Company Defined Items

1. The "by county" information listed is grouped by policy issuing county. There have been no changes made to the way this has been grouped in the last ten years.
2. There have been no changes to reserving or claim payment practices in the past ten years.
3. Closed claims are considered closed when both indemnity plus expense reserves are $0, which is also when it is assigned a close date. There have been no changes made to this definition in the past ten years.
4. Business entity coverage is written on the same policy as that of the physician to provide for vicarious liability exposure. Therefore, no policies have been identified as corporate in the data submission.
5. TDC uses a base class of Internal Medicine and a base territory called Territory A. Territory A is comprised of Cook, Madison, St. Clair, and Will counties. Will county was moved into Territory A effective 5/1/01. There have been no other changes made to either the base class or base territory in the past ten years.
6. There have been no explicit adjustments made to exposures for extended reporting endorsements. There is no impact on the exhibits for exposure adjustments.
7. TDC maturity factors and tail factor are listed in Exhibit 1.
8. The expense factor in column 314 of Exhibit 1 consists of general and other acquisition expenses.
9. The "other" miscellaneous factor in column 349 (6.13%), is the ratio of unallocated loss adjustment expenses to premium (not relative to loss) incorporated in the most recent rate review. As defined in Exhibit 1, the average credit and profit load are 7% and 5.57%, respectively.
10. TDC does not conduct a sufficient volume of business in Illinois to justify the estimation of bulk and IBNR reserves based strictly on Illinois data. Therefore, a percentage of the nationwide bulk and IBNR reserves are allocated to Illinois for reporting purposes. Allocation percentages are produced for indemnity and ALAE reserves separately. The allocation percentages are equal to the ratio of Illinois case reserves (indemnity or ALAE) to nationwide case reserves (indemnity or ALAE) by report year for claims made business, and by accident year for occurrence business.

Miscellaneous Notes:

- The Company reported amounts in Exhibit 2A Surplus in 000's in order for its data to fit within the State's required field lengths.
- For Exhibit 2A Reserves:
    - the Company expanded the Policy Type (Code) field length from 2 to 4 in order to enter the 4 digit codes defined by the IL DOI.
    - the Company had a single record that exceeded the field Direct and Assumed Loss and Loss Expense Percentage (3,2) field length requirements. The record was for Policy Type = OERE, and Report Year 2000. The actual loss ratio = 1630.48%, the Company reported 999.99% to comply with the field limitations.

RECONCILIATION
12/31/08

Exhibit 2a Surplus data reconciles to the Company's annual statutory financial statement, page 4, Statement of Income, Capital and Surplus Account section, for all five years reported: 12/31/04 to 12/31/08.

Exhibit 2b Reserves data reconciles to the Company's 2008 annual statutory statement, page 19.IL, line 11, Exhibit of Premium and Losses in the state of Illinois, to the extent that the data is limited to the last 10 years ending 12/31/99 to 12/31/08. Any reconciling items are due to prior 1999 data not included in the submission.

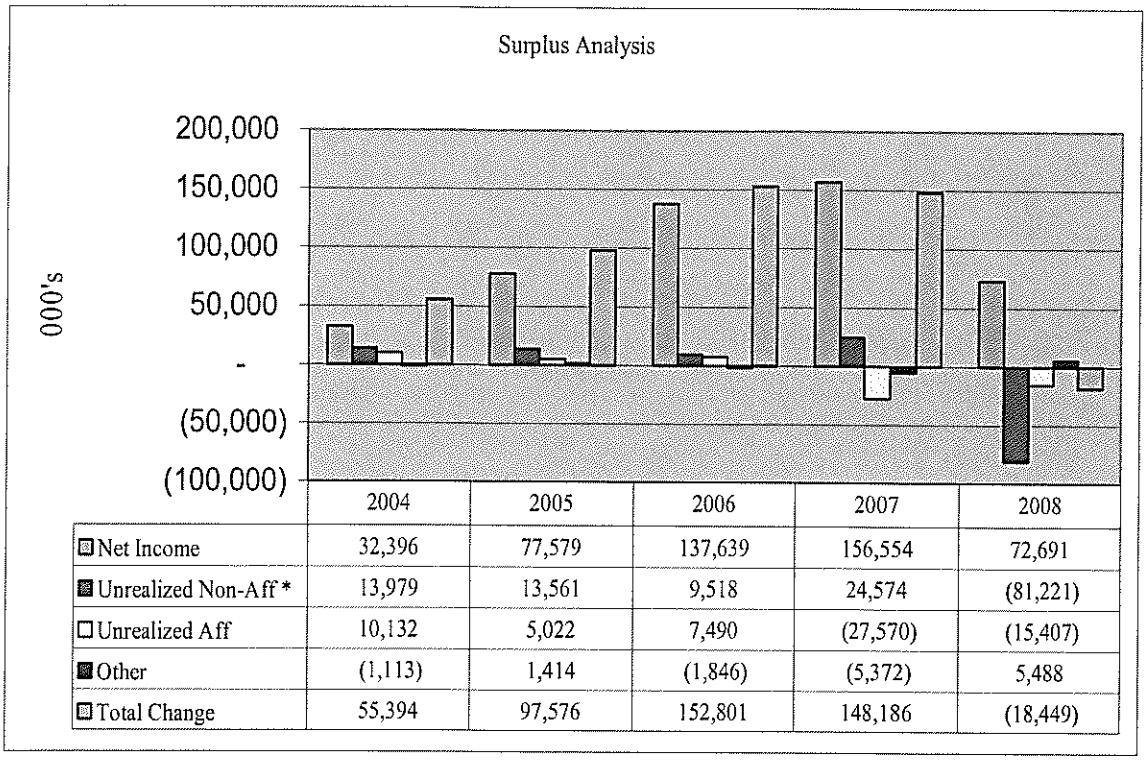
Paid losses and loss reserves from Exhibit 1cii and Exhibit 1ciii also reconcile closely to the Company's 2008 annual statutory statement, page 19.IL, line 11, Exhibit of Premium and Losses in the state of Illinois.

Exhibit 2B Reserve Study Descriptions

1. TDC uses a variety of standard actuarial methods in determining loss and loss adjustment expense reserves. These reviews are performed quarterly by in-house actuaries. Additionally, TDC solicits an actuarial opinion on carried loss reserves annually from an independent consulting firm (Ernst & Young).
2. As of the most recent year end, TDC's medical malpractice loss and loss adjustment expense reserves have been opined on by in-house actuaries and consulting actuaries of Ernst & Young. Both parties determined that reserves are adequate. Recently, there have been no material changes in reserving methods. Based on the results of IRIS tests 11 and 12, TDC has not experienced unfavorable trends in loss reserves in recent years.
3. In terms of trends in reserve development and present reserve adequacy, we believe TDC experience has been similar to that of the industry as a whole. As for specific business written, TDC exclusively targets physicians and surgeons while some of the rest of the industry has a greater concentration of hospitals and other healthcare institutions.

Surplus Analysis

In 2008, surplus decreased by $18,449 primarily as a result of net income of $72,691 offset by a change in unrealized capital losses of $81,222. Surplus as of December 31, 2008 was $785,696 vs. $804,146 as of December 31, 2007. (Note: The Exchange's surplus numbers do not include the $35,000 in surplus notes issued by PULIC and UFTPIC. On a consolidated basis, PULIC and UFTPIC's surplus notes would also be included in the surplus of the Exchange bringing the TDC group surplus to $820,696 as of December 31, 2008). Table 13 below shows sources and growth of surplus from 2004 through 2008.



	2004	2005	2006	2007	2008
Net Income	32,396	77,579	137,639	156,554	72,691
Unrealized Non-Aff *	13,979	13,561	9,518	24,574	(81,221)
Unrealized Aff	10,132	5,022	7,490	(27,570)	(15,407)
Other	(1,113)	1,414	(1,846)	(5,372)	5,488
Total Change	55,394	97,576	152,801	148,186	(18,449)

Table 13

The decline in surplus of $18,449 represents a decrease of 2.2% for the year over December 31, 2007. The Exchange recorded a decrease in the value of its subsidiaries of $15,407 as a result of the $48,600 dividends paid to the Exchange discussed above. Cost, book value and net income of each member of the TDC Group can be seen in Table 14 on the next page. Please see each individual Company's MDA for discussion of their results.

Other items including deferred federal income tax, non-admitted assets, and Tribute Plan payments, represented a change in surplus of $44,369, -$39,991, and $534, respectively.

Net deferred income taxes increased as a result of increased deferred tax assets of $17,828 and decreased offsetting deferred tax liabilities of $26,541 primarily the result of unrealized losses on non-affiliated equity investments.

Non-admitted assets increased because of an increase in non-admitted deferred tax assets of $34,989.

Carrying Value of Subsidiaries

	2008			2007		
	Cost	Book Value	Net Income	Cost	Book Value	Net Income
PULIC	21,500	42,490	98	21,500	49,473	(293)
SHI	300,432	278,516	8,951	-	-	-
OHIC	92,725	91,173	21,524	92,725	69,915	(9,475)
UFTPIC	21,250	73,313	16,597	21,250	73,560	(5,399)
TDLIC	10,600	15,991	254	10,600	16,734	539
TDMC	1,166	3,908	(403)	1,166	3,589	(228)
TDCIS	500	680	-	500	1,753	-
PULIS	100	837	-	100	1,841	-
Sub Total	448,273	506,908	47,021	147,841	216,865	(14,856)
NPIC	36,960	41,263	3,352	35,769	43,841	10,009
TDC Group	485,233	548,171	50,373	183,610	260,706	(4,847)

Table 14

THE DOCTORS COMPANY

December 9, 2005

Honorable Michael T. McRaith
Director of Insurance
Illinois Department of Financial and Professional Regulation
Division of Insurance
320 West Washington Street
Springfield, Illinois 62767

Attention: Mr. John Gatlin
Supervisor, Property and Casualty Compliance Unit

RE: The Doctors Company, an Interinsurance Exchange
NAIC Number: 831-34495
FEIN Number: 95-3014772
Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
Rate and Rule Revision
Effective Date: January 1, 2006-New Business
March 1, 2006-Renewal Business
State of Illinois
Filing Number 2005-IL-01

Dear Director McRaith:

On behalf of The Doctors Company, An Interinsurance Exchange (TDC), we are enclosing a rate and rule revision for our Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program. Based on our current book of business, the overall rate level impact of this revision for all specialties and territories combined is +5.0%.

This revision consists of the following changes:

- +5.0% change to manual rates for all specialties and territories (See Pages 25 and 26 of Rules and Rates Manual).
- In accordance with new 215 ILCS 5/155.18(e) (2005 Senate Bill 475), we are formally filing our current premium payment plans (See Pages 13 and 15 of Rules and Rates Manual)

We have also enclosed an Actuarial Memorandum that provides support for this revision.

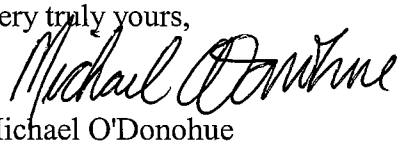
We propose that this revision apply to all new policies effective on or after January 1, 2006 and to all renewal policies effective on or after March 1, 2006.

