

RECEIVED

MAR -9 2010

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

March 3, 2010

Honorable Michael T. McRaith
Director of Insurance
Illinois Department of Insurance
320 West Washington Street
Springfield, Illinois 62767**WITHDRAWN**

JUN 02 2010

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOISAttention: Mr. John Gatlin
Supervisor, Property and Casualty Compliance UnitRE: The Doctors Company, an Interinsurance Exchange 95-3014772 ✓
NAIC Number 831-34495
Physicians, Surgeons and Ancillary Healthcare Providers Professional
Liability Insurance Program~~RATE~~ / Rule RevisionEffective Date: July 1, 2010-New Business
July 1, 2010-Renewal Business

State of Illinois

Filing Number 2010-IL-01

On behalf of The Doctors Company, an Interinsurance Exchange (TDC), we are enclosing a rule revision for our Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program. Based on our current book of business, there is no rate level impact resulting from this revision.

This revision consists of the following changes:

- extended reporting period coverage rules for death, disability and retirement have been revised (See Section 1-Pages GR-4 and GR-5 of Countrywide Rules and Rates Manual). Revised Endorsement MPL101IL (7/10)-Illinois Changes reflecting this change has been submitted concurrently in SERFF Filing Number DCTR-126523216 (2010-IL-MPL01).
- minimum premium for Surgicenters has been revised (See Section 1-Page GR-7 of Countrywide Rules and Rates Manual)
- shared business entity coverage premium charge has been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual)
- minimum premium for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual)
- prep ("new to practice") discounts have been revised (See Section 1-Page GR-11 of Countrywide Rules and Rates Manual).

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Honorable Michael T. McRaith

March 3, 2010

Page 2

- risk management discount rule has been introduced (See Section 1-Page GR-12 of Countrywide Rules and Rates Manual)
- deductible discounts have been revised (See Section 2- Page SC-E-1 and SC-E-2 of Countrywide Rules and Rates Manual)
- Experience Rating Plan has been introduced (See Section 2-Pages IL-E-5 and IL-E-6 of Countrywide Rules and Rates Manual).
- various point values for imposed surcharges have been revised (See Appendix-Illinois General Rules Exception Pages).
- other changes of an editorial nature only have been made to current rating rules

The rates and rules included in this revision replace all currently filed rates and rules. Due to a significant change in the format of the new rates and rules manual, a “side-by side” comparison of current and revised rules is not practical. However, we have enclosed a Rules Changes Explanatory Memorandum that describes our rating rule changes.

This revision will apply to all new and renewal policies effective on or after July 1, 2010.

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)
- Rate/Rule Filing Schedule (PC RRFS-1)
- Summary Sheet (Form RF-3)
- 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) 421-2368 Ext. 1318 or email me at modonohue@thedoctors.com.

Very truly yours,



Michael O'Donohue
Vice President
Regulatory Compliance

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: RECEIVED d. Date of disposition of the filing: e. Effective date of filing: MAR - 9 2010 <table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none; text-align: center;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

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

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

5. Company Tracking Number	
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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) 421-2368 Ext. 1318	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	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input checked="" type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: July 1, 2010 Renewal: July 1, 2010

Property & Casualty Transmittal Document---

15.	Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16.	Reference Organization (if applicable)	Not Applicable
17.	Reference Organization # & Title	Not Applicable
18.	Company's Date of Filing	March 3, 2010
19.	Status of filing in domicile	<input checked="" type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

20.	This filing transmittal is part of Company Tracking #	2010-IL-01
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21.	Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
 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]
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Check #:
Amount:

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

*****Refer to 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, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	2010-IL-01
2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	SERFF Filing No. DCTR-126523216 Company Filing No. 2010-IL-MPL01

Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	
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4a.	Rate Change by Company (As Proposed)
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
The Doctors Company	0.0%	0.0%	\$0	131	\$2,538,070	0.0%	0.0%

4b.	Rate Change by Company (As Accepted) For State Use Only
------------	--

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a.	Overall percentage rate indication (when applicable)		
5b.	Overall percentage rate impact for this filing		
5c.	Effect of Rate Filing – Written premium change for this program		
5d.	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	+5.0%
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7.	Effective Date of last rate revision	January 1, 2006- new March 1, 2006-renewal
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8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	File and Use
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9.	Rule # or Page # Submitted for Review	Replacement or Withdrawn?	Previous state filing number, if required by state
01	Rules and Rates Manual Pages 1-28 (3-06)	<input type="checkbox"/> New <input type="checkbox"/> Replacement <input checked="" type="checkbox"/> Withdrawn	2005-IL-01
02	Countrywide General Rules Pages Pages GR-1 to GR-13 (1-09)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable
03	Illinois General Rules Exception Pages Pages IL-E-1 to IL-E-6 (7-10)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable

