	115,475	129,678	143,882
15	47,733	93,623	124,215	139,512	154,808

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	6,819	11,794	15,111	16,770	18,428
2	9,307	16,770	21,745	24,233	26,720
3	11,794	21,745	28,379	31,695	35,012
4	14,282	26,720	35,012	39,158	43,304
5	16,770	31,695	41,646	46,621	51,596
6	19,755	37,666	49,606	55,577	61,547
7	21,745	41,646	54,913	61,547	68,181
8	26,720	51,596	68,181	76,473	84,765
9	31,695	61,547	81,448	91,398	101,349
10	36,671	71,497	94,715	106,324	117,933
11	41,646	81,448	107,983	121,250	134,517
12	46,621	91,398	121,250	136,176	151,101
13	51,596	101,349	134,517	151,101	167,685
14	66,522	131,200	174,319	195,879	217,438
15	71,497	141,151	187,586	210,804	234,022

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,112	12,380	15,892	17,648	19,404
2	9,746	17,648	22,916	25,550	28,183
3	12,380	22,916	29,939	33,451	36,963
4	15,014	28,183	36,963	41,353	45,743
5	17,648	33,451	43,987	49,255	54,523
6	20,808	39,773	52,416	58,737	65,059
7	22,916	43,987	58,035	65,059	72,083
8	28,183	54,523	72,083	80,863	89,642
9	33,451	65,059	86,130	96,666	107,202
10	38,719	75,595	100,178	112,470	124,762
11	43,987	86,130	114,226	128,274	142,321
12	49,255	96,666	128,274	144,077	159,881
13	54,523	107,202	142,321	159,881	177,441
14	70,327	138,810	184,465	207,292	230,120
15	75,595	149,345	198,513	223,096	247,680

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago	0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago	0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago	0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago	0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago	0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago	0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago	0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago	0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	2.088	2.136	2.172	2.196	2.208
1+ to 2 yrs. ago	1.416	1.452	1.476	1.488	1.488
2+ to 3 yrs. ago	0.912	0.936	0.948	0.948	0.948
3+ to 4 yrs. ago	0.576	0.588	0.588	0.588	0.588
4+ to 5 yrs. ago	0.408	0.408	0.408	0.408	0.408
5+ to 6 yrs. ago	0.288	0.288	0.288	0.288	0.288
6+ to 7 yrs. ago	0.192	0.192	0.192	0.192	0.192
7+ to 8 yrs. ago	0.120	0.120	0.120	0.120	0.120
8+ to 9 yrs. ago	0.072	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago	0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago	0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago	0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago	0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago	0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago	0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**Major Surgery**
Endocrinology	80238	-	-
Infectious Disease	80246		-

2. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

CLARIFICATION OF SPECIALTY CODES

Code	Specialty Description
80102(A)	Emergency Medicine – Moonlighting - no surgery
80102(B)	Emergency Medicine – Moonlighting - minor surgery
80102(C)	Emergency Medicine – clinic/hosp. primarily
80117(A)	Family/General Practice, No OB – major surgery
80117(B)	Family/General Practice, Limited OB – major surgery
80117(C)	Family/General Practice, Significant OB – major surgery
80145(A)	Urology – no surgery
80145(B)	Urology – minor surgery
80145(C)	Urology – major surgery
80154(A)	Orthopedic (No Spines) – major surgery
80154(B)	Orthopedic (Spines) – major surgery
80222(A)	Hospitalist – Hosp. Employed/ Single Hospital Affiliation
80222(B)	Hospitalist – Non-Hosp. Employed/Multiple Hospital Affiliations
80256(A)	Dermatology – no surgery
80256(B)	Dermatology – no surgery (specified procedures)
80281(A)	Cardiovascular Dis. – minor surgery
80281(B)	Cardiovascular Dis. – minor surgery, specified procedures
80421(A)	FP or GP – assist in major surgery - own patients only (no minor)
80421(B)	FP or GP – minor surgery & assist in major surgery- own patients
80421(C)	FP or GP – assist in major surgery
80424(F)	Urgent Care – no surgery
80424(V)	Urgent Care – no surgery, rated on a per-visit basis
80475(A)	Pain Management – no major surgery
80475(B)	Pain Management – basic procedures
80475(C)	Pain Management – intermediate procedures
80475(D)	Pain Management – advanced procedures
80116(A)	Physician Assistant
80116(B)	Surgeon Assistant
80960(D)	Nurse Anesthetist – Dental
80960(M)	Nurse Anesthetist – Medical

3. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

5. Item V, Scheduled Rating Program, of Section 4, Professional Liability Discounts, is amended as follows:

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

6. Item VI, Deductibles, of Section 4, Professional Liability Discounts, is hereby replaced by the following:

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

Per Claim/Aggregate		Per Claim/Aggregate	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

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

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. 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.

B. Rules

1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.

   A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy

effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

   With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

SECTION 8

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.

2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard rating factors.

Claims-made Rate Per 100 Patient Visits $1,000,000 / $3,000,000						
Class	**Code**	**Territory 1**	**Territory 2**	**Territory 3**	**Territory 4**	**Territory 5**
Emergency Room	80429	$2,287	$1,613	$1,298	$1,950	$2,062
Urgent Care	80424(V)	$1,725	$1,220	$984	$1,472	$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 7, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
c. Determine the remaining optional separate limit premium, if applicable.
d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules

SECTION 9

STATE RATES AND EXCEPTIONS – PHYSICIAN EXTENDER, PARAMEDICAL

AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

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

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

4. Item I of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.026	0.080	0.025
Surgeon's Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041
Psychologist	0.018	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.500	0.149

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.022	0.045	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

5. Item II of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.128
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse – Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.080
Physiotherapist	80938	0.018
Psychologist	80912	0.054
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.125
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80151)
Nurse Anesthetist – Medical	80960(M)	0.350
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

Health Care Professional NOC	80301	Refer to Company

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

C. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

II. STATE REQUIREMENTS

A. Policy Issuance

1. If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

   This policy is issued through the Central Illinois Physicians Risk Purchasing Group, underwritten by ProAssurance Casualty Company.

2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

3. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

   III. QUARTERLY INSTALLMENT OPTIONS

   1. Quarterly Installment Option One – (40/20/20/20)
      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.

B. Rules