In accordance with your requirements, we have enclosed the following:

- Two copies of the filing letter
- One copy of the filing
- Property & Casualty Transmittal Document (PC TD-1 (1/1/2003))
- Rate/Rule Filing Schedule (PC RRFS-1 (1/1/2003))
- Summary Sheet (Form RF-3)
- Actuarial Certification
- A self-addressed, postage pre-paid envelope

If you have any questions or if I may be of further assistance, please contact me at (800) 225-0318 or email me at modonohue@thedoctors.com.

Very truly yours,



Michael O'Donohue
Vice President
Regulatory Compliance

Enclosures

Effective January 1, 2003

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	f. State Filing #:
	g. SERFF Filing #:

3.	Group Name	Group NAIC #
	The Doctors Insurance Group	831

4.	Company Name(s)	Domicile	NAIC #	FEIN #
	The Doctors Company, An Interinsurance Exchange	California	831-34495	95-3014772

5.	Company Tracking Number	2005-IL-01

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Michael O'Donohue 185 Greenwood Rd, Napa, CA 94558	Vice President	800-225-0318	707-226-0162	modonohue@thedoctors.com
7.	Signature of authorized filer				
8.	Please print name of authorized filer		Michael O'Donohue		

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	11.1 Medical Malpractice-Claims-Made Only
10.	**Sub-Type of Insurance (Sub-TOI)**	11.1000 Medical Malpractice Sub-TOI Combinations
11.	**State Specific Product code(s)**(if applicable)[See State Specific Requirements]	Commercial
12.	**Company Program Title** (Marketing title)	Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☒ Rates/Rules ☐ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: January 1, 2006 Renewal: March 1, 2006
15.	**Reference Filing?**	☐ Yes ☒ No
16.	**Reference Organization** (if applicable)	Not Applicable
17.	**Reference Organization # & Title**	Not Applicable
18.	**Company's Date of Filing**	December 9, 2005
19.	**Status of filing in domicile**	☐ Not Filed ☐ Pending ☒ Authorized ☐ Disapproved

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	2005-IL-01

21.	**Filing Description** [This area should be similar to the body of a cover letter and is free-form text]

Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
Rate and Rule Revision

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: Not Applicable
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing.)

1.	**This filing transmittal is part of Company Tracking #**	2005-IL-01
2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	Not Applicable

☒ Rate Increase ☐ Rate Decrease ☐ Rate Neutral (0%)

3.	**Overall percentage rate impact for this filing**	+5.0%
4.	**Effect of Rate Filing – Written premium change for this program**	$555,716
5.	**Effect of Rate Filing – Number of policyholders**	55
6.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

7. **Rate Change by Company**

Company Name	Percentage Change	Effect of Rate Filing	
		# of policyholders for this program	Written premium change for this program
The Doctors Company	+5.0%	55	$555,716

8.	**Overall percentage of last rate revision**	+39.7%
9.	**Effective Date of last rate revision**	November 1, 2004-new/January 1, 2005-renewal
10.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

11.	Exhibit Name/Description /Synopsis	Rule # or Page #	Replacement or Withdrawn?	Previous state filing number, if required by state
01	Rules and Rates Manual	Pages 1-26 (3/06)	☒ Replacement ☐ Withdrawn ☐ Neither	2005-IL-MPL01
02			☐ Replacement ☐ Withdrawn ☐ Neither	
03			☐ Replacement ☐ Withdrawn ☐ Neither	
04			☐ Replacement ☐ Withdrawn ☐ Neither	
05			☐ Replacement ☐ Withdrawn ☐ Neither	

To be complete, a rate/rule filing must include the following:

1. A completed Rate/Rule Filing Transmittal document (PC RRFS-1) (Do not refer to the body of the filing for the component/exhibit listing.) and,
2. A completed Property & Casualty Transmittal Document (PC TD-1) and,
3. One copy of all rate/rule components/exhibits submitted with the filing, and
4. The appropriate state review requirements, if required, and
5. The appropriate filing fees, if required, and
6. A postage-paid, self-addressed envelope large enough to accommodate the return
7. You should refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

Form (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 1/1/06-New 3/1/06-Renewal .

	(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1.	Automobile Liability		
	Private Passenger		
	Commercial		
2.	Automobile Physical Damage		
	Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Medical Malpractice Line of Insurance	$11,114,331	+5.0%

Does filing only apply to certain territory (territories) or certain classes? If so, specify:

Filing applies differently to each territory. No. See Actuarial Memorandum

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):

Rate and Rule Revision

* Adjusted to reflect all prior rate changes.

** Change in Company's premium level which will result from application of new rates.

The Doctors Company, an Interinsurance Exchange

Name of Company

Michael O'Donohue

Vice President-Regulatory Compliance

Official - Title

H29219D

THE DOCTORS COMPANY,
An Interinsurance Exchange

Actuarial Certification

I, Steven J. Vercellini, am employed with The Doctors Company, an Interinsurance Exchange, and am a member of the American Academy of Actuaries, and an Associate of the Casualty Actuarial Society. The rate projections included in this filing are based on sound actuarial assumptions and methods and are not inconsistent with the company's experience.

Steven J. Vercellini, A.C.A.S., M.A.A.A.

The Doctors Company
Illinois
Actuarial Memorandum

The Doctors Company (TDC), in compliance with Illinois insurance laws and rate regulations, hereby files its rates for medical malpractice insurance in the state of Illinois. The indicated rate change is +5.0% statewide. With this filing we propose the following revisions:

- Increasing manual rates for a statewide premium impact of +5.0%. This includes increases to physician/surgeon rates by specialty.

The overall statewide premium impact from the above changes is +5.0%.

EXHIBIT I provides the derivation of the indicated $1,000,000/$3,000,000 limit mature claims-made manual rate change. Detailed line notes are attached.

EXHIBIT II shows the calculation of the indicated pure premium.

EXHIBIT III displays the current and proposed $1,000,000/$3,000,000 limit manual rates by specialty.

EXHIBIT IV details the calculation of the permissible loss and ALE ratio.

EXHIBIT V details the derivation of and support for the permissible loss and ALE ratio.

The Doctors Company
Illinois
Exhibit I Line Notes

(1) The trended base class (Internal Medicine), basic limit ($250,000) pure premium is based on the combined experience of TDC and ISMIE (see Exhibit II).

(2) The territory rate relativities.

(3) The projected territory base class, basic limit pure premium. It is calculated by taking: [(1) x (2)].

(4) The indicated average specialty relativity is a weighted average of TDC indicated specialty relativities.

(5) The increased limit factor is the rating factor used to adjust manual rates to a $1,000,000 limit basis.

(6) The indicated average $1M/$3M limit pure premium. It is derived by taking: [(3) x (4) x (5)].

(7) The permissible loss ratio (see Exhibit IV).

(8) The current average premium discount.

(9) The indicated average $1M/$3M premium. It is derived as: [(6) / (7) / (1.0 - (8))].

(10) The current average $1M/$3M premium based on TDC's current physician distribution.

(11) The indicated manual rate change. It is calculated by taking: [(9) / (10) - 1.0].

(12) The proposed average manual rate change.

(13) The current average discount/surcharge.

(14) The proposed average discount/surcharge

(15) The impact of the proposed change in average discount. It is derived by taking: [1.0 – (14)] / [1.0 – (13)] - 1.0.

(16) The proposed overall rate change. It is calculated by taking: [(1.0 + (12)) * (1.0 + (15))] - 1.0.

The Doctors Company
Illinois
October 2005 Review : Renewal Policies Effective 1/1/06
Indicated Physician Rate Calculation
$1M/$3M Limit Mature Claims Made Policies
Weighted By TDC Doctor Counts

		TERRITORY				
		A	B	C	D	STATE
		Cook, Madison, St. Clair and Will Counties	Champaign, Macon, McHenry and Sangamon Counties	Remainder of State	DuPage, Kane, Lake and Vermilion Counties	
(1)	Projected $250k/$750k Base Territory Internal Medicine Pure Premium :	$16,510	$16,510	$16,510	$16,510	$16,510
(2)	Territory Relativity :	1.000	0.800	0.700	0.900	
(3)	Projected $250k/$750k INT01 Pure Premium : = [(1) * (2)]	$16,510	$13,208	$11,557	$14,859	$14,558
(4)	Indicated Average Specialty Relativity :	2.165	1.782	1.414	3.497	
(5)	Increased Limits Factor :	1.943	1.943	1.943	1.943	
(6)	Indicated Average $1M/$3M Pure Premium : = [(3) * (4) * (5)]	$69,439	$45,710	$31,749	$100,926	$64,380
(7)	Permissible Loss & ALE Ratio:	68.1%	68.1%	68.1%	68.1%	68.1%
(8)	Current Average Premium Discount:	7.0%	7.0%	7.0%	7.0%	7.0%
(9)	Indicated Average $1M/$3M Premium : (TDC Weighted)	$109,641	$72,174	$50,130	$159,358	$101,654
(10)	Current Average $1M/$3M Premium : (TDC Weighted)	$104,424	$68,739	$47,744	$151,775	$96,817
(11)	**Indicated Territory Manual Rate Change :** = [(9) / (10)] - 1.0	**5.0%**	**5.0%**	**5.0%**	**5.0%**	**5.0%**
(12)	Proposed Manual Rate Change :	5.0%	5.0%	5.0%	5.0%	5.0%
(13)	Current Average Discount :	7.0%	7.0%	7.0%	7.0%	7.0%
(14)	Proposed Average Discount :	7.0%	7.0%	7.0%	7.0%	7.0%
(15)	Impact of Change In Average Discounts : =[(1.0 - (14)) / (1.0 - (13))] -1.0	0.0%	0.0%	0.0%	0.0%	0.0%
(16)	**Proposed Overall Rate Change :** =[(1.0 + (12)) * (1.0 + (15))] -1.0	**5.0%**	**5.0%**	**5.0%**	**5.0%**	**5.0%**

Notes:

Per Procedure, Auxiliary Physician, Hospital, Very Large Accounts and Schools omitted.

(7) *Based on 94.4% Target Combined Ratio and 13.3% ROE. See Exhibit IV.*

(8) *Based on Nationwide ex-California average manual premium discount including entity and PAR adjustments. Net of schedule adjustments. For comparison, see Exhibit I, Page 3 for current Illinois-specific average discounts.*

The Doctors Company
Illinois
October 2005 Review : Renewal Policies Effective 1/1/06
Pure Premium Development

		ISMIE	TDC
(1)	Effective Date	7/1/2005	1/1/2006
(2)	Basic Limit	$500k	$250k
(3)	Base Class, Base Terr. and Basic Limit Pure Premium:	$25,595	$16,595
(4)	Decreased Limit Factor (to $250k) :	0.674	1.000
(5)	Specialty Off Balance :	0.980	1.000
(6)	Maturity Off Balance :	0.972	1.000
(7)	Territory Off Balance :	0.952	1.000
(8)	Trend to 1/1/06 Effective Date (6.0%.) :	1.030	1.000
(9)	Trended IM, Terr A, $250k Limit Pure Premium : [(3) * (4) * (5) * (6) * (7) * (8)]	$16,103	$16,595
(10)	TDC Claims		739
(11)	Market Share	55%	
(12)	Credibility Weight TDC Credibility = [Sqrt((10) / 1082)]	17%	83%
(13)	Cred Wtd Int Med, Terr A, $250k Limit Pure Premium :		$16,510
(14)	Increased Limit Factor ($250k to $250k/$750k Limit Pure Premium):		1.000
(15)	Cred Wtd Int Med, Terr A, $250k/$750k Limit Pure Premium: [(13) * (14)]		**$16,510**

Notes: (3) TDC experience period is report years 1995-2004, trended at 6% annual.