04	Illinois Rate Pages Pages IL-R-1 to IL-R-3 (7-10)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable
05	Appendix-Illinois General Rules Exception Pages Pages IL-A-1 to IL-A-8 (7-10)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable

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, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	2010-IL-01
2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	SERFF Filing No. DCTR-126523216 Company Filing No. 2010-IL-MPL01

Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)
-----------	--

4a. Rate Change by Company (As Proposed)							
Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
The Doctors Company	0.0%	0.0%	\$0	131	\$2,538,070	0.0%	0.0%

4b. Rate Change by Company (As Accepted) For State Use Only							
Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)			
		COMPANY USE	STATE USE
5a.	Overall percentage rate indication (when applicable)		
5b.	Overall percentage rate impact for this filing		
5c.	Effect of Rate Filing – Written premium change for this program		
5d.	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	+5.0%
7.	Effective Date of last rate revision	January 1, 2006- new March 1, 2006-renewal
8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	File and Use

9.	Rule # or Page # Submitted for Review	Replacement or Withdrawn?	Previous state filing number, if required by state
01	Rules and Rates Manual Pages 1-28 (3-06)	<input type="checkbox"/> New <input type="checkbox"/> Replacement <input checked="" type="checkbox"/> Withdrawn	2005-IL-01
02	Countrywide General Rules Pages Pages GR-1 to GR-13 (1-09)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable
03	Illinois General Rules Exception Pages Pages IL-E-1 to IL-E-6 (7-10)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable

04	Illinois Rate Pages Pages IL-R-1 to IL-R-3 (7-10)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable
05	Appendix-Illinois General Rules Exception Pages Pages IL-A-1 to IL-A-8 (7-10)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Not Applicable

MAR -9 2010

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD

Form (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective July 1, 2010

(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		
<u>Line of Insurance</u>	\$2,538,070	0.0%

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

Not Applicable

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

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

Official - Title

**THE DOCTORS COMPANY,
An Interinsurance Exchange**

Actuarial Certification

I, Jeff Donaldson, am an officer with The Doctors Company, an Interinsurance Exchange and a Fellow of the Casualty Actuarial Society. The rates included in this filing were developed based on sound actuarial assumptions and methods and are not inconsistent with the company's experience.



Jeff Donaldson, F.C.A.S.
Senior Vice President

The Doctors Company, an Interinsurance Exchange
Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability

Rules Changes Explanatory Memorandum

This filing proposes the following changes to current Illinois rating rules for physicians, surgeons and ancillary healthcare providers professional liability:

- extended reporting period coverage rules for death, disability and retirement have been revised (See Section 1-Pages GR-4 and GR-5 of Countrywide Rules and Rates Manual). An appropriate state amendatory policy endorsement reflecting this change has been submitted via SERFF in a separate filing.

The free Extended Reporting Period Coverage retirement benefit may now be exercised by an insured at any age upon 5 continuous years of coverage with TDC or its subsidiary companies. Our previous rules allowed free retirement benefits at age 55. We have also incorporated new rules addressing how the free Extended Reporting Period Coverage retirement benefit is impacted if the insured returns to the practice of medicine after retiring or being on permanent disability

- minimum premium for Surgicenters has been revised (See Section 1-Page GR-7 of Countrywide Rules and Rates Manual).

This change was made based on underwriting judgment. The previous minimum of \$1,800 was insufficient for the cost of issuance and maintenance and, as a consequence, TDC has written very few surgicenters. SCPIE Indemnity Company, a recent acquisition of TDC writes a larger number of such facilities, and has a minimum premium of \$20,000. As a compromise between the rules of the two companies, \$10,000 was selected. TDC currently writes no Surgicenters in Illinois.

- shared business entity coverage premium charge has been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual).

We have replaced the current 4% charge with an “up to 4%” charge. This revised charge provides the Company with flexibility to apply a charge commensurate with the exposure presented by the individual entity.

- quarterly minimum premium of \$750 for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual).

