Professional SOLUTIONS INSURANCE COMPANY

14001 University Avenue, Clive, Iowa 50325-8258
515-313-4701 • Fax 515-313-4886
Toll-Free 800-864-8026 • Toll-Free Fax 800-510-6370

August 3, 2011

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DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

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DEPARTMENT OF INSURANCE
SPRINGFIELD

Illinois Insurance Division
Attn: Gayle Neuman
320 West Washington Street
Springfield, IL 62767

VIA OVERNIGHT MAIL

RE: Professional Solutions Insurance Company
FEIN: 42-1520773
NAIC Number: 11127
Physicians and Surgeons Professional Liability Rate Filing
Filing Number: 2011 RM DISCOUNT
Proposed Effective Date: 10/01/2011 New Business and 11/01/2011 Renewals

Dear Ms. Neuman:

Professional Solutions Insurance Company (PSIC) currently has on file with the Illinois Insurance Division a claims made professional liability rating manual for our physicians and surgeons professional liability program. PSIC would like to submit for your review and approval an amended claims made professional liability rating manual to replace the manual that is currently pending review with the Illinois Insurance Division under filing number: **PSIC MD 2011**. Please see the enclosed explanatory memorandum and side-by-side rating manual comparison which detail all the changes being made.

Please be advised that that Professional Solutions Insurance Company continues to utilize National Independent Statistical Service for our reporting of statistics.

If you have any questions or need any additional information regarding this filing, please feel free to contact me directly. I thank you in advance for your attention to this matter.

Sincerely,

Rejeana Otte

Rejeana Otte
Lead Compliance Analyst
PH: (515) 313-4717
FX: (515) 313-4476
Email: rotte@ncmic.com

Enclosures

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PROFESSIONAL SOLUTIONS

INSURANCE COMPANY

STATE OF ILLINOIS

PHYSICIANS AND SURGEONS

MEDICAL PROFESSIONAL LIABILITY MANUAL

CLAIMS MADE COVERAGE

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I. APPLICATION OF THIS MANUAL-ELIGIBILITY

This claims made program covers Physicians and Surgeons engaged in the rendering of professional services specific to their disciplines. Refer to the classification plan for a description of each risk/rating category for physicians and surgeons.

Employees of health care professionals are also included as insureds for their acts while performing duties within the scope of their discipline while under the direction and supervision of the insured named in the coverage summary. Refer to the listing of the mid-level healthcare providers who may be covered by either a shared or separate limit of liability.

This program also provides coverage for both medical clinics and individual practicing physicians for the liability exposure of a partnership, corporation or professional association on either a separate or shared limit basis. Refer to the professional entity coverage section for a description of the partnership, corporation or professional association rating factors.

II. PREMIUM DETERMINATION

1. Determine the manual rate for the appropriate territory.
2. Refer to Classification Listing and apply the factor for the appropriate class specialty being rated.
3. Apply the appropriate increase limit factor.
4. Apply the appropriate claims made step factor to reach the undiscounted premium.
5. .Apply discounts, as appropriate, for part-time or new practitioner.
6. Apply any applicable credits/debits for experience rating.
7. Apply any applicable credits/debits for schedule rating.
8. Apply the deductible credit, if applicable.
9. Apply rounding.
10. Example Premium Calculation:

    Assume the full time undiscounted premium is $1,000 and no new practitioner or part-time status applies. Additional credits or debits will be applied in consecutive order.

    $1,000 x .95 = $950.00 (Claims Free credit of 5%)
    $950.00 x .95 = $902.50 (Schedule Rating credit of 5%)
    $902.50 = $903.00 (Apply rounding)

III. POLICY PERIOD

The policy period shall be for a one-year term. Insureds added or removed mid-term will be pro-rated.

IV. WHOLE DOLLAR PREMIUM RULE

All premiums shown on the policy and endorsements shall be rounded to the nearest whole dollar. If the premium is .50 or greater, round to next higher whole dollar. If the premium is .49 or less, round down. In the event of cancellation, the return premium shall be rounded to the nearest whole dollar. Rounding is the last step of the premium calculation.

Example: $1,234.30 is rounded to $1,234.
$1,234.60 is rounded to $1,235.

V. PRACTICE LOCATION

The following parameters will be applied for healthcare providers who practice in multiple territories or states:

A. For healthcare providers classified as No Surgery or Minor Surgery, the location of the primary office practice will determine the manual rate.
B. For healthcare providers classified as Anesthesiology, Intensive Care/Critical Care Medicine, Pathology, Radiology or Major Surgery, the location of the primary healthcare facility practice will determine the manual rate.

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C. If a healthcare provider practices equally in two or more states or territories, the rate from the highest territory or state will be applied.