The Doctors Company

Illinois Current and Proposed Manual Premiums

$1M/$3M Limit Mature Claims-Made Coverage

TERRITORY A : Cook, Madison, St. Clair and Will Counties

SPECIALTY	CURRENT MANUAL PREMIUM	PROPOSED MANUAL PREMIUM	RATE CHANGE
PHYSICIANS / SURGEONS :			
Administrative Medicine	14,469	15,192	5.0%
Allergy/Immunology	17,603	18,483	5.0%
Anesthesiology	51,587	54,166	5.0%
Anesthesiology - Pain Management	47,534	49,911	5.0%
Cardiology (Invasive)	66,435	69,757	5.0%
Chiropractor	7,234	7,596	5.0%
Colon&Rectal Surg(Min/Ltd)	106,103	111,408	5.0%
Dermatology	31,349	32,916	5.0%
Dermatology W/ Liposuction	111,987	117,586	5.0%
Diagnostic Radiology	71,017	74,568	5.0%
Emergency Medicine	101,280	106,344	5.0%
FGP (No Surgery)	36,895	38,740	5.0%
FGP (Minor Surgery-No Ob)	52,087	54,691	5.0%
FGP (Rest Maj Surg-No Ob)	69,931	73,428	5.0%
FGP (With Obstetrics)	96,216	101,027	5.0%
Gastroenterology	57,271	60,135	5.0%
General Medicine (Restricted)	33,760	35,448	5.0%
General Surgery	188,092	197,497	5.0%
General Surgery (Bariatric)		197,497	New
Gynecology (Major Surgery)	93,684	98,368	5.0%
Gynecology (w/ In-vitro Fertilization)	152,222	159,833	5.0%
Hand & Foot Surgery	64,144	67,351	5.0%
Internal Medicine	48,229	50,640	5.0%
Internal Medicine Subspecialties*	42,441	44,563	5.0%
Neonatology	67,520	70,896	5.0%
Neurology	62,697	65,832	5.0%
Neurosurgery	313,968	329,666	5.0%
Nuclear Medicine	22,185	23,294	5.0%
Obstetrics & Gynecology	210,759	221,297	5.0%
Occupational Medicine	16,880	17,724	5.0%
Ophthalmology (No Sur)	15,192	15,952	5.0%
Ophthalmology (Min Sur)	30,384	31,903	5.0%
Ophthalmology (Maj Sur)	47,746	50,133	5.0%
Orthopedic Surgery	143,239	150,401	5.0%
Otolaryngology (Maj, No Facial)	79,577	83,556	5.0%
Otolaryngology (Maj, Facial)	96,457	101,280	5.0%
Pathology	48,229	50,640	5.0%
Pediatrics	45,480	47,754	5.0%
Physical Medicine & Rehab (Non-Invasive)	30,384	31,903	5.0%
Physical Medicine & Rehab (Minor Proc)	38,101	40,006	5.0%
Physical Medicine & Rehab (Major Proc)	63,662	66,845	5.0%
Plastic Surgery	111,890	117,485	5.0%
Podiatry	32,988	34,637	5.0%
Psychiatry	20,864	21,907	5.0%
Pulmonary Medicine	60,286	63,300	5.0%
Surgical Specialty (Office,Min)	68,967	72,415	5.0%
Therapeutic Radiology	60,286	63,300	5.0%
Thoracic/Cardiovascular Surgery	159,154	167,112	5.0%
Urology	80,301	84,316	5.0%
PER PROCEDURE RATES :			
Surgicenter	31.12	32.67	5.0%
DENTAL RATES :			
Dental (Local anes and nitrous ox only)	9,646	10,128	5.0%
Dental (Sedation)	19,292	20,256	5.0%
Oral Surgeons	57,875	60,768	5.0%
Dental Anesthesiologists	67,521	70,896	5.0%

* Internal Medicine Subspecialties include Non-Invasive Cardiology, Endocrinology, Hematology, Infectious Disease, Nephrology, Oncology and Rheumatology.

The Doctors Company

Illinois Current and Proposed Manual Premiums

$1M/$3M Limit Mature Claims-Made Coverage

TERRITORY B : Champaign, Macon, McHenry and Sangamon Counties

SPECIALTY	CURRENT MANUAL PREMIUM	PROPOSED MANUAL PREMIUM	RATE CHANGE
PHYSICIANS / SURGEONS :			
Administrative Medicine	11,575	12,154	5.0%
Allergy/Immunology	14,083	14,787	5.0%
Anesthesiology	41,269	43,332	5.0%
Anesthesiology - Pain Management	38,027	39,928	5.0%
Cardiology (Invasive)	53,148	55,805	5.0%
Chiropractor	5,787	6,077	5.0%
Colon&Rectal Surg(Min/Ltd)	84,882	89,126	5.0%
Dermatology	25,079	26,333	5.0%
Dermatology W/ Liposuction	89,589	94,068	5.0%
Diagnostic Radiology	56,813	59,654	5.0%
Emergency Medicine	81,024	85,075	5.0%
FGP (No Surgery)	29,516	30,992	5.0%
FGP (Minor Surgery-No Ob)	41,670	43,754	5.0%
FGP (Rest Maj Surg-No Ob)	55,945	58,742	5.0%
FGP (With Obstetrics)	76,973	80,822	5.0%
Gastroenterology	45,817	48,108	5.0%
General Medicine (Restricted)	27,008	28,358	5.0%
General Surgery	150,473	157,997	5.0%
General Surgery (Bariatric)		157,997	New
Gynecology (Major Surgery)	74,947	78,694	5.0%
Gynecology (w/ In-vitro Fertilization)	121,777	127,866	5.0%
Hand & Foot Surgery	51,315	53,881	5.0%
Internal Medicine	38,583	40,512	5.0%
Internal Medicine Subspecialties*	33,953	35,651	5.0%
Neonatology	54,016	56,717	5.0%
Neurology	50,158	52,666	5.0%
Neurosurgery	251,175	263,734	5.0%
Nuclear Medicine	17,748	18,635	5.0%
Obstetrics & Gynecology	168,607	177,037	5.0%
Occupational Medicine	13,504	14,179	5.0%
Ophthalmology (No Sur)	12,154	12,762	5.0%
Ophthalmology (Min Sur)	24,307	25,522	5.0%
Ophthalmology (Maj Sur)	38,197	40,107	5.0%
Orthopedic Surgery	114,591	120,321	5.0%
Otolaryngology (Maj, No Facial)	63,662	66,845	5.0%
Otolaryngology (Maj, Facial)	77,166	81,024	5.0%
Pathology	38,583	40,512	5.0%
Pediatrics	36,384	38,203	5.0%
Physical Medicine & Rehab (Non-Invasive)	24,307	25,522	5.0%
Physical Medicine & Rehab (Minor Proc)	30,480	32,004	5.0%
Physical Medicine & Rehab (Major Proc)	50,929	53,475	5.0%
Plastic Surgery	89,512	93,988	5.0%
Podiatry	26,391	27,711	5.0%
Psychiatry	15,318	16,084	5.0%
Pulmonary Medicine	48,229	50,640	5.0%
Surgical Specialty (Office,Min)	55,174	57,933	5.0%
Therapeutic Radiology	48,229	50,640	5.0%
Thoracic/Cardiovascular Surgery	127,323	133,689	5.0%
Urology	64,240	67,452	5.0%
PER PROCEDURE RATES :			
Surgicenter	24.89	26.14	5.0%
DENTAL RATES :			
Dental (Local anes and nitrous ox only)	7,717	8,102	5.0%
Dental (Sedation)	15,433	16,205	5.0%
Oral Surgeons	46,300	48,614	5.0%
Dental Anesthesiologists	54,016	56,717	5.0%

* Internal Medicine Subspecialties include Non-Invasive Cardiology, Endocrinology, Hematology, Infectious Disease, Nephrology, Oncology and Rheumatology.

The Doctors Company

Illinois Current and Proposed Manual Premiums

$1M/$3M Limit Mature Claims-Made Coverage

TERRITORY C : Remainder of State

SPECIALTY	CURRENT MANUAL PREMIUM	PROPOSED MANUAL PREMIUM	RATE CHANGE
PHYSICIANS / SURGEONS :			
Administrative Medicine	10,128	10,634	5.0%
Allergy/Immunology	12,322	12,938	5.0%
Anesthesiology	36,111	37,917	5.0%
Anesthesiology - Pain Management	33,274	34,938	5.0%
Cardiology (Invasive)	46,504	48,829	5.0%
Chiropractor	5,064	5,317	5.0%
Colon&Rectal Surg(Min/Ltd)	74,272	77,986	5.0%
Dermatology	21,944	23,041	5.0%
Dermatology W/ Liposuction	78,391	82,311	5.0%
Diagnostic Radiology	49,712	52,198	5.0%
Emergency Medicine	70,896	74,441	5.0%
FGP (No Surgery)	25,826	27,117	5.0%
FGP (Minor Surgery-No Ob)	36,461	38,284	5.0%
FGP (Rest Maj Surg-No Ob)	48,952	51,400	5.0%
FGP (With Obstetrics)	67,351	70,719	5.0%
Gastroenterology	40,090	42,095	5.0%
General Medicine (Restricted)	23,632	24,814	5.0%
General Surgery	131,664	138,247	5.0%
General Surgery (Bariatric)		138,247	New
Gynecology (Major Surgery)	65,579	68,858	5.0%
Gynecology (w/ In-vitro Fertilization)	106,555	111,883	5.0%
Hand & Foot Surgery	44,901	47,146	5.0%
Internal Medicine	33,760	35,448	5.0%
Internal Medicine Subspecialties*	29,709	31,194	5.0%
Neonatology	47,264	49,627	5.0%
Neurology	43,888	46,082	5.0%
Neurosurgery	219,778	230,767	5.0%
Nuclear Medicine	15,530	16,307	5.0%
Obstetrics & Gynecology	147,531	154,908	5.0%
Occupational Medicine	11,816	12,407	5.0%
Ophthalmology (No Sur)	10,634	11,166	5.0%
Ophthalmology (Min Sur)	21,269	22,332	5.0%
Ophthalmology (Maj Sur)	33,422	35,093	5.0%
Orthopedic Surgery	100,267	105,280	5.0%
Otolaryngology (Maj, No Facial)	55,704	58,489	5.0%
Otolaryngology (Maj, Facial)	67,520	70,896	5.0%
Pathology	33,760	35,448	5.0%
Pediatrics	31,836	33,428	5.0%
Physical Medicine & Rehab (Non-Invasive)	21,269	22,332	5.0%
Physical Medicine & Rehab (Minor Proc)	26,670	28,004	5.0%
Physical Medicine & Rehab (Major Proc)	44,563	46,791	5.0%
Plastic Surgery	78,323	82,239	5.0%
Podiatry	23,092	24,247	5.0%
Psychiatry	12,154	12,762	5.0%
Pulmonary Medicine	42,200	44,310	5.0%
Surgical Specialty (Office,Min)	48,277	50,691	5.0%
Therapeutic Radiology	42,200	44,310	5.0%
Thoracic/Cardiovascular Surgery	111,408	116,978	5.0%
Urology	56,210	59,021	5.0%
PER PROCEDURE RATES :			
Surgicenter	21.78	22.87	5.0%
DENTAL RATES :			
Dental (Local anes and nitrous ox only)	6,752	7,090	5.0%
Dental (Sedation)	13,504	14,179	5.0%
Oral Surgeons	40,512	42,538	5.0%
Dental Anesthesiologists	47,264	49,627	5.0%

* Internal Medicine Subspecialties include Non-Invasive Cardiology, Endocrinology, Hematology, Infectious Disease, Nephrology, Oncology and Rheumatology.