This change was made based on underwriting judgment. The auxiliary physician product feature is used for rating physician exposure on an hourly basis. Without a minimum, the rating can result in a premium that is insufficient for the cost of issuance and maintenance. Since the average premium for all specialties is in the range of \$12,000, it was felt that a minimum premium of \$3,000 was reasonable. TDC currently writes no auxiliary healthcare professionals in Illinois

- Prep (“new to practice”) discounts have been revised for new business only. Where applicable, current prep discounts will be “grandfathered” for existing insureds (See Section 1-Page GR-11 of Countrywide Rules and Rates Manual).
- risk management discount rule has been introduced (See Section 1-Page GR-12 of Countrywide Rules and Rates Manual).
- deductible discounts have been revised (See Section 2-Page IL-E-2 of Countrywide Rules and Rates Manual). No Illinois insureds currently receive this discount.
- Experience Rating Plan has been introduced (See Section 2-Pages IL-E-5 and IL-E-6 of Countrywide Rules and Rates Manual).
- various point values for imposed surcharges have been revised (See Appendix-Illinois General Rules Exception Pages).
- All other rating rule changes are strictly of an editorial nature with no intended substantive change.

Neuman, Gayle

From: O'Donohue, Michael [MODonohue@thedoctors.com]
Sent: Tuesday, April 06, 2010 11:38 AM
To: Neuman, Gayle
Cc: Embree, Dana; Fleming, Bill; Donaldson, Jeff
Subject: The Doctors Company - Filing #2010-IL-01
Attachments: Illinois Rate Pages (7-10).pdf; Illinois General Rules Exception Pages (7-10).pdf; Actuarial Certification.pdf

Dear Ms. Neuman:

In response to your March 30, 2010 email below regarding the captioned filing, we offer the following:

- 1) Effective January 1, 2008, The Doctors Company began reporting statistical data for its Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program to Insurance Services Office (ISO). Prior to this date, statistical data was reported to the National Independent Statistical Service (NISS).
- 2) We have enclosed the required Actuarial Certification.
- 3) We have enclosed revised Illinois Rate Pages (7-10) reflecting a corrected factor of 0.810 for the .5M/1.5M limit for other than chiropractic. We apologize for the oversight.
- 4) We have enclosed revised Illinois General Rules Exception Pages (7-10) reflecting your requested change to the Premium Payment Plans rule on Page IL-E-6.
- 5) We have enclosed revised Illinois General Rules Exception Pages (7-10) reflecting your requested change to Rule G. Extended Reporting Period Coverage on Page IL-E-1.
- 6) We have enclosed revised Illinois General Rules Exception Pages (7-10) reflecting your requested change to Rule E. Deductible Discount on Page IL-E-3.
- 7) For clarification purposes, we have enclosed revised Illinois General Rules Exception Pages (7-10) reflecting definitions of "incident" and "demand" basis coverage under Rule C. Rating Factors on Page IL-E-1. "Incident" basis coverage is provided under our basic policy form (MPL001 (11-04)) previously approved by your Department. At the request of the insured, "demand" basis coverage may be added by attaching previously approved Endorsement MPL223 (11-04)-Asserted Claims Only ("Demand Trigger").

If you have any additional questions, please feel free to contact me.

Michael O'Donohue

Vice President-Regulatory Compliance
The Doctors Company, an Interinsurance Exchange
Telephone: (800) 421-2368 Ext. 1318
FAX: (707) 226-0162
email: modonohue@thedoctors.com

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, March 30, 2010 11:36 AM
To: O'Donohue, Michael
Subject: The Doctors Company - Filing #2010-IL-01

Mr. O'Donohue,

4/6/2010

I am in receipt of the above referenced filing submitted by your letter dated March 3, 2010. Please respond to the following questions/issues:

1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?
2. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This information is required in every rate/rule filing for medical malpractice.
3. On Page IL-R-2 under B. LIMITS OF LIABILITY, the factor for .5M/1.5M limits for other than chiropractic was changed from 0.810 to 0.857. This change was not disclosed. Please advise.
4. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining quarterly installments premium payments was removed – however it is required pursuant to 50 Ill. Adm. Code 929. Additionally, wording should indicate if there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.
5. The extended reporting period information fails to disclose that the coverage is for an unlimited period. Such wording should be added.
6. On page GR-12 under E. Deductible Discount, please clarify that although the deductible applies to damages and claims expenses, defense costs must be paid as a supplement to the limits of liability.
7. On page GR-3 and GR-7, there is reference to “incident” and “demand” basis. Please explain.