For the purposes of this section, primary means 51% or more of the healthcare provider's practice time is spent in the given territory or state.

The insured must be licensed in all states where practicing.

VI. POLICY CANCELLATION

A. Cancellation By the Insured

The insured may cancel the policy by mailing or delivering notice to the Company stating when such cancellation shall be effective.

This policy will remain in full force and effect until its regular anniversary date unless the policy is cancelled sooner by the Company in accordance with the laws of the State of Illinois.

If the insured cancels the policy, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the Company cancels the policy, earned premium shall be computed pro rata.

B. Cancellation/Non-Renewal By the Company

The Company may cancel or non-renew the policy in accordance with the insurance laws of the State of Illinois. Standard cancellation notice will be sent sixty (60) days prior to cancellation, except that in the event of non-payment of premium, then not less than ten (10) days prior notice will be given.

VII. PREMIUM PAYMENT OPTIONS

1. Annual
2. Semi-Annual 50% prepayment required
3. Quarterly 25% prepayment required as the initial down payment with remaining payments of 25% each due at 3, 6 & 9 months after policy inception

There is no installment fee charge or interest charged for utilizing the premium payment options. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium. If there are no remaining installments, additional premium resulting from changes in coverage may be due immediately as a separate transaction. If the policy is issued with a final fully discounted premium less than $500, the policy must be billed on an annual basis.

VIII. RENEWALS

The policy will be renewed upon receipt of the required premium on or before the date of each successive policy period. The renewal premium shall be based on rates in effect on the renewal or anniversary date. The applicable forms and endorsements must be made a part of the policy. Additional premiums for policy changes occurring during the current policy term shall be computed pro rata of the annual premium.

IX. SPECIAL PROVISIONS

A. Retroactive Coverage

This extension covers incidents which occurred subsequent to the prior carrier's retroactive date, but which are neither known nor reported as of the inception date of the replacement coverage written by Professional Solutions Insurance Company. The insured may apply for a Retroactive Date that is equal to the retroactive date shown on the previous policy.

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Premium for this extension is derived by rating the policy based upon the claims made step factor determined by using the previous carrier's retroactive date.

B. Automatic Reporting Extension

This provision applies when coverage under the policy ends, either by action of the insured or the Company through cancellation, termination or non-renewal.

Under the circumstances stated above, the Company will provide a thirty (30) day Automatic Reporting Extension which allows claims to be reported during this time that result from incidents that happened during the time the coverage was in force. The thirty (30) day Automatic Reporting Extension does not apply if the insured purchases any subsequent insurance that replaces in whole or in part the coverage provided by this policy.

Within thirty (30) days of when the policy coverage terminates, the Company must advise the insured of the availability of Extended Reporting Coverage, the premium cost, and the importance of buying this additional coverage extension, commonly called "Tail Coverage".

The insured will have the greater of sixty (60) days from the date the coverage is terminated, or thirty (30) days from the date of notice, to accept the Extended Reporting Coverage in writing.

C. Extended Reporting Coverage, also called Tail Coverage

Extended Reporting Coverage will be provided for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. Extended Reporting Coverage can be applied to individual or entity policies.

The following factors will be applied to the expiring annual premium:

# of Years Completed in Claims Made Program	Tail Factor
1	3.680
2	2.860
3	2.179
4	2.022
5+	1.870

Professional Solutions Insurance Company cannot cancel the Extended Reporting Coverage except for non-payment of the additional premium. Premium is due in full at the time of purchase; no payment plans will be offered.

The Company provides Extended Reporting Coverage automatically, at no additional charge, in the event that the insured dies or becomes permanently disabled.

The Company also provides Extended Reporting Coverage automatically, at no additional charge, in the event the insured retires at or after age fifty-five (55) and after having been continuously insured with Professional Solutions Insurance Company under a claims made policy for five (5) years. The Extended Reporting Coverage premium will be discounted for Insureds who retire at or after age fifty-five (55) with fewer than five (5) years of continuous coverage as follows:

# of Years of Continuous Coverage	Extended Reporting Coverage Credit
1 full year	20%
2 full years	40%
3 full years	60%
4 full years	80%

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D. Change in Rating Classification

In the event of a change in exposure or medical specialty of the practitioner, a premium charge reflecting the difference between the previous and such new exposure or specialty shall be calculated and collected at the time of such change unless:

1. otherwise eligible for Extended Reporting Coverage at no additional charge;
2. with regard to medical specialty, both the prior and the current specialty fall within the same class;
3. the exposure or medical specialty of the practitioner changed more than 4 years prior while insured under claims made coverage; or
4. the exposure or medical specialty of the practitioner changed while insured under occurrence coverage.