The Doctors Company

Illinois Current and Proposed Manual Premiums

$1M/$3M Limit Mature Claims-Made Coverage

TERRITORY D : DuPage, Kane, Lake and Vermilion Counties

SPECIALTY	CURRENT MANUAL PREMIUM	PROPOSED MANUAL PREMIUM	RATE CHANGE
PHYSICIANS / SURGEONS :			
Administrative Medicine	13,022	13,673	5.0%
Allergy/Immunology	15,843	16,635	5.0%
Anesthesiology	46,428	48,749	5.0%
Anesthesiology - Pain Management	42,781	44,920	5.0%
Cardiology (Invasive)	59,791	62,781	5.0%
Chiropractor	6,511	6,836	5.0%
Colon&Rectal Surg(Min/Ltd)	95,493	100,268	5.0%
Dermatology	28,214	29,625	5.0%
Dermatology W/ Liposuction	100,788	105,827	5.0%
Diagnostic Radiology	63,915	67,111	5.0%
Emergency Medicine	91,152	95,710	5.0%
FGP (No Surgery)	33,205	34,865	5.0%
FGP (Minor Surgery-No Ob)	46,878	49,222	5.0%
FGP (Rest Maj Surg-No Ob)	62,938	66,085	5.0%
FGP (With Obstetrics)	86,594	90,924	5.0%
Gastroenterology	51,544	54,121	5.0%
General Medicine (Restricted)	30,384	31,903	5.0%
General Surgery	169,282	177,746	5.0%
General Surgery (Bariatric)		177,746	New
Gynecology (Major Surgery)	84,316	88,532	5.0%
Gynecology (w/ In-vitro Fertilization)	137,000	143,850	5.0%
Hand & Foot Surgery	57,730	60,617	5.0%
Internal Medicine	43,406	45,576	5.0%
Internal Medicine Subspecialties*	38,197	40,107	5.0%
Neonatology	60,768	63,806	5.0%
Neurology	56,427	59,248	5.0%
Neurosurgery	282,571	296,700	5.0%
Nuclear Medicine	19,967	20,965	5.0%
Obstetrics & Gynecology	189,683	199,167	5.0%
Occupational Medicine	15,192	15,952	5.0%
Ophthalmology (No Sur)	13,673	14,357	5.0%
Ophthalmology (Min Sur)	27,346	28,713	5.0%
Ophthalmology (Maj Sur)	42,972	45,121	5.0%
Orthopedic Surgery	128,915	135,361	5.0%
Otolaryngology (Maj, No Facial)	71,619	75,200	5.0%
Otolaryngology (Maj, Facial)	86,811	91,152	5.0%
Pathology	43,406	45,576	5.0%
Pediatrics	40,932	42,979	5.0%
Physical Medicine & Rehab (Non-Invasive)	27,346	28,713	5.0%
Physical Medicine & Rehab (Minor Proc)	34,291	36,006	5.0%
Physical Medicine & Rehab (Major Proc)	57,296	60,161	5.0%
Plastic Surgery	100,701	105,736	5.0%
Podiatry	29,690	31,175	5.0%
Psychiatry	18,704	19,639	5.0%
Pulmonary Medicine	54,257	56,970	5.0%
Surgical Specialty (Office,Min)	62,070	65,174	5.0%
Therapeutic Radiology	54,257	56,970	5.0%
Thoracic/Cardiovascular Surgery	143,239	150,401	5.0%
Urology	72,271	75,885	5.0%
PER PROCEDURE RATES :			
Surgicenter	28.00	29.40	5.0%
DENTAL RATES :			
Dental (Local anes and nitrous ox only)	8,681	9,115	5.0%
Dental (Sedation)	17,362	18,230	5.0%
Oral Surgeons	52,087	54,691	5.0%
Dental Anesthesiologists	60,768	63,806	5.0%

* Internal Medicine Subspecialties include Non-Invasive Cardiology, Endocrinology, Hematology, Infectious Disease, Nephrology, Oncology and Rheumatology.

The Doctors Company

Illinois

October 2005 Review : Renewal Policies Effective 1/1/06

Permissible Loss & ALE Ratio Calculation

(1)	Target Combined Ratio (13.3% ROE) :	94.4%
(2)	Budgeted Expenses (% Of Premium):	
	Commission :	4.5%
	General Expenses :	8.7%
	Other Acquisition :	0.8%
	Tax, License, Fees and Assessments :	2.7%
	DD&R :	3.5%
	Total Premium Related Expenses :	20.2%
(3)	Permissible Loss & LAE Ratio : = [(1) - (2)]	74.2%
(4)	ULE to Loss & ALE Ratio :	9.0%
(5)	**Permissible Loss & ALE Ratio :** = [(3) / (1.0 + (4))]	**68.1%**

The Doctors Company
Illinois
Permissible Loss & ALAE Ratio Derivation
$1M/$3M Limit Mature Claims-Made Coverage

The Doctors' Company uses a **Present Value Cash Flow Return Model** to determine the **Permissible Loss & ALE Ratio.** The derivation of the target return on equity (ROE) formula is as follows:

TARGET ROE	=			**13.3%**
	=	Total Return / Equity		
	=	(Return from insurance operation + return from surplus) / Equity		
	=	(Return from insurance operation) / Equity	+	3.25%
	=	Present Value(prem - loss - expense - ULE - fed inc tax) / Equity	+	3.25%
	=	(d1 x prem - d2 x loss - d3 x expense - d4 x ULE) x (1.0 - T) / E	+	3.25%
	=	[prem x (d1 - d3 x V) - loss x (d2 + d4 x U)] x (1.0 - T) x S / prem	+	3.25%
	=	[(d1 - d3 x V) - loss / prem x (d2 + d4 x U)] x (1.0 - T) x S	+	3.25%

This formula can be arranged to produce a permissible loss & ALE ratio (PLR) as well:

PLR	=	**[d1 - d3 x V - (ROE - 3.3%) / (S x (1 - T))] / [d2 + d4 x U]**	=	**68.1%**

The Target Combined Ratio (TCR) is therefore :

TCR	=	**PLR + V + (U x PLR)**	=	**94.4%**

where	V =	Expense to Premium Ratio	=	0.202
	U =	ULE / Loss Ratio	=	0.090
	S =	Premium to Equity Ratio	=	1.000
	T =	Federal Income Tax Rate	=	0.350
	E =	Equity		
	Loss =	Indemnity plus ALE		
	d1=	Premium Discount Factor	=	1.031
	d2=	Loss Reserve Discount Factor	=	0.896
	d3=	Expense Discount Factor	=	1.028
	d4=	ULE Reserve Discount Factor	=	0.960

Note: All cash flows are discounted to the policy year-end.

The Doctors Company

Permissible Loss & ALE Ratio Derivation

$1M/$3M Limit Mature Claims-Made Coverage

NATIONWIDE EX-CALIFORNIA INCREMENTAL PATTERNS

	Prem & Expense	Loss & LAE	Premium		Indemnity + ALE		ULE		Variable Expense	
Quarter	Discount Factor	Discount Factor	Percent Increment	Present Value	Percent Increment	Present Value	Percent Increment	Present Value	Percent Increment	Present Value
0	1.050	----	25.0%	26.3%	0.0%	0.0%	0.0%	0.0%	30.0%	31.5%
1	1.037	1.044	25.0%	25.9%	0.7%	0.7%	12.8%	13.4%	17.5%	18.2%
2	1.025	1.031	25.0%	25.6%	0.8%	0.8%	12.9%	13.3%	17.5%	17.9%
3	1.012	1.018	25.0%	25.3%	1.6%	1.6%	13.3%	13.5%	17.5%	17.7%
4	1.000	1.006	0.0%	0.0%	2.4%	2.4%	13.7%	13.8%	17.5%	17.5%
5	0.988	0.994	0.0%	0.0%	3.8%	3.7%	1.9%	1.9%	0.0%	0.0%
6	0.976	0.982	0.0%	0.0%	4.6%	4.5%	2.3%	2.2%	0.0%	0.0%
7	0.964	0.970	0.0%	0.0%	5.7%	5.5%	2.8%	2.7%	0.0%	0.0%
8	0.952	0.958	0.0%	0.0%	5.8%	5.5%	2.9%	2.8%	0.0%	0.0%
9	0.941	0.947	0.0%	0.0%	6.8%	6.4%	3.4%	3.2%	0.0%	0.0%
10	0.929	0.935	0.0%	0.0%	6.8%	6.3%	3.4%	3.2%	0.0%	0.0%
11	0.918	0.924	0.0%	0.0%	6.6%	6.1%	3.3%	3.1%	0.0%	0.0%
12	0.907	0.913	0.0%	0.0%	5.3%	4.8%	2.6%	2.4%	0.0%	0.0%
13	0.896	0.902	0.0%	0.0%	5.5%	4.9%	2.7%	2.5%	0.0%	0.0%
14	0.885	0.891	0.0%	0.0%	5.1%	4.5%	2.5%	2.3%	0.0%	0.0%
15	0.874	0.880	0.0%	0.0%	4.9%	4.3%	2.5%	2.2%	0.0%	0.0%
16	0.864	0.869	0.0%	0.0%	3.6%	3.1%	1.8%	1.6%	0.0%	0.0%
17	0.853	0.859	0.0%	0.0%	3.3%	2.8%	1.7%	1.4%	0.0%	0.0%
18	0.843	0.848	0.0%	0.0%	3.0%	2.6%	1.5%	1.3%	0.0%	0.0%
19	0.833	0.838	0.0%	0.0%	3.5%	3.0%	1.8%	1.5%	0.0%	0.0%
20	0.823	0.828	0.0%	0.0%	3.2%	2.6%	1.6%	1.3%	0.0%	0.0%
21	0.813	0.818	0.0%	0.0%	2.5%	2.1%	1.3%	1.0%	0.0%	0.0%
22	0.803	0.808	0.0%	0.0%	1.5%	1.2%	0.7%	0.6%	0.0%	0.0%
23	0.793	0.798	0.0%	0.0%	2.2%	1.8%	1.1%	0.9%	0.0%	0.0%
24	0.784	0.788	0.0%	0.0%	2.5%	2.0%	1.2%	1.0%	0.0%	0.0%
25	0.774	0.779	0.0%	0.0%	2.4%	1.8%	1.2%	0.9%	0.0%	0.0%
26	0.765	0.769	0.0%	0.0%	1.2%	0.9%	0.6%	0.5%	0.0%	0.0%
27	0.755	0.760	0.0%	0.0%	0.7%	0.5%	0.3%	0.3%	0.0%	0.0%
28	0.746	0.751	0.0%	0.0%	0.5%	0.4%	0.3%	0.2%	0.0%	0.0%
29	0.737	0.742	0.0%	0.0%	0.4%	0.3%	0.2%	0.1%	0.0%	0.0%
30	0.728	0.733	0.0%	0.0%	0.4%	0.3%	0.2%	0.1%	0.0%	0.0%
31	0.719	0.724	0.0%	0.0%	0.5%	0.4%	0.2%	0.2%	0.0%	0.0%
32	0.711	0.715	0.0%	0.0%	0.5%	0.3%	0.2%	0.2%	0.0%	0.0%
33	0.702	0.706	0.0%	0.0%	0.5%	0.3%	0.2%	0.2%	0.0%	0.0%
34	0.694	0.698	0.0%	0.0%	0.3%	0.2%	0.1%	0.1%	0.0%	0.0%
35	0.685	0.689	0.0%	0.0%	0.4%	0.3%	0.2%	0.1%	0.0%	0.0%
36	0.677	0.681	0.0%	0.0%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%
37	0.669	0.673	0.0%	0.0%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%
38	0.661	0.665	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%
39	0.653	0.657	0.0%	0.0%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%
40	0.645	0.649	0.0%	0.0%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%
Total			100.0%	103.1%	99.9%	89.6%	99.9%	96.0%	100.0%	102.8%
Present Value Factor (@Discount Rate of 5%)				1.031		0.896		0.960		1.028