I request receipt of your response by no later than April 7, 2010.

Gayle Neuman

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

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

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

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<u>Physicians/Surgeons Specialties (Continued)</u>	<u>Territory</u>			
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
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
Plastic Surgery	117,485	93,988	82,239	105,736
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
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Other Healthcare Professionals

Chiropractic	7,596	6,077	5,317	6,836
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
Podiatry	34,637	27,711	24,247	31,175

B. LIMITS OF LIABILITY

All Specialties Except Chiropractic

Chiropractic

<u>Per Claim/Aggregate Limits of Liability</u>	<u>Factor</u>	<u>Per Claim/Aggregate Limits of Liability</u>	<u>Factor</u>
.1M/.3M	Not Available	.1M/.3M	0.526
.2M/.6M	Not Available	.2M/.6M	0.684
.25M/.75M	Not Available	.25M/.75M	0.737
.5M/1.5M	0.857	.5M/1.5M	0.842
1M/3M	1.000	1M/3M	1.000
2M/5M	1.350	2M/5M	1.350
3M/6M	1.554	3M/6M	1.554
4M/7M	1.673	4M/7M	1.673
5M/8M	1.742	5M/8M	1.742
6M/9M	1.798	6M/9M	1.798
7M/10M	1.843	7M/10M	1.843
8M/11M	1.884	8M/11M	1.884
9M/12M	1.916	9M/12M	1.916
10M/13M	1.946	10M/13M	1.946
11M/14M	1.976	11M/14M	1.976

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.

**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 2-ILLINOIS GENERAL RULES EXCEPTION PAGES

I. GENERAL GUIDELINES

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing 1. Premium Calculation and Payment, item d. with the following:

- d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date 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. At the option of the insured, the following three payment plans will be available with no interest or installment charges:

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

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted.

III. ADDITIONAL COVERAGES

Rule B. Entities is deleted and replaced with the following:

B. Entities

Entity coverage is available when a group of two or more physicians have formed a business organization. The entity coverage also covers nonratable employees and shared limit ancillaries of the entity. Shared or separate limits of liability coverage may be provided to the entity:

Separate Limits of Liability Coverage = 15% of each physician's/surgeon's premium

Shared Limits of Liability Coverage = up to 4% of each physician's/surgeon's premium. The shared limits of liability charge is dependent upon the exposure presented by the entity.

Rule C. Slot Positions is deleted.

Rule F. Punitive Damages Coverage is deleted.

IV. DISCOUNTS/SURCHARGES

Rule A. Claims-Free Discount is deleted and replaced with the following:

A. Claims-Free Discount

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

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective date of the policy.
2. Cumulative outstanding claims 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 three full years immediately preceding the effective dates of the policy.

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

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistant, Certified Nurse Practitioner, etc.) that share limits with any Named Insured
- healthcare professionals rated on a "per procedure" basis

Rule E. Deductible Discount is revised by deleting and replacing the first paragraph with the following:

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-1.5% premium discount
- b. \$10,000 deductible per claim-3.0% premium discount

Rule F. Defense Within Limits of Liability Discount is deleted.

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

See Appendix-Illinois General Rules Exception Pages

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

<u>Modification Factors</u>	<u>Range of Modifications—Credit/Debit</u>
1) Loss Control/Claims Management	-20% to +20%
2) Accreditation/Credentialing	-5% to +5%
3) Laboratory/Radiological Services	0% to +5%
4) Collection Procedural Services	-5% to +5%
5) Pharmacy/Optical Supply Unit	0% to +5%
6) Unusual Risk Characteristics	-25% to +25%
Maximum Credit/Debit for all factors:	-40% to +40%

Purpose

This schedule rating plan is intended to allow flexibility in computing premiums for upcoming policy periods where there is a solid underwriting justification for deviating from published rates. The following factors appear in the Company's schedule rating plan and are described briefly to suggest underwriting philosophy and information required for consideration.

1) Loss Control/Claims Management

Has the Named Insured attended a risk management seminar within the previous 12 months?

Is there a risk management/loss control program in place within the practice? Is it operated and monitored by an administrator or a principal of the Named Insured?

Has the Named Insured retained an independent risk management/ loss control consultant to perform these functions on a continuing basis?

Does the Named Insured have a risk manager on staff, and is this his/her primary duty?