E. Locum Tenens

Locum Tenens working in the place of an insured shall be provided coverage at no additional premium, for a period not to exceed sixty (60) days per policy term. A completed application must be submitted to the Company for prior underwriting approval.

X. DISCOUNTS

A. New Practitioner

A new practitioner is defined as a person who has completed his or her training, whose only contact with patients has been in the course of his or her training, and who has not been previously insured by Professional Solutions Insurance Company.

1st year	50% credit
2nd year	30% credit
3rd year	10% credit

Those who receive a new practitioner credit will not be eligible to receive any further credits, except for schedule rating and the experience rating modification. The total of all new practitioner and schedule rating credits will not exceed 50%.

B. Part-Time Practitioner

A practitioner must practice 20 hours or less per week to become eligible for this credit. Surgery classes are not eligible for the part-time credit. The insured must complete an application for part-time credit. If the application is approved, credits will be given by year according to the following schedule:

1st year	30% credit
2nd year	40% credit
3rd year	50% credit

Those who receive a part-time practitioner credit will not be eligible to receive any further credits, except for schedule rating and the experience rating modification. The total of all part-time practitioner and schedule rating credits will not exceed 50%.

C. Risk Management Discount

Insureds will qualify for a risk management discount, up to 15% per policy period, based on the following criteria:

1. Courses and webinars must be those provided by Professional Solutions Insurance Company.
2. Credits accumulated during a given calendar year will be applied to policy renewals beginning January 1 of the subsequent year in which they were earned. Maximum credit earned per calendar year is 15%.
3. Duplicate credit will not be given for repeating any courses.
4. PRA1 (Personal Risk Assessor 1) discount earned is applicable for 2 calendar years.

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5. PRA2 (Personal Risk Assessor 2) discount earned is applicable for 2 calendar years if the provider shows improvement (higher score than PRA1) due to implementation of suggested risk management recommendations.

PRA1-Personal Risk Assessor	
Passing Score	Discount earned
70-80%	8%
81-90%	9%
91-100%	10%

PRA2-Personal Risk Assessor	
Passing Score	Discount earned
If improvement noted	5%

Courses/RM Activity	Discount Earned
Webinars - 1 hour	.5%
Webinars - 1.5-2 hours	1.0%
Online Courses - 1 hour	.5%
Online courses - 1.5 hours or more	1.0%
Live CME seminars (2-3 hours)	3.0%

Those who receive a risk management discount will not be eligible to receive the experience rating modification. The total of all discounts and/or credits used in conjunction with the risk management discount will not exceed 40%.

XI. EXPERIENCE RATING

Claims free credits

A claim is defined as a claim closed with incurred indemnity equal to or greater than $10,000.00 or allocated loss adjustment expense (ALAE) payments plus any Company established reserves for loss or ALAE exceeding $100,000.

A claim free credit shall apply if the insured has achieved at least 3 years without a claim.

The following schedule will apply:

3 yrs	5%
4 yrs	10%
5+ yrs	15%

XII. SCHEDULE RATING

Professional Solutions Insurance Company will use the following schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of Professional Solutions Insurance Company uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with the following, subject to a maximum modification of a 25% credit to a 25% debit to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The actual determination of the appropriate credit or debit will be determined through the underwriting review of the applicant's application.

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SCHEDULE RATING PROGRAM		Maximum Credit	Maximum Debit
Historical Loss Experience (Not applicable to insureds receiving Experience Rating Modification)	The frequency or severity of claims for the insured(s) is greater/less than expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.	N/A	25%
Cumulative Years of Patient Experience	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.	10%	10%
Classification Anomalies	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of a recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.	25%	25%
Claims Anomalies	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or unusual circumstances of a claim(s) which understate/overstate the severity of the claims(s).	10%	10%
Management Control Procedures	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.	10%	10%
Number/Type of Patient Exposures	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.	10%	10%
Organizational Size / Structure	The organization's size and processes are such that economies of scale are achieved while servicing the insured.	10%	10%
Medical Standards, Quality & Claim Review	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and developed corrective action.	10%	10%
Training, Accreditation & Credentialing	The insured(s) exhibits greater/less than normal participation and support of such activities.	10%	10%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatment and equipment into the practice, or failure to meet accepted standards of care.	10%	10%

XIII. EXPERIENCE RATING MODIFICATION

A. Eligibility

This experience rating plan may apply to a group policy of five or more practitioners with total manual premium of at least $250,000.

B. Application

The experience modification developed according to this rule will apply to the otherwise applicable premium generated for the group, reflecting the applicable limits of liability and any other rating factors, discounts, or surcharges that may apply. The experience modification factor will be applied prior to the application of any deductible credit. The experience modification factor will apply to premium at time of policy issuance or renewal, as well as to the premium associated with any subsequent policy modification during the policy term.