Notes: All cash flows are discounted to the end of the policy period.
Premium and Variable Expense payments made at the end of each calendar quarter.
Loss & LAE payments assumed made in the middle of each calendar quarter.

The Doctors Company
Medical Malpractice
Projected Investment Income Ratio

Nationwide Actual Investment Performance

(1) Calendar Year	*(2)* Cash and Invested Assets	*(3)* Interest, Dividends, Real Estate Income Due & Accrued	*(4)* Average (2) Prior Year & Current Year	*(5)* Net Investment Gain (Loss)	*(6)* Net Investment Income Earned	*(7)* Average Investment Income Yield
1995	765,064,698	9,480,056	756,603,796	50,543,545	43,997,922	5.9%
1996	788,341,304	9,138,053	776,703,001	62,781,772	42,634,550	5.6%
1997	865,541,561	9,057,132	826,941,433	50,477,238	42,238,423	5.2%
1998	967,837,096	10,103,340	916,689,329	60,746,709	42,118,453	4.7%
1999	1,008,680,502	10,197,143	988,258,799	41,346,451	39,587,190	4.0%
2000	904,617,225	8,350,016	956,648,864	47,900,068	40,566,274	4.3%
2001	981,698,724	7,976,548	943,157,975	62,570,733	41,384,798	4.4%
2002	1,158,583,135	7,921,249	1,070,140,930	23,042,248	38,479,520	3.6%
2003	1,158,432,328	7,748,286	1,158,507,732	28,745,153	32,913,169	2.9%
2004	1,355,160,546	8,512,137	1,256,796,437	48,510,613	34,487,835	2.8%
10-Yr Avg (95-04)						4.1%
5-Yr Avg (00-04)						3.5%
3-Yr Ave (02-04)						3.0%
4-Yr Ave (01-04)						3.3%
6-Yr Ave (99-04)						3.6%
Selected						3.5%

(8) Calendar Year	*(9)* Net Realized Capital Gain (Loss)	*(10)* *=(9)/(4)* Avg Realized Capital Gain (Loss) Yield	*(11)* Net Unrealized Capital Gain (Loss)	*(12)* *=(11)/(4)* Avg Unrealized Capital Gain (Loss) Yield	*(13)* *=((6)+(9)+(11))/(4)* Combined Investment Yield
1995	6,545,623	0.9%	12,800,659	1.7%	8.4%
1996	20,147,222	2.6%	8,262,324	1.1%	9.1%
1997	8,238,815	1.0%	24,020,394	2.9%	9.0%
1998	18,628,256	2.0%	26,707,779	2.9%	9.5%
1999	1,759,261	0.2%	30,605,123	3.1%	7.3%
2000	7,333,794	0.8%	(39,242,760)	-4.1%	0.9%
2001	21,185,935	2.2%	(11,151,745)	-1.2%	5.5%
2002	(15,437,272)	-1.4%	7,879,069	0.7%	2.9%
2003	(4,168,016)	-0.4%	45,277,163	3.9%	6.4%
2004	14,022,778	1.1%	24,111,468	1.9%	5.8%
10-Yr Avg (95-04)		0.8%		1.3%	6.7%
5-Yr Avg (00-04)		0.4%		0.5%	5.1%
3-Yr Ave (02-04)		-0.2%		2.2%	3.1%
4-Yr Ave (01-04)					5.2%
6-Yr Ave (99-04)					4.9%
Selected		0.5%		1.0%	**5.0%**

Notes:
(2) TDC Annual Statement Page 2 - Line 10, Column 3
(3) TDC Annual Statement Page 2 - Line 11, Column 3
(5) TDC Annual Statement Page 4 - Line 11 - Column 1
(6) TDC Annual Statement Page 4 - Line 9, Column 1
(7) [2.0 x (6)]/[(2)current + (2)prior + (3)current + (3)prior - (6)]
(9) TDC Annual Statement Page 4 - Line 10 - column 1
(11) TDC Annual Statement Page 4 - Line 23 - Column 1

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS
RULES AND RATES MANUAL

STATE OF ILLINOIS

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VI. MANUAL RATES

I. CLASSIFICATION

A. RATE

An insured is rated full-time, part-time or prep.

A part-time discount is available to insureds that practice less than full time. The discount is either 50% or 75% depending on the number of hours or days worked per year. A 50% part-time discount is available to those insureds that work 20 hours or less per week or who work 26 weeks or less per year. A 75% "limited" part-time discount is available to those insureds that work 10 hours or less per week. The "limited" part-time discount shall not apply to any policy that does not include at least one full-time or part-time (excluding "limited" part-time) insured. Surgical specialties are not eligible for part-time or "limited" part time discounts.

For an Anesthesiologist to be eligible for the part-time discount, no more than 15 hours per week may be billable. Anesthesiologist are not eligible for a "limited' part time discount.

A discounted prep rate is available to those physicians entering private practice for the first time who purchase a claims-made policy within three (3) years upon completing an internship program, fellowship program, residency program or military service. The applicable prep discount is based on the number of years since the physician completed the program or service as follows:

75% - less than 1 year
50% - 1 year to less than 2 years
25% - 2 years to less than 3 years
0% - 3 years or greater

Coverage for auxiliary physicians may be provided on an hourly basis. The hourly rate is determined by the application of the factor .000625 to the applicable medical specialty rate.

B. YEAR/STATE/AREA

The number of years of claims-made coverage is calculated from the effective date with The Doctors Company (the Company) or, in the case of prior acts coverage, the retroactive date.

Physician professional liability rates differ by state, territory within state, limits of liability and specialty. See Section VI-Manual Rates of this Rules and Rates Manual.

Maturation is the process of the policy aging, which is reflected in the premium rates. The policy attains maturity through premium increases occurring on the anniversary of the retroactive date. The policy is mature upon the completion of five consecutive years of claims-made coverage.

The claims-made maturity factors are as follows:

Claims-Made Maturity Year	"Incident" Basis Factor	"Demand" Basis Factor
1	0.35	0.21
2	0.60	0.45
3	0.80	0.72
4	0.92	0.88
5	1.000	1.000

C. LIMITS OF LIABILITY

For all specialties except Chiropractic, the minimum limits of liability provided shall be $500,000 per claim/$1,500,000 annual aggregate. The following increased limits factors apply:

Limits of Liability	Factor	Limits of Liability	Factor
.5M/1.5M	0.810	6M/9M	1.798
1M/3M	1.000	7M/10M	1.843
2M/5M	1.350	8M/11M	1.884
3M/6M	1.554	9M/12M	1.916
4M/7M	1.673	10M/13M	1.946
5M/8M	1.742	11M/14M	1.976

For Chiropractic only, the following increased limits factors apply. The minimum limits of liability provided shall be $100,000 per claim/$300,000 annual aggregate.

Limits of Liability	Factor	Limits of Liability	Factor
.1M/.3M	0.526	5M/8M	1.742
.2M/.6M	0.684	6M/9M	1.798
.25M/.75M	0.737	7M/10M	1.843
.5M/1.5M	0.842	8M/11M	1.884
1M/3M	1.000	9M/12M	1.916
2M/5M	1.350	10M/13M	1.946
3M/6M	1.554	11M/14M	1.976
4M/7M	1.673		

For each $1,000,000 increase in the annual aggregate limit, add 0.005 to the applicable increased limits factor.

For each $1,000,000 decrease in the annual aggregate limit, subtract 0.005 from the appropriate increased limits factor.

D. PRIOR ACTS COVERAGE

Prior Acts Coverage (Retroactive Coverage) insures protected parties against claims for acts or omissions during the time a previous "claims-made" policy(ies) was in force. It provides coverage for those claims unreported from the initial coverage date on which the other policy(ies) began to the date the current policy became effective with the Company. Coverage will therefore be continuous. Once established, the retroactive coverage date can only be advanced at the request or written knowledge of the Named Insured. In calculating the premium, maturity is dated from the initial retroactive coverage date of the other policy(ies).

The Company requires that any claim is first reported during the policy period as stated on the Coverage Summary; that the claim and the professional services are within the coverage of the policy and not excluded by it; and that the amount paid does not exceed the Company claim aggregate limits of liability applicable to the Named Insured.

E. ANCILLARIES

Ancillaries include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists, Perfusionists and Psychologists. These ancillaries share limits with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physician Assistants
Surgeon Assistants
Certified Nurse Practitioners
Certified Nurse Midwifes
Certified Registered Nurse Anesthetists
Optometrists

1. Rating Options for Physician Assistants (PA), Surgeon Assistants (SA) and Certified Nurse Practitioners (NP)

   The Company insures PAs, SAs and NPs when employed by or independently contracting with a Named Insured. Coverage may be provided under the policy of the Named Insured in the following ways:

   a. Employed PA, SA or NP with a separate set of limits of liability

      Rate: Nurse Practitioner/Physician Assistant/Surgeon Assistant
      (Specialty Code NUR01/PHA01/SRA01)
      25% of Family/General Practice-No Surgery Rate

   b. Employed PA, SA or NP as a Protected Party

      This option provides that the PA, SA or NP share the limits of liability with the Named Insured physician.