Does the Named Insured have a medical record review/audit committee? How often does it meet?

What loss prevention recommendations have been made to the Named Insured and have they been implemented?

What level of supervision is utilized for employees of the Named Insured?

What are the type, condition and care of the premises?

Does management cooperate with the Company in the handling of losses and implementation of loss control measures?

2) Accreditation/Credentialing

How does the Named Insured select/credential employees?

What is the overall level of training and experience of the Named Insured's employees?

Is the Named Insured a member of a national organization such as MGMA or AGPA?

Is the entity certified or accredited by AAAHC, ARC, CAP, JCAHO or another recognized credentialing body?

Does the Named Insured have an active medical standards committee, peer review and/or claims review committee?

Does the Named Insured have privileges at a reputable hospital?

3) Laboratory/Radiological Services

Does the Named Insured have these exposures?

Is the equipment up-to-date and well maintained?

Are there appropriately trained ancillary personnel to staff these services?

4) Collection Procedures

Does the Named Insured use a collection service?

Does the service require the signature of the Named Insured before sending a patient to collection?

5) Pharmacy/Optical Supply Unit

Does the Named Insured provide laboratory, radiological, pharmacy, optical services, etc.?

Is the equipment up-to-date and well maintained?

Are there appropriately trained ancillary personnel to staff these services?

6) Unusual Risk Characteristics

Does the Named Insured own, control or staff any medically related enterprise?

Is the paramedical/physician ratio acceptable?

What is the historical attrition rate?

Is the Named Insured subject to any contractual, vicarious or contingent liability exposures?

Is there an arbitration plan in place?

Do any factors exist which minimize direct patient care exposure (e.g. Are all patients seen on a referral basis with other primary care physicians continuing an active involvement?)?

Is there a university affiliation that is likely to benefit the medical knowledge of the Named Insured?

Are the Named Insured and paramedical personnel engaged in continuing medical education?

Note: The Company must maintain complete files of how and why it applied specific Schedule Rating Plan credits/debits and make these files available to the Illinois Department of Insurance upon request. Specific documentation must be included at the inception of new business and upon each anniversary or renewal date of a policy.

The following additional rules are added:

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 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.

Group Size Discount

<u>Group Size</u>	<u>% Discount</u>
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 quarter time Named Insureds.

Experience Rating Plan

Eligibility

A group of physicians/surgeons is eligible for experience rating subject to a review of the exposure characteristics, a pre-designated minimum manual premium requirement and verification of reliable prior carrier loss and exposure data.

Experience Base

The experience modification is determined from the latest available six report years. If the experience for the full six years is not available, then the total available experience is used subject to a minimum requirement of one complete report year.

The experience period used in generating the modification must end with the year prior to the year in which the experience modification calculation is performed. Loss experience from other companies or self-insurance experience may be used if it is reliable.

Experience Modification Factor

The Experience Modification Factor is calculated in two steps. First, the Expected Loss Based on Experience is credibility-weighted with the Expected Loss Based on Manual Premium to arrive at the Credibility-Weighted Expected Loss. Then the Credibility-Weighted Expected Loss is divided by the Expected Loss Based on Manual Premium to arrive at the Experience Modification Factor.

The Expected Loss Based on Experience is a loss forecast based on the account's own experience. It is calculated by first limiting individual claim indemnities to the basic limit and ALAE on a pro-rata basis, and then trending and developing them to an ultimate, current cost level basis. The total experience period basic limit loss is then divided by the number of Experience Period Exposure Units (base class equivalent) to arrive at a Pure Premium estimate:

Pure Premium = Ultimate Trended Basic Limit Loss / Experience Period Exposure Units.

Losses are trended to six months beyond the policy effective date. The Expected Loss Based on Experience is then found by multiplying the Pure Premium estimate by the Current Exposure Units and an increased limit factor:

Expected Loss Based on Experience = Pure Premium x Current Exposure Units x Increased Limit Factor.

The Expected Loss Based on Manual Premium is determined by calculating the account's manual premium and then multiplying by the Permissible Loss Ratio. The Permissible Loss Ratio is the loss ratio underlying our manual rates. The Credibility-Weighted Expected Loss is then calculated using the following formula:

Credibility-Weighted Expected Loss = [Expected Loss Based on Experience x Credibility Factor] + [Expected Loss Based on Manual Premium x (100% - Credibility Factor)].