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C. Experience Used

To the extent that it is available, a five-year experience period for each individual member and the corporation/partnership will be used to calculate the group's experience modification under this plan. In no instance will less than three years' experience be utilized. The prior years' experience will be compiled by report year. The experience period will start with the second prior policy period, and end with the sixth prior policy period. The experience period ending immediately before the policy period to which the modification will apply is excluded from the experience period.

Experience of the group related to policy periods during which the entity was not covered by Professional Solutions Insurance Company will be included in the experience modification calculations to the extent such prior experience is considered to be complete and accurate.

D. Experience Period Premium Subject to Experience Rating

The development of the Experience Period Premium Subject to Experience Rating (Subject Premium) is as follows:

First, for each year in the experience period, the premium at present rate level is calculated. This calculation involves rating the group's historical exposures in each experience period using the current rates and rating plan factors. The experience period premium at present rates should reflect the $200,000 policy limit underlying this experience rating plan, as well as any discounts, surcharges or other rating factors that are currently applicable, with the exception of any deductible credit. The claims-made step factor used in developing the premiums for each experience period should be consistent with the claim history provided. For example, if a physician's retroactive date implies a second year claims-made policy exposure, but a longer-term history of claims is available, then the retroactive date should be adjusted to reflect the more mature claims experience.

The next step in the development of Subject Premium is to adjust the premiums at present rates to reflect claim cost inflation. The calculation involves de-trending the experience period premiums at present rates from the current claim cost level to the experience period claim cost level.

E. Experience Period Losses Subject to Experience Rating

The development of the Experience Period Losses Subject to Experience Rating (Subject Losses) is as follows:

All claims, open, closed, loss only, loss expense only, paid or reserved, are included for purposes of determining the Experience Modification Factor. Actual claims from each year in the experience period are compiled. Claims are compiled by report year/policy period. In each case, incurred to date loss values (i.e., paid indemnity plus outstanding reserves) are capped at $200,000 per claim and allocated loss adjustment expenses are included in full. The sum of the limited indemnity and unlimited ALAE is then limited to the maximum single loss of $300,000 (limited loss and ALAE).

The next step in the development of the Subject Losses is to include a factor to reflect losses which are "Incurred But Not Reported", or IBNR. IBNR factors are applied to the expected losses (Subject Premium x Expected Loss and ALAE Ratio) for each policy year in the experience period.

The Subject Losses are the sum of the actual limited losses and ALAE and IBNR.

F. Valuation Date

All of the losses for the experience period should be valued as of 6 months prior to the issuance/renewal date. This date will be referred to as the "valuation date".

G. Actual Experience Loss Ratio

The Actual Experience Loss Ratio (AELR) is determined by dividing the Experience Period Subject Losses by the Experience Period Subject Premium.

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H. Expected Loss Ratio

The Expected Loss Ratio (ELR) for the group is equal to the state-specific individual physician expected loss ratio adjusted to reflect group underwriting expense savings.

I. Credibility

The credibility will be calculated by taking the square root of the following fraction:

$$\frac{\text{Experience Period Base Class Equivalent Exposures}}{2{,}700}$$

The base class equivalent exposures are calculated as the total Experience Rating Subject Premium divided by the current mature claims-made base rate at $200,000 policy limits. The maximum credibility a risk may receive is 100%. If a risk receives less than 100% credibility, the remaining credibility (100% - actual credibility) is given to unity (i.e., no debit and no credit).

J. Experience Modification Factor

The experience modification factor for the working layer of premium (first $200,000/$600,000 policy limits premium) is calculated as follows:

$$\text{Experience Modification Factor} = [\ \text{AELR/ELR} - 1\ ] \times \text{Credibility} + 1$$

The experience modification factor for the excess layer of premium will equal the square root of the working layer factor.

A final Combined Experience Modification Factor is then determined by applying the experience modifications by layer. The Combined Experience Modification Factor is applicable to the premium gross of deductible.

XIV. DEDUCTIBLE

The insured may elect to pay a deductible towards the amount paid to claimants as damages. The deductible will be collected after the payment of the claim. The following credits apply to the discounted premium.