      Rate: 25% less than the rate charged for NUR01/PHA01/SRA01
      (Specialty Code NUR02/PHA02/SRA02)

   c. Independent Contractor (Vicarious Liability Coverage for supervising Named Insured physician only)

      This option provides Vicarious Liability Coverage not to the PA, SA or NP but to a Named Insured physician for supervisory responsibilities.

      Rate: 10% of the physician's premium

2. Rating Options for Certified Nurse Midwives (CNM)

   The Company insures CNMs when employed by or independently contracting with a Named Insured. Coverage may be provided under the policy of a Named Insured in the following ways:

   a. Employed CNM with a separate set of limits of liability (Direct Supervision)

      This option provides the CNM with a separate set of limits of liability. Professional

services connected with labor and/or delivery are covered only when under the direct physical supervision and control of a Named Insured physician.

Rate: CNM- Direct Supervision (Specialty Code CNM01)
15% of Obstetrics/Gynecology Rate

b. Employed CNM with a separate set of limits of liability (Indirect Supervision)

This option provides the CNM with a separate set of limits of liability. Professional services connected with labor and/or delivery not under the direct physical supervision and control of a Named Insured physician are covered.

Rate: CNM - Indirect Supervision (Specialty Code CNM02)
30% of Obstetrics/Gynecology Rate

c. Employed CNM as a Protected Party (Direct Supervision)

This option provides that the CNM share the limits of liability with the Named Insured physician. Professional services connected with labor and/or delivery are covered only when under the direct physical supervision and control of the Named Insured physician.

Rate: CNM - Direct Supervision (Specialty Code CNM03)
25% less than the rate charged for CNM01

d. Employed CNM as a Protected Party (Indirect Supervision)

This option provides that the CNM share the limits of liability with the Named Insured physician. Professional services connected with labor and/or delivery not under the direct physical supervision and control of the Named Insured physician are covered.

Rate: CNM - Indirect Supervision (Specialty Code CNM04)
25% less than the rate charged for CNM02

e. Independent Contractor (Vicarious Liability Coverage for supervising Named Insured physician only)

This option provides Vicarious Liability Coverage not to the CMN but to a Named Insured physician for supervisory responsibilities. .

Rate: 10% of the physician's premium

3. Rating Options for Certified Registered Nurse Anesthetists (CRNA)

The Company insures CRNAs when employed by or independently contracting with a Named

Insured. Coverage will be provided under the policy of a Named Insured in the following ways:

a. Employed or independent contractor CRNA supervised by an Anesthesiologist with a separate set of limits of liability

This option provides the CRNA with a separate set of limits and includes coverage for professional services rendered at a location supervised by a Named Insured Anesthesiologist or the Named Insured's Anesthesiology group.

Rate: CRNA - Supervised by an Anesthesiologist (Specialty Code ANE02)
25% of Anesthesiology Rate

b. Employed or independent contractor CRNA supervised by a Surgeon other than an Anesthesiologist with a separate set of limits of liability

This option provides the CRNA with a separate set of limits and includes professional services rendered at a location supervised by the Named Insured Surgeon or the Named Insured's Surgical Group.

Rate: CRNA - Supervised by a Surgeon (Specialty Code ANE03)
45% of Anesthesiology Rate

c. Employed CRNA as a Protected Party

This option provides that the CRNA share the limits of liability with the Named Insured Anesthesiologist and includes coverage for professional services rendered at a location supervised by a Named Insured Anesthesiologist or the Named Insured's Anesthesiology Group.

Rate: CRNA - Supervised by an Anesthesiologist (Specialty Code ANE04)
25% less than the rate charged for ANE02

d. Employed CRNA as a Protected Party

This option provides that the CRNA share the limits of liability with the Named Insured Surgeon and includes coverage for professional services rendered at a location supervised by a Named Insured Surgeon or the Named Insured's Surgical Group.

Rate: CRNA - Supervised by a Surgeon (Specialty Code ANES05)
25% less than the rate charged for ANES03

e. Independent Contractor (Vicarious Liability Coverage for supervising Named Insured physician only)

This option provides Vicarious Liability Coverage not to the CRNA but to the Named Insured Anesthesiologist or Surgeon for supervisor responsibilities.

Rate: 10% of the physician's premium

4. Rating Options for Optometrists

The Company insures Optometrists when employed by or independently contracting with a Named Insured. Coverage may be provided under the policy of a Named Insured in the following ways:

a. Employed Optometrists with a separate set of limits of liability

Rate: Optometrists (Specialty Code OPT01)
16% of Internal Medicine Rate

b. Employed Optometrists as a Protected Party

This option provides that the Optometrists share the limits of liability with the Named Insured physician.

Rate: 25% less than rate charged for OPT01
(Specialty Code OPT02)

c. Independent Contractor (Vicarious Liability Coverage for supervising Named Insured physician only)

This option provides Vicarious Liability Coverage not to the Optometrists but to a Named Insured physician for supervisory responsibilities.

Rate: 10% of the physician's premium

F. BUSINESS ENTITY COVERAGE CHARGE

When a group of two or more physicians have formed a corporation, partnership or association, business entity coverage is available. Shared coverage or separate limits of liability may be provided to the business entity. The shared business entity coverage premium is 4% of each physician's premium. The separate limits business entity coverage premium is 15% of each physician's premium.

II. DISCOUNTS

A. DISCOUNT PROGRAMS

1. Claims-free Discount

A 12.5% claims-free discount shall be applied on the effective date of the policy for all Named Insureds meeting the following criteria:

1. Named Insured is a policyholder with the Company for at least 3 full years immediately preceding the effective date of the policy.

2. Cumulative outstanding claim reserves (indemnity and allocated loss adjustment expenses) less than $20,000.

3. Cumulative claim payments (indemnity and allocated loss adjustment expenses) less than $10,000 in the last 3 full years immediately preceding the effective date of the policy.

If the Named Insured is a policyholder with the Company less than 3 full years, the 12.5% claims-free discount shall also be available if the insured has cumulative outstanding claim reserves less than $20,000 (including no outstanding claim reserves with previous carrier(s)) and cumulative claim payments less than $10,000 in the last 3 full years immediately preceding the effective date of the policy. In order to receive the discount, the insured is required to submit acceptable documentation of "claims-free" experience from its previous insurance carrier(s).

The claims-free discount shall NOT apply to:

- any Named Insured rated under surcharge program
- part-time, "limited" part-time, prep and auxiliary physicians
- ancillary healthcare providers (e.g. Physician's Assistant, Certified Nurse Practitioners, etc.) that share limits with any Named Insured
- Named Insureds rated on a "per procedure" basis

2. Group Size Discount

Group Size	% Discount
10-20	5%
21-30	7.5%
31 or more	10%

This discount is based solely on the size of the group. It applies to full-time, part-time and prep Named Insureds only. It does not apply to "limited" part-time Named Insureds.

The group size discount eligibility is evaluated annually at policy renewal. Changes made to the group size during the policy period will not be reflected until the next policy renewal.

3. Waiver of Consent to Settle Discount

A Named Insured may elect to waive his or her right to consent to settle any claim and give the Company the sole right to investigate, negotiate and settle. When a Named Insured makes such an election, a 5% discount shall be applied the Named Insured's premium.

4. Deductible Discount

A Named Insured can elect that a deductible apply on a per claim basis. The two deductible options are:

a. $5,000 deductible per claim-5% premium discount
b. $10,000 deductible per claim-10% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the $1,000,000/$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. A physician may not increase, decrease or cancel his/her deductible during the course of one policy year.

The above discounts are applied in the following order and are multiplicative:

1. Claims-Free Discount
2. Group Size Discount
3. Waiver of Consent to Settle Discount
4. Deductible Discount

B. SLOT POSITIONS

This rule does **NOT** apply in Illinois.

III. GENERAL RULES

A. LOCUM TENENS

A Locum Tenens ("hold the place of") works in place of a Named Insured, never at the same time. The Company will allow Locum Tenens coverage for a maximum total of 30 days each policy year.

B. SUSPENSION OF INSURANCE

A Named Insured can request suspension of insurance, due to a disability, pregnancy, family leave, or sabbatical leave for training. The Named Insured will not be covered for claims or suits based on an occurrence within the period of suspension. The Named Insured may report claims during the period of suspension, which arise from incidents that take place subsequent to the retroactive date, but not during the period of suspension.

Suspension can be secured for a minimum period of 90 consecutive days and for a maximum of 12 consecutive months. This option is allowed only once every four years except for reason of disability.

Any refund of premium is made that is due for that period of suspension.
Note:

1. Normal maturation of the policy continues during the period of suspension.

2. If a Named Insured's coverage is suspended because of disability, and he or she does not return to practice due to permanent and total disability, the Company will provide free Extended Reporting Period Coverage, issued retroactively to the first day of the period of suspension. Cancellation will be on the same date of the suspension if cancellation is at the Named Insured's request. If the Company cancels the policy, the Company would send proper notice of cancellation.

3. If a Named Insured coverage is suspended for reasons other than disability, and he or she does not return to practice after the period of suspension, the Company will date the cancellation, and calculate the premium for the Extended Reporting Period Endorsement, effective on the first day of the period of suspension. Premium is calculated based on the rates and rules in effect on the inception date listed in the Coverage Summary. Cancellation will be on the same date of the suspension if cancellation is at the Named Insured's request. If the Company cancels the policy, the Company would send proper notice of cancellation.

C. CHANGES

1. Changes in Territory

   If a Named Insured moves to a different territory, the premium adjustment (if appropriate) is billed or refunded effective the date of the change. This change is computed as a Special Rate as discussed below.

2. Changes in Limits of Liability

   The Company requires a written request for changes in Limits of Liability and a "no known loss" disclaimer signed by each Named Insured under the policy. Increases in limits of liability are made at renewal and are not backdated. The Company must receive the request for the increase thirty days prior to renewal. Decreases in limits of liability are made effective immediately.

3. Changes in Specialty/Rate

Changes in specialty occur when a physician adds or drops certain procedures, such as obstetrics. Changes in rate occur when the status of the physician changes, such as from full-time to part-time.

An endorsement changing specialty/rate cancels coverage for the previous specialty/rate except for claims reported that occurred prior to the endorsement effective date.

The new premium after a change in specialty rate is computed at either the standard rate of the new coverage (a "Straight Change") or a mixed rate that is partially based on the specialty/rate of the previous coverage (a "Special Rate").

a. Straight Change

A straight change is made:

1. If the period of coverage preceding the change is six (6) months or less (eighteen (18) months or less for a "Prep" physician).

2. If the change is by Company election, such as a general rate change for a specialty, the change is only done at the renewal date with required notification.

3. If the Named Insured is over the age of 55 and has been continuously insured by the Company for at least five complete years and the change is based on semi-retirement.