Finally, the Experience Modification Factor is calculated using the following formula:

Experience Modification Factor = Credibility-Weighted Expected Loss / Expected Loss Based on Manual Premium - 1.00.

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

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SECTION 2 STATE GENERAL RULES EXCEPTION PAGES

General Rules modified in accordance with state requirements.

SECTION 3 STATE RATE PAGES

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
SPRINGFIELD, ILLINOIS

**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 1- GENERAL RULES

I. GENERAL GUIDELINES

A. Application of Manual

This manual provides the rates, rules, classifications and territories for writing Healthcare Professional Liability Insurance for The Doctors Company ("the Company").

B. Application of General Rules

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the State General Rules Exception Pages in Section 2 of this manual.

C. Prior Acts Coverage

Prior Acts Coverage (retroactive/nose coverage) provides coverage for those claims arising from incidents that take place after the retroactive date and prior to the date the insured's policy became effective with the Company. The initial retroactive date will impact the rating of a policy based on the years of claims-made policy maturity. Once established the retroactive coverage date can only be advanced at the request or written knowledge of the insured.

If the limits of liability on policies carried by an applicant in the Prior Acts Coverage period are lower than those the applicant requests from the Company, then the policy will be endorsed to provide the lower limits of liability for Prior Acts Coverage. The premium is computed using the Blended Rate methodology (See I. General Guidelines, E. Policy Changes).

D. Suspension of Insurance

An insured may request temporary suspension of insurance, due to a disability, military duty, pregnancy, family leave, or sabbatical leave for training. Suspension allows for cessation of practice without the need to purchase Extended Reporting Period coverage, and then restart the claims-made maturation process when practice is resumed. The insured may report claims during the period of suspension which arise from incidents that take place after the retroactive date, but not incidents that take place during the period of suspension.

1. No premium is charged during the period of suspension. When the period of suspension commences for a policy covering only one Named Insured, any unearned premium will be refunded to the Named Insured on a pro-rata basis. For group policies, any unearned premium for the applicable suspended Named Insured will be credited on a pro-rata basis toward the group premium.
2. Normal maturation of the policy continues during the period of suspension.
3. If a insured's coverage is suspended because of temporary disability, and he or she does not return to the practice of medicine due to permanent and total disability, the Company will waive the premium for Extended Reporting Period Coverage (as described in part G of this Section), 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 insured's request. If the Company cancels the policy, the

Company will send advance notice of cancellation or nonrenewal in accordance with state requirements.

4. If a insured's coverage is suspended for reasons other than disability, and he or she does not return to the practice of medicine after the period of suspension, the Company will cancel the policy, 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 insured's request. If the Company cancels the policy, the Company will send advance notice of cancellation or nonrenewal in accordance with state requirements.

E. Policy 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 Blended 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. 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.

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 "Blended Rate").

a. Straight Change

A straight change is made:

1. If the period of coverage preceding the change is six months or less (eighteen 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, if any.
3. If the insured 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 Blended Rates.

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b. Blended Rate

When an insured is reclassified as a result of a territory, specialty/rate or other change, a "blended rate" computation is done to cover the previous exposure.

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

1. The rate for each previous and new scope of coverage.
2. The effective date, the retroactive date, and the effective date of each subsequent change.
3. The period of coverage to be considered (usually over a five-year period).

Computing a Blended Rate involves:

1. Determining the mature claims-made annual premium for the "old" and "new" classifications.
2. Application of a pro-rata factor to compute how much "old" premium and "new" premium applies within each calendar year considered.
3. After the Blended Rate has been computed, any additional charges or discounts on the policy are applied.

F. Cancellation/Nonrenewal

The policy can be cancelled by written request of the First Named Insured and stating a prospective effective date of cancellation. Any unearned premium will be refunded, less the customary short rate fee.

The Company may cancel or nonrenew a policy in accordance with state requirements. A pro-rata refund is made of any unearned premium.

G. Extended Reporting Period Coverage

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported 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 the retroactive date is five or more years before 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 the retroactive date is less than five years, but more than nine months prior 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 months factored pro rata with regard to maturity.

- c. If the retroactive date is nine months or less prior 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 to 30 days	.090
ii. 31-91 days	.276
iii. 92-182 days	.520
iv. 182-273 days	.760

- d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date 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 (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

2. 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; and
- b. has been continuously insured with the Company or one of its subsidiaries for at least five years.