	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$5K/$15K**	**$10K/$30K**	**$15K/$45K**	**$20K/$60K**	**$25K/$75K**
$100,000 / $300,000	0.962	0.938	0.913	0.889	0.867
$200,000 / $600,000	0.972	0.953	0.935	0.916	0.900
$250,000 / $750,000	0.974	0.957	0.940	0.923	0.907
$500,000 / $1,000,000	0.979	0.965	0.951	0.938	0.925
$1,000,000 / $3,000,000	0.983	0.972	0.961	0.950	0.940
$2,000,000 / $4,000,000	0.986	0.977	0.968	0.959	0.951

	Per-Claim with Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$50K/$150K**	**$100K/$300K**	**$200K/$600K**	**$250K/$750K**	**$500K/$1.5M**
$100,000 / $300,000	0.802	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.851	0.759	0.632	N/A	N/A
$250,000 / $750,000	0.863	0.778	0.661	0.599	N/A
$500,000 / $1,000,000	0.889	0.820	0.725	0.675	0.588
$1,000,000 / $3,000,000	0.911	0.856	0.780	0.740	0.670
$2,000,000 / $4,000,000	0.927	0.882	0.820	0.788	0.731

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	Per-Claim No Aggregate Deductible (Loss Only)				
Policy Limits	**$5K**	**$10K**	**$15K**	**$20K**	**$25K**
$100,000 / $300,000	0.954	0.926	0.896	0.867	0.847
$200,000 / $600,000	0.966	0.944	0.922	0.899	0.885
$250,000 / $750,000	0.969	0.948	0.928	0.908	0.893
$500,000 / $1,000,000	0.975	0.958	0.941	0.926	0.914
$1,000,000 / $3,000,000	0.980	0.966	0.953	0.940	0.931
$2,000,000 / $4,000,000	0.983	0.972	0.962	0.951	0.944

	Per-Claim No Aggregate Deductible (Loss Only)				
Policy Limits	**$50K**	**$100K**	**$200K**	**$250K**	**$500K**
$100,000 / $300,000	0.782	0.680	N/A	N/A	N/A
$200,000 / $600,000	0.836	0.740	0.632	N/A	N/A
$250,000 / $750,000	0.849	0.760	0.641	0.599	N/A
$500,000 / $1,000,000	0.878	0.806	0.709	0.662	0.588
$1,000,000 / $3,000,000	0.902	0.844	0.767	0.730	0.663
$2,000,000 / $4,000,000	0.920	0.873	0.809	0.780	0.726

	Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$5K**	**$10K**	**$15K**	**$20K**	**$25K**
$100,000 / $300,000	0.982	0.967	0.948	0.927	0.916
$200,000 / $600,000	0.986	0.975	0.961	0.944	0.937
$250,000 / $750,000	0.988	0.977	0.964	0.949	0.941
$500,000 / $1,000,000	0.990	0.981	0.971	0.959	0.953
$1,000,000 / $3,000,000	0.992	0.985	0.977	0.967	0.962
$2,000,000 / $4,000,000	0.993	0.987	0.981	0.973	0.969

	Per-Insured Aggregate Deductible (Loss Only)				
Policy Limits	**$50K**	**$100K**	**$200K**	**$250K**	**$500K**
$100,000 / $300,000	0.869	0.792	0.680	0.605	N/A
$200,000 / $600,000	0.902	0.831	0.742	0.700	0.600
$250,000 / $750,000	0.909	0.844	0.749	0.699	0.615
$500,000 / $1,000,000	0.927	0.874	0.796	0.747	0.691
$1,000,000 / $3,000,000	0.941	0.899	0.837	0.798	0.747
$2,000,000 / $4,000,000	0.952	0.917	0.866	0.835	0.795

Additional deductible options are available based upon specific group size and specialty. Refer to underwriting

XV. ENDORSED COVERAGES – Coverage Options

Accelerated Vesting For Extended Reporting Period Endorsement - Form PSIC-CM-02

This endorsement amends the years of continuous coverage requirement for the Extended Reporting Endorsement at no additional charge upon retirement.

Active Military Suspension Endorsement - Form PSIC-CM-03

This endorsement suspends coverage, including premium payments, if an insured is called to active military duty. This endorsement provides coverage for claims arising from acts, errors or omissions that occurred prior to the inception of the active military leave. There is no coverage for acts, errors or omissions during the period of active military duty. For claims made policies, because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail) while on active military duty.

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Additional Interests Endorsement - Form PSIC-CM-05

This optional endorsement provides coverage for an additional interest. For an individual practice, the charge for this endorsement will be up to 15% of the named insured's undiscounted manual premium for each additional interest. For a group practice, the charge for this endorsement will be up to 15% of the undiscounted manual rate of the top 5 highest rated healthcare providers for each additional interest.

The addition of an additional interest will be based upon the underwriter's assessment of additional exposure imputed to an insured physician and/or surgeon, solo practitioner corporation, partnership or multi shareholder corporation.

Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are financially and medically controlled by the Named Insured.	0%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially controlled by the Named Insured.	10%
Locations or services being provided by the **additional interest** to or on behalf of the Named Insured are not financially and medically controlled by the Named Insured.	15%

Temporary Leave of Absence Endorsement - Form PSIC-CM-06

This endorsement may be utilized if an insured must take a leave of absence from their practice. Insureds who become disabled or take a leave of absence shall become eligible for suspension of coverage at a rate reduction of 90% of the otherwise applicable rate for the period of disability or leave of absence. The period must extend for a minimum length of sixty (60) days or more up to a maximum of one hundred eighty (180) days or until renewal. The lower premium will apply retroactively to the first day of the disability or leave.

This option provides continued protection to the provider who experiences a temporary interruption in his or her practice (subject to the stated eligibility requirements), for claims arising from acts, errors or omissions which occurred prior to the inception of the disability or leave. There is no coverage for acts, errors or omissions during the leave or disability period. Because the policy does not cancel, there is no need for the purchase of Extended Reporting Coverage (Tail).

If disabled, proof of disability must be submitted to the Company for approval, and the calculation of the credit will be on a pro rata basis for the period of the qualifying disability.

While on disability or leave, credit toward extended reporting vesting will continue to accrue, and the insured must continue to pay premiums when due.

Eligible Situations For Temporary Leave of Absence: Short-Term Disability, Maternity Leave, Military Leave or any other reason pre-approved by Professional Solutions Insurance Company – Does not apply to vacations.

Extended Reporting Endorsement - Form PSIC-CM-07

This endorsement provides coverage for an unlimited time period with aggregate liability limits equal to or less than those of the expired coverage to report claims, which arose from incidents that occurred when the coverage was in force. The liability limits provided by this option are the only limits that shall be applicable to the unlimited time period designated above. This endorsement can be applied to group or entity policies.

Covered Full Time Equivalent Healthcare Provider Endorsement - Form PSIC-CM-08

A Full-time Equivalency (FTE) is used to accommodate multiple healthcare providers sharing one or more full-time positions within the given specialty. This endorsement provides one separate limit of liability to be shared by the covered FTE healthcare providers within the same FTE position as designated in the endorsement. All covered FTE healthcare providers within an FTE position must have the same specialty. The premium for the FTE position is based on the total hours of practice of the FTE position and the full-time, mature rate for the given specialty.

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Covered Healthcare Provider Slot Endorsement - Form PSIC-CM-09

A slot is used to accommodate one full-time position for a given specialty in practices with a high position turnover. This endorsement provides one separate limit of liability to be shared by the covered slot healthcare providers within the same slot position as designated in the endorsement. All covered slot healthcare providers within a slot position must have the same specialty. The premium for the slot position is based on the full-time, mature rate for the given specialty.

Covered Physician Locum Tenens Endorsement - Form PSIC-CM-10

This endorsement adds coverage for the substitute physician or surgeon listed on the endorsement while the named insured is temporarily absent from professional practice. There is no additional premium for this endorsement.

Illinois Restricted Practice Endorsement - Form PSIC-CM-IL-03

This endorsement excludes the designated specialty, procedure or practice activity for the insured(s) specified on the endorsement.

Vicarious Liability for Affiliated Healthcare Provider Endorsement - Form PSIC-CM-12

Coverage is provided for the vicarious liability of the affiliated healthcare provider(s) stated in the endorsement, who at the time of the alleged incident, were not otherwise named as an insured under the policy. There is a 25% additional premium charge for each affiliated physician and a 3% additional premium charge for each affiliated mid-level healthcare provider.

Illinois Vicarious Liability Risks Excluded Endorsement - Form PSIC-CM-IL-04

This endorsement excludes any vicarious liability arising from professional services provided by, or which should have been provided by, any excluded healthcare provider(s) designated on the endorsement.

XVI. CLASSIFICATION PLAN – Refer to rate sheet for manual rate information.

ISO Specialty Codes M.D.	ISO Specialty Codes D.O.	Class	Description	FACTOR
80999		1	Administrative excl. Direct Patient Care	0.650
80133		1	Aerospace Medicine	0.650
80254		1	Allergy/Immunology	0.650
80256		1	Dermatology - No Surgery	0.650
80240		1	Forensic & Legal Medicine	0.650
80248		1	Nutrition	0.650
80233		1	Occupational Medicine	0.650
80263		1	Ophthalmology - No Surgery	0.650
80235		1	Physical & Rehab Med. excl. Chronic Pain Management	0.650
80231		1	Preventive Medicine - No Surgery	0.650
80251		1	Psychosomatic Medicine - No Surgery	0.650
80236		1	Public Health - No Surgery	0.650
80237		2	Diabetes - No Surgery	0.850
80238		2	Endocrinology - No Surgery	0.850
80243		2	Geriatrics - No Surgery	0.850
80244		2	Gynecology - No Surgery	0.850
80260		2	Nephrology - No Surgery	0.850
80262		2	Nuclear Medicine	0.850
80268		2	Physician (NOC) - No Surgery	0.850