In all other cases, the territory and specialty/rate changes are Special Rates.

b. Special Rate

When a Named Insured is reclassified as a result of a territory or specialty/rate change, a "mixed rate" computation is done to cover the previous exposure.

In the computation of a Special Rate, the following variables are used:

1. The specialty and rate for each previous and new scope of coverage.

2. The effective date, including prior acts coverage ("retroactive date"), with the Company and the effective date of each specialty/rate change since then ("change date(s)").

3. The period(s) of coverage to be considered (usually over a five-year period).

4. The geographical territory of medical practice.

Computing a Special Rate involves:

1. Determining the mature annual premium for the "old" and "new" classifications.

2. Application of a pro-rata factor to compute how much "old" premium and "new" premium is used within each calendar year considered.

3. The maturity of the policy that is determined by the retroactive date

4. After the Special Rate has been computed, any additional charges or discount on the policy are applied.

D. CANCELLATION/NONRENEWAL AND REINSTATEMENT

The policy can be cancelled by requesting the cancellation in writing and stating a prospective effective date of cancellation. Any unearned premium will be refunded, less the customary short rate fee.

A policy may be canceled for non-payment of premium. The Company will give ten (10) days advanced written notice of cancellation for non-payment of premium. If a policy has been in force sixty (60) days or less and the Company cancels for any other reason, thirty (30) days written notice of cancellation is given. If a policy has been in force more than sixty (60) days and the Company cancels for any other reason permitted by Illinois laws and regulations or nonrenews a policy, sixty (60) days written notice is given for such cancellation/nonrenewal. A pro-rata refund is made of any unearned premium. Where applicable, Extended Reporting Period Coverage will be offered.

Cancellation for non-payment of premium will not be effective if the amount due is paid before the cancellation effective date set forth in the notice of cancellation.

E. EXTENDED REPORTING PERIOD COVERAGE

In the event of termination of the policy or a Named Insured's coverage under the policy because of cancellation or non-renewal, Extended Reporting Period Coverage may be purchased in order to cover claims reported after the termination date of the coverage, which are based on incidents which happened on or after the retroactive date and prior to the termination date of the coverage. Extended Reporting Period Coverage provides an unlimited extended reporting period.

When Extended Reporting Period Coverage is purchased, the aggregate limits of liability provided under the expiring policy will be reinstated. This aggregate limit shall be available for the entire Extended Reporting Period Coverage period and shall be reduced by any and all amounts the Company pays for damages for claims during the entire Extended Reporting Period Coverage period.

1. Premium Calculation and Payment - The premium for the Extended Reporting Period Coverage is calculated as follows:

   a. If coverage has been afforded with a retroactive date five or more years previous to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage.

   b. If coverage has been afforded with a retroactive date less than five years, but more than nine months previous to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve (12) months factored pro rata with regard to maturity.

   c. If the coverage has been afforded with a retroactive date nine months or less previous to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on

the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:

i.	One (1) to thirty (30) days	.090
ii.	Thirty-one (31) to ninety-one (91) days	.276
iii.	Ninety-two (92) to one hundred eighty-two (182) days	.520
iv.	One hundred eighty-three (183) to two hundred seventy-three (273) days	.760

d. The Extended Reporting Period Coverage must be requested and paid for within thirty (30) days of the termination or cancellation of the coverage .

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement.

As described in (3), (4) and (5) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

2. Payment

The Extended Reporting Period Coverage must be requested and paid for within thirty (30) days of the termination or cancellation of the policy. Full or appropriate partial payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement.

At the option of the insured, the following three payment plans with no interest or installment charges will be available:

- 1 single payment
- 2 payments billed 12 months apart
- 8 quarterly payments over 2 years

3. Retirement

The Company will waive the premium for Extended Reporting Period Coverage if a Named Insured:

a. Has permanently and completely retired from the practice of medicine;

b. Is fifty-five (55) years of age or older; and

c. Has been continuously insured with the Company for at least five (5) years.

If such retirement later ends, the premium for the Extended Reporting Period Coverage is reinstated and due in full within 30 days.

4. Retirement-Anesthesiologist

The Company will waive the premium for Extended Reporting Period Coverage if a Named Insured anesthesiologist:

a. Has permanently and completely retired from the practice of medicine; and

b. Has been continuously insured with the Company for at least five (5) years.

If such retirement later ends, the premium for the Extended Reporting Period Coverage is reinstated and due in full within 30 days.

5. Death and Disability

The Company will waive the premium for Extended Reporting Period Coverage in the event of:

a. The death of the Named Insured while his/her policy is in force; or

b. The total and permanent disability of the Named Insured when the disability commences while the policy is in force.

If such disability later ends, the premium for the Extended Reporting Period Coverage is reinstated and due in full within 30 days.

F. MEDIGUARD COVERAGE

Basic Limits Coverage - Included as part of medical professional liability premium - $25,000 Per Disciplinary Proceeding/$25,000 Annual Maximum for all Disciplinary Proceedings/$1,000 Deductible Per Disciplinary Proceeding

Optional Excess Limits Coverage - Basic limits coverage of $25,000/$25,000 may be optionally increased to either $50,000/$50,000, $75,000/$75,000 or $100,000/$100,000 for the following additional charges:

$25,000/$25,000 Excess:	$300 per person
$50,000/$50,000 Excess	$550 per person
$75,000/$75,000 Excess:	$800 per person

These optional excess limits may also be purchased by an entity at the applicable per person charge provided that the limits for the entity do not exceed the lowest limits purchased by any one person insured under the endorsement.

Group Aggregate Limits For Coverage under Section V, 2(iv)-Medicare/Medicaid only

This is applicable to groups only. Depending on the group size (number of physicians including the entity with separate professional liability limits on the policy) and the total limits selected, i.e., basic limit plus optional excess for the lowest total limits amount selected among all of the group members, the following Maximum Aggregate Limit automatically applies with respect to the group as a whole for coverage under Section V, 2(iv)-Medicare/Medicaid only:

Group Size	Selected Limits	Maximum Group Aggregate Limit For All Proceedings Under Section V, 2(iv)
2 - 4	$ 25,000/$ 25,000	$ 50,000
	$ 50,000/$ 50,000	$100,000
	$ 75,000/$ 75,000	$125,000
	$100,000/$100,000	$175,000

Group Size	Selected Limits	Maximum Group Aggregate Limit For All Proceedings Under Section V, 2(iv)
5 - 9	$ 25,000/$ 25,000	$100,000
	$ 50,000/$ 50,000	$150,000
	$ 75,000/$ 75,000	$175,000
	$100,000/$100,000	$225,000
10-25	$ 25,000/$ 25,000	$150,000
	$ 50,000/$ 50,000	$250,000
	$ 75,000/$ 75,000	$375,000
	$100,000/$100,000	$500,000
26+	$ 25,000/$ 25,000	$250,000
	$ 50,000/$ 50,000	$500,000
	$ 75,000/$ 75,000	$750,000
	$100,000/$100,000	$1,000,000

If a group has mixed limits of liability, the lowest limits of the group drive the Group Coverage Aggregate Limit available. For example, in a group of 5-9 practitioners with mixed limits of liability such as four practitioners with the basic limits of $25,000/$25,000, three with $50,000/$50,000 and two with $100,000/$100,000, the Group Coverage Aggregate Limit available will be that associated with the $25,000/$25,000 limits, or $100,000.

G. PREMIUM PAYMENT PLANS

Full or appropriate partial payment of the annual policy premium is due on or before the effective date of the policy.

At the option of the insured, the following two payment plans with no interest or installment charges will be available:

- 1 single payment due on or before the effective date of the policy
- 4 quarterly installment payments of 25% of the annual premium. The initial installment payment is due on or before the effective date of the policy. Additional installment payments are due 3, 6 and 9 months after the effective date of the policy.

IV. SCHEDULE RATING PLAN

SCHEDULE OF DEBITS AND CREDITS (+/-)

1. Claims Management.....+/-30%

    - Internal Review Procedures +/-20%
    - Commitment to Loss Prevention +/-20%
    - Incident/Claim Reporting Procedures +/-20%
    - Other +/-20%

2. Risk Management .....+/-30%

    - Credentialing/Peer Review +/-20%
    - Medical Record/Consent Form Documentation +/-20%
    - Quality Assurance Procedures +/-20%
    - Employee Selection, Training and Supervision +/-20%
    - Participation in Risk Management Programs +/-20%
    - Other +/-20%

3. Factors General .....+/-30%

    - Geographic Location (outside of an urban area) +/-20%
    - Loss Experience/History +/-20%
    - Hospital Staff Privileges +/-20%
    - Managed Care Network Participation +/-20%
    - Other +/-20%

Maximum Credit/Debit .....+/-40%

V. SURCHARGE PROGRAM-PROFILE ADJUSTED RATING (PAR)

Program Eligibility-New Business

A risk that does not meet the minimum underwriting guidelines established for the Company will be considered for rating under this program.

Program Eligibility-Renewal Business

The following will be considered for rating under this program:

(a) a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard

(b) a risk for which underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established for the Company

Subject to the point ranges set forth on the Points Evaluation Worksheet, surcharges of 20% to 400% will be applied as a percentage of premium. With the exception of part-time and claims-free discounts, all rating discounts apply under this program.

All $2 million/$5 million rates for this program will be surcharged by an additional 5.5%. Limits above $2 million/$5 million are not available for this program.

POINTS SCHEDULE

CLAIMS WITHIN THE LAST 10 YEARS FROM DATE OF REPORT

	Points
A. Frequency and Severity Claims Schedule	Total Points From Schedule
B. No claims reported in the past five full years.	-100

DRUG OR ALCOHOL IMPAIRMENT – HEALTH

A. Has experienced drug, alcohol, or mental illness problems more than 5 years ago.	50
B. Has experienced drug, alcohol, or mental illness problems within the past 5 years.	75
C. Currently in treatment for unresolved substance abuse.	150
D. Any relapse within the past 5 years.	150
E. Physical or mental impairment that impacted physician's ability to practice medicine safely.	100

GOVERNMENT AGENCY ACTIONS

A. Medical license in any state has been revoked.	150
B. Medical license in any state has been suspended.	100
C. Medical license has been placed on probation with restrictions on the type of services he or she can provide.	75

D. Medical license has been placed on probation for more than 5 years. 75

E. Medical license has been placed on probation for 1 to 5 years. 50

F. Medical license is under investigation. 40

G. Public letter of reprimand, fine, citation, etc. 50

H. Failure to report license investigation as required by affirmative duty language in policy 50

Note: Items A, B, C, D, E, F, G and H – only applies per occurrence – i.e., highest point value.

I. During the preceding 5 years, DEA license has been revoked suspended, or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician. 100

J. Has been convicted or indicted of a criminal act, or has been found to be in violation of a civil statute, per occurrence.