If the Named Insured returns to the practice of medicine, he or she may reapply to the Company. If the Company agrees to offer coverage, the premium for the Extended Reporting Period Coverage is reinstated and due in full. However, if such return is within two years of the date of retirement, coverage will be retroactively suspended, Extended Reporting Period Coverage canceled and active coverage reinstated without additional charge, subject to underwriting of the risk.

If the Named Insured returns to the practice of medicine more than two years after the date of retirement, the Named Insured will pay a prorated Extended Reporting Period Coverage premium based on the length of time since the date of retirement. However, such Named Insureds are not eligible for a second waiver of Extended Reporting Period Coverage premium upon subsequent retirement from the practice medicine.

If the Named Insured returns to the practice of medicine more than one year after the date of retirement, and purchases active coverage from another company, the premium will be prorated based on the length of time since the date of retirement.

3. Death or 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.

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If the Named Insured returns to the practice of medicine after disability, he or she may reapply to the Company. If the Company agrees to offer coverage, the premium for the Extended Reporting Period Coverage is reinstated and due in full. However, if such return is within two years of the date of disability, coverage will be retroactively suspended, Extended Reporting Period Coverage canceled and active coverage reinstated without additional charge, subject to underwriting of the risk.

If the Named Insured returns to the practice of medicine more than two years after the date of disability, the Named Insured will pay a prorated Extended Reporting Period Coverage premium based on the length of time since the date of disability. However, such Named Insured is not eligible for a second waiver of Extended Reporting Period Coverage premium upon subsequent disability or retirement from the practice medicine.

If the Named Insured returns to the practice of medicine more than one year after the date of disability, and purchases active coverage from another company, the premium will be prorated based on the length of time since the date of disability.

If a Named Insured dies during the Extended Reporting Period, any remaining premium is waived.

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The Doctors Company

II. RATING GUIDELINES

A. Premium Calculation

Premium is calculated in consideration of the following:

1. State and territory in which the insured practices,
2. Medical specialty,
3. Limits of liability,
4. Policy maturation based on the retroactive date.

All changes requiring additional premium or return premium are computed on a prorated basis. Premium calculations are rounded to the nearest dollar.

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least \$100,000 at \$1,000,000/\$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must maintain complete files of how it modified the applicable rates, rules and coverages for the risk and make these files available to the Department of Insurance upon request.

C. Rating Factors

Policies are rated under the following calculation using the factors detailed below.

Manual Base Premium = Manual Base Rate x Increased Limit Factor x Claims-Made Maturity Year Factor

The manual base premium may be adjusted to reflect applicable discounts/surcharges set forth in this manual.

1. Manual Base Rate

The manual base rate is the 1M/3M claims-made mature rate based on specialty. See State Rate Pages for applicable manual base rates.

2. Increased Limits Factors

For all specialties except Chiropractic, the Company offers the following limits of liability: 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

For Chiropractic only, the Company also offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M and 0.25M/0.75M.

The applicable increased limits factors are shown on the State Rate Pages.

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3. Claims-Made Maturity Year

Claims-made maturation is the process of the policy aging. 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:

<u>Claims-Made Maturity Year</u>	<u>"Incident" Basis Factor</u>	<u>"Demand" Basis Factor</u>
Year 1	0.35	0.21
Year 2	0.60	0.45
Year 3	0.80	0.72
Year 4	0.92	0.88
Year 5	1.00	1.00

D. Minimum Premium-Surgicenters

Surgicenters are rated on a per procedure basis and are subject to a minimum premium of \$10,000. See State Rate Pages for applicable manual base rates.

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The Doctors Company

III. ADDITIONAL COVERAGES

A. Ancillary Healthcare Professionals

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

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 25% less than the separate limits of liability rate. The supervising physician/surgeon may purchase vicariously liability only coverage for 10% of the applicable physician's/surgeon's premium.

B. Entities

Entity coverage is available when a group of two or more physicians have formed a business organization. The entity coverage also covers nonratable employees of the entity. Shared or separate limits of liability coverage may be provided to the entity:

Separate Limits of Liability Coverage = 10% of each physician's/surgeon's premium

Shared Limits of Liability Coverage = up to 2% of each physician's/surgeon's premium. The shared limits of liability charge is dependent upon the exposure presented by the entity.

C. Slot Positions

Slotting of coverage allows for the adding and deleting of healthcare professionals in the same specialty without the need to purchase Extended Reporting