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80993	2	Podiatry - Soft Tissue	0.850
80249	2	Psychiatry - No Surgery	0.850
80252	2	Rheumatology - No Surgery	0.850
80182	3	Anesthesiology incl. Chronic Pain Management	1.000
80183	3	Anesthesiology	1.000
80255	3	Cardiovascular Disease - No Surgery	1.000
80420	3	Family Practice, GP (excl. OB) - No Surgery	1.000
80241	3	Gastroenterology - No Surgery	1.000
80245	3	Hematology - No Surgery	1.000
80246	3	Infectious Diseases - No Surgery	1.000
80257	3	Internal Medicine - No Surgery	1.000
80302	3	Oncology - No Surgery	1.000
80268	3	Orthopedic Diagnostic (office only) - No Surgery	1.000
80265	3	Otorhinolaryngology - No Surgery	1.000
80182	3	Pain Management	1.000
80266	3	Pathology - No Surgery	1.000
80267	3	Pediatrics - No Surgery	1.000
80269	3	Pulmonary Diseases - No Surgery	1.000
80425	3	Radiation Oncology	1.000
80287	4	Nephrology - Minor Surgery	1.250
80301	4	Oncology - Minor Surgery	1.250
80289	4	Ophthalmology - Minor Surgery	1.250
80114	4	Ophthalmology - Major Surgery	1.250
80294	4	Pulmonary Diseases - Minor Surgery	1.250
80120	4	Urology - Minor Surgery	1.250
80281	5	Cardiovascular Disease - Minor Surgery	1.500
80282	5	Dermatology - Minor Surgery	1.500
80271	5	Diabetes - Minor Surgery	1.500
80272	5	Endocrinology - Minor Surgery	1.500
80421	5	Family Practice, GP (excl. OB) - Minor Surgery	1.500
80274	5	Gastroenterology - Minor Surgery	1.500
80276	5	Geriatrics - Minor Surgery	1.500
80277	5	Gynecology - Minor Surgery	1.500
80278	5	Hematology - Minor Surgery	1.500
80222	5	Hospitalist	1.500
80279	5	Infectious Diseases - Minor Surgery	1.500
80284	5	Internal Medicine - Minor Surgery	1.500
80261	5	Neurology - No Surgery	1.500
80291	5	Otorhinolaryngology - Minor Surgery	1.500
80293	5	Pediatrics - Minor Surgery	1.500
80208	5	Physical & Rehab Med. incl. Pain Mgmt - Minor Procedures	1.500
80294	5	Physician (NOC) - Minor Surgery	1.500
80253	5	Radiology Diagnostic - No Surgery	1.500
80268	5	Urgent Care excl. Emergency Med. - No Surgery	1.500
80145	5	Urology - Major Surgery	1.500
80283	6	Intensive & Critical Care Medicine	1.650
80288	6	Neurology - Minor Surgery	1.650
80292	6	Pathology - Minor Surgery	1.650
80208	6	Physical & Rehab Med. incl. Pain Mgmt - Major Procedures	1.650
80280	6	Radiology Diagnostic - Minor Surgery	1.650
80360	6	Radiology Interventional - including invasive procedures	1.650
80101	7	Broncho-Esophagology - Major Surgery	2.150
80103	7	Endocrinology - Major Surgery	2.150

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80104	7	Gastroenterology - Major Surgery	2.150
80105	7	Geriatrics - Major Surgery	2.150
80804	7	Neonatal/Perinatal Medicine	2.150
80108	7	Nephrology - Major Surgery	2.150
80159	7	Otorhinolaryngology excl. Facial Plastic – Major Surgery	2.150
80115	8	Colon & Rectal - Major Surgery	2.500
80164	8	Oncology - Major Surgery	2.500
80117	8	Physician (NOC) - Major Invasive Procedures	2.500
80160	8	Rhinology Surgery	2.500
80102	9	Emergency Medicine - excl. Major Surgery	3.000
80420	9	Family Practice, GP - incl. OB & assist CS	3.000
80143	9	General (NOC) excl. Bariatrics - Major Surgery	3.000
80154	9	Orthopedic excl. Spine - Major Surgery	3.000
80156	9	Plastic (NOC) - Major Surgery	3.000
80169	10	Hand - Major Surgery	3.350
80154	10	Orthopedic incl. Spine - Major Surgery	3.350
80155	10	Otorhinolaryngology incl. Facial Plastic - Major Surgery	3.350
80166	11	Abdominal - Major Surgery	3.750
80157	11	Emergency Medicine - incl. Major Surgery	3.750
80167	11	Gynecology - Major Surgery	3.750
80170	11	Head & Neck - Major Surgery	3.750
80141	12	Cardiac - Major Surgery	4.500
80150	12	Cardiovascular Disease - Major Surgery	4.500
80156	12	Dermatology - Major Surgery	4.500
80144	12	Thoracic - Major Surgery	4.500
80171	12	Traumatic - Major Surgery	4.500
80146	12	Vascular - Major Surgery	4.500
80153	13	OB/GYN - Major Surgery	5.500
80168	13	Obstetrics - Major Surgery	5.500
80152	14	Neurology - Major Surgery	6.750