Medically related:		
	Within 5 years	100
	More than 5 years	50
Not medically related:		
	Within 5 years	50
	More than 5 years	25

K. Medicare/MediCal/Medicaid investigation 40

L. Loss of Medicare/MediCal/Medicaid privileges 50

M. Loss of any health insurance provider privileges 50

INAPPROPRIATE PATIENT CONTACT

A. Proven with a single patient. 75

B. Proven with more than one patient. 150

C. Alleged with one or more patients. 50

MEDICAL EDUCATION

A. Attended more than one medical school or a residency program due to actual or planned disciplinary action. 25

B. Residency completed at two or more facilities. 25

C. Started, but did not complete, a full residency program. 25

D. Did not begin a residency. 25

E. Has never received board certification	50

MEDICAL RECORDS

A. Records alterations with material change and intent.	150
B. Records alterations not a material change to records, just cleaning up.	25
C. Generally poor record keeping.	50

INFORMED CONSENT

A. Incomplete consent obtained.	25
B. Lack of Informed Consent.	50

PRIVILEGES - ANY STATE
(Hospital, Surgery Center, etc.)

A. Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per occurrence).	50
B. Privileges have been suspended in the past 10 years (per occurrence).	100
C. Privileges have been revoked in the past 10 years (per occurrence).	150
D. Has unexplained changes in privileges (per occurrence).	25
E. Has been notified by facility of its intent to:	
Restrict privileges	30
Suspend privileges	50
Revoke privileges	100
Note: Only applies per occurrence-i.e. highest point value	
F. No privileges at any facility.	100
G. Currently undergoing peer review.	75
H. Notice of peer review received.	50

PROCEDURES

A. Is performing a medical procedure that is considered experimental but not directly dangerous.	15
B. Is performing a medical procedure that is in violation of policy exclusions.	50
C. Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D. Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E. Is performing a procedure(s) outside his/her medical specialty.	100

F. Is performing high risk procedures within his/her medical specialty 100

RISK MANAGEMENT

A. Mandatory risk management previously recommended and insured did not comply. 50

B. Mandatory risk management previously recommended and insured had initial compliance but no follow through. 35

GAPS IN MEDICAL PRACTICE

A. Gaps in medical practice of 90-179 days duration. 50

B. Gaps in medical practice of 180-239 days duration. 100

PAYMENT HISTORY

A. Two or more late payments within the last three years. 100

B. Two or more cancellations for non-payment of premium within the last three years. 150

OTHER

A. Uncooperative in Claims Handling 75

B. Patient Load:

For Surgeons, 61-99 patients per week	50
For Surgeons, 100 or more patients per week	100
For All Others, 101-149 patients per week	50
For All Others, 150 or more patients per week	100

C. Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio 25

D. Uses collection agency that can file suit without insured's written consent. 25

E. Previous insurance history (bare, insolvent prior insurer or nonrenewed). 100

F. Claim experience of Associates, Partners or Corporation:

If one member with claim(s)	75
If more than one member with claim(s)	100
Favorable experience of group as a whole	-150

G. For each claim or suit in which the physician breached the standard of care:

Mixed Reviews	50
All Negative Reviews	100
Admitted or Clear Liability	100

H. For two or more claims, suits or incidents arising out of the same or similar procedures or treatments. 50

I. Claim is too early in discovery period:

Surgical Class	-100
Non-Surgical Class	-50

J. For each claim or suit in which expert reviewers state the insured met the standard of care:

Surgical Class	-150
Non-Surgical Class	-100

K. High risk surgical patient selection. 150

L. Loss Ratio in excess of 500%. 150

M. Loss Ratio less than 100%. -100

Frequency and Severity Claims Schedule

Insured: _____ **Policy #:** _____

Effective Date: _____ **Review Date:** _____

Claims Without Indemnity

ALAE From:	ALAE To:	Claim Score
$ 5,001	$ 25,000	1
$ 25,001	$ 50,000	2
$ 50,001	$ 100,000	3
$ 100,001	& up	4

Claims With Indemnity

Indemnity + ALAE From:	Indemnity + ALAE To:	Claim Score
$ 1	$ 25,000	4
$ 25,001	$ 50,000	5
$ 50,001	$ 100,000	6
$ 100,001	$ 250,000	7
$ 250,001	$ 500,000	8
$ 500,001	$750,000	9
$ 750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$	$	
Claim # 2		/ /	$	$	$	
Claim # 3		/ /	$	$	$	
Claim # 4		/ /	$	$	$	
Claim # 5		/ /	$	$	$	
Claim # 6		/ /	$	$	$	
Claim # 7		/ /	$	$	$	
Claim # 8		/ /	$	$	$	
Claim # 9		/ /	$	$	$	
Claim # 10		/ /	$	$	$	
					Total:	

Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties No. of Years w/TDC (1) (2)			
	0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties * No. of Years w/TDC (1) (2)			
	0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for <u>each</u> Total Claim Score above 15.

*** Emergency Medicine, General Surgery, Gynecology, Neurosurgery, Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology**

Points Evaluation Worksheet

Insured:_____ Policy #:_____

Renewal Date:_____ Evaluation Date:_____

Criteria	Points
Claims	_____
Drug or Alcohol Impairment - Health	_____
Government Agency Actions	_____
Inappropriate Patient Contact	_____
Medical Education	_____
Informed Consent	_____
Privileges - Any State	_____
Procedures	_____
Risk Management	_____
Gaps In Coverage	_____
Other	_____
TOTAL POINTS	_____

Ranges & Surcharges

0 to 50 points-No surcharge	51 to 90 points-20% surcharge	91 to 130 points-30% surcharge
131 to 170 points-40% surcharge	171 to 210 points-50% surcharge	211 to 250 points-60% surcharge
251 to 280 points-70% surcharge	281 to 300 points-80% surcharge	301 to 325 points-90% surcharge
326 to 350 points-100% surcharge	351 to 370 points-125% surcharge	371 to 390 points-150% surcharge
391 to 410 points-175% surcharge	411 to 430 points-200% surcharge	431 to 450 points-225% surcharge
451 to 470 points-250% surcharge	471 to 490 points-275% surcharge	491 to 510 points-300% surcharge
511 to 530 points-325% surcharge	531 to 550 points-350% surcharge	551 to 570 points-375% surcharge
571 to 590 points-400% surcharge	591 or more points-Nonrenew	

Comments:_____

_____

_____

_____

Completed by:_____ Approved by:_____

VI. MANUAL RATES

THE DOCTORS COMPANY
ILLINOIS
$1M/$3M Limit Mature Claims-Made Coverage

SPECIALTY	Territory A	Territory B	Territory C	Territory D
PHYSICIANS/SURGEONS				
Administrative Medicine	15,192	12,154	10,634	13,673
Allergy/Immunology	18,483	14,787	12,938	16,635
Anesthesiology	54,166	43,332	37,917	48,749
Anesthesiology-Pain Management	49,911	39,928	34,938	44,920
Cardiology (Invasive)	69,757	55,805	48,829	62,781
Chiropractic	7,596	6,077	5,317	6,836
Colon & Rectal Surgery (Minor Surgery Limited to Anal Ring)	111,408	89,126	77,986	100,268
Dermatology	32,916	26,333	23,041	29,625
Dermatology (With Liposuction)	117,586	94,068	82,311	105,827
Diagnostic Radiology	74,568	59,654	52,198	67,111
Emergency Medicine	106,344	85,075	74,441	95,710
Family General Practice (No Surgery-Hospital Care)	38,740	30,992	27,117	34,865
Family General Practice (Minor Surgery-No Obstetrics)	54,691	43,754	38,284	49,222
Family General Practice (Restricted Major Surgery-No Obstetrics)	73,428	58,742	51,400	66,085
Family General Practice (With Obstetrics)	101,027	80,822	70,719	90,924
Gastroenterology	60,135	48,108	42,095	54,121
General Medicine (Restricted)	35,448	28,358	24,814	31,903
General Surgery	197,497	157,997	138,247	177,746
Gynecology (Major Surgery)	98,368	78,694	68,858	88,532
Gynecology (With In-Vitro Fertilization)	159,833	127,866	111,883	143,850
Hand & Foot Surgery	67,351	53,881	47,146	60,617
Internal Medicine	50,640	40,512	35,448	45,576
Internal Medicine Subspecialties*	44,563	35,651	31,194	40,107
Neonatology	70,896	56,717	49,627	63,806
Neurology	65,832	52,666	46,082	59,248
Neurosurgery	329,666	263,734	230,767	296,700
Nuclear Medicine	23,294	18,635	16,307	20,965
Obstetrics & Gynecology	221,297	177,037	154,908	199,167
Occupational Medicine	17,724	14,179	12,407	15,952
Ophthalmology (No Surgery)	15,952	12,762	11,166	14,357
Ophthalmology (Minor Surgery)	31,903	25,522	22,332	28,713
Ophthalmology (Major Surgery)	50,133	40,107	35,093	45,121
Orthopedic Surgery	150,401	120,321	105,280	135,361
Otolaryngology (Major With No Facial Plastic)	83,556	66,845	58,489	75,200
Otolaryngology (Major With Facial Plastic)	101,280	81,024	70,896	91,152
Pathology	50,640	40,512	35,448	45,576
Pediatrics	47,754	38,203	33,428	42,979
Physical Medicine & Rehabilitation	31,903	25,522	22,332	28,713
Physical Medicine & Rehabilitation-Pain Management (Minor Procedures)	40,006	32,004	28,004	36,006
Physical Medicine & Rehabilitation-Pain Management (Major Procedures)	66,845	53,475	46,791	60,161

* Internal Medicine Subspecialties include Non-Invasive Cardiology, Endocrinology, Hematology, Infectious Disease, Nephrology, Oncology and Rheumatology.

Territory A = Cook, Madison, St. Clair and Will Counties
Territory B = Champaign, Macon, McHenry and Sangamon Counties
Territory C = Remainder of State
Territory D = DuPage, Kane, Lake and Vermilion Counties

VI. MANUAL RATES

THE DOCTORS COMPANY
ILLINOIS
$1M/$3M Limit Mature Claims-Made Coverage

SPECIALTY	Territory A	Territory B	Territory C	Territory D
PHYSICIANS/SURGEONS (CONTINUED)				
Plastic Surgery	117,485	93,988	82,239	105,736
Podiatry	34,637	27,711	24,247	31,175
Psychiatry	21,907	16,084	12,762	19,639
Pulmonary Medicine	63,300	50,640	44,310	56,970
Surgical Specialty (Office with Minor Surgery)	72,415	57,933	50,691	65,174
Therapeutic Radiology	63,300	50,640	44,310	56,970
Thoracic/Cardiovascular Surgery	167,112	133,689	116,978	150,401
Urology	84,316	67,452	59,021	75,885
PER PROCEDURE RATES				
Surgicenter	32.67	26.14	22.87	29.40
Note: $1,800 minimum premium applies				
DENTISTS				
Dental (Local Anesthesia and Nitrous Only)	10,128	8,102	7,090	9,115
Dental (Sedation)	20,256	16,205	14,179	18,230
Oral Surgeons	60,768	48,614	42,538	54,691
Dental Anesthesiologists	70,896	56,717	49,627	63,806

Territory A = Cook, Madison, St. Clair and Will Counties
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Territory D = DuPage, Kane, Lake and Vermilion Counties