XVII. PROFESSIONAL ENTITY COVERAGE

A. Solo Practitioner Corporation:

Coverage for an insured's professional entity may be written with a shared limit of liability at no additional charge as long as the entity does not employ any other licensed physicians or surgeons.

B. Shared Limits of Liability:

Coverage for professional entities other than solo practitioners may be written with a shared limit of liability. The charge for shared limits of liability will be 3% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed of the Declarations and Schedule of Insureds when calculation the premium.

C. Separate Limits of Liability:

Coverage for professional entities may be written with a separate limit of liability. The premium charge for separate limits in which all members, stockholders or employees are insured with Professional Solutions Insurance Company will be 10% of the discounted manual rate, prior to the application of any applicable deductibles, of all insured providers, with the maximum premium limited to a cap of the top 5 highest rated healthcare providers listed on the Declarations and Schedule of Insureds when calculating the premium.

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XVIII. MID-LEVEL HEALTHCARE PROVIDER COVERAGE

A. Shared Limits of Liability:

Coverage for licensed, mid-level healthcare providers may be written so the mid-level healthcare providers share a separate limit of liability with another insured as stated on the Schedule of Mid-level Providers. There is no additional premium charge for up to 5 mid-level providers sharing in a separate limit. More than 5 mid-level providers requesting to share in a separate limit will be referred to Underwriting.

B. Separate Limits of Liability:

Coverage for licensed, mid-level healthcare providers is available on an individual, separate limits basis for employees of physicians insured by PSIC.

Mid-Level Healthcare Provider Classification Plan

ISO Specialty Codes	Mid-Level Healthcare Provider	Separate Limit Factor
80998	Other Ancillary Healthcare Provider	0.200
80960	Certified Registered Nurse Anesthetist	0.300
80965	Nurse Practitioner	0.300
80116	Physician Assistant	0.300
80116	Surgeon Assistant	0.300

XVIII. MISCELLANEOUS MEDICAL FACILITIES

Coverage for miscellaneous medical facilities may be written with a separate limit of liability.

Miscellaneous Medical Facility Mature Claims Made Rate (@ 100/300 limits)

Illinois Territory 01 - (Cook, Madison and St. Clair counties)	**$10.94**
Illinois Territory 02 - (DuPage, Kane, Lake, McHenry and Will counties)	**$8.10**
Illinois Territory 03 - (Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph, Winnebago and Jackson counties)	**$7.15**
Illinois Territory 04 - (Remainder of State)	**$5.24**

ISO Specialty Codes	Description	Factor
80613	Dialysis Center	0.150 Per Visit
80453	Ambulatory Surgical Center	1.000 Per Surgery
80613	Cancer Treatment Center	0.150 Per Visit
80613	Medical Spa	0.050 Per Visit
80613	Urgent Care	0.200 Per Visit
80715	Laboratory	0.500 Per $1,000 of Receipts
80715	Imaging Facility	0.500 Per $1,000 of Receipts

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XX. RATES

Physicians and Surgeons Mature Claims Made Rate (for Class 3 provider @ 100/300 limits)

Illinois Territory 01 - **(Cook, Madison and St. Clair counties)**	**$10,282.00**
Illinois Territory 02 - **(DuPage, Kane, Lake, McHenry and Will counties)**	**$7,613.00**
Illinois Territory 03 - **(Champaign, Macon, Jackson, Vermillion, Sangamon, DeKalb, Kankakee, LaSalle, Ogle, Randolph and Winnebago counties)**	**$6,717.00**
Illinois Territory 04 - **(Remainder of State)**	**$4,925.00**

Increase limit factors: The applicable limit factor is determined by the chosen limit option on the application.

Limits of Liability	Increase Limit Factors
$100,000/$300,000	1.000
$200,000/$600,000	1.375
$250,000/$750,000	1.500
$500,000/$1,000,000	1.875
$1,000,000/$3,000,000	2.500
$2,000,000/$4,000,000	3.125

Claims-Made Step Factors:

Year	Claims-Made Step Factor
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

6th Month Rule: If the period between the retroactive date and the policy effective date is less than 6 months, rate at year 1. If the period is more than 6 months, rate at year 2, with each of the next consecutive claims made step increases applied at each renewal.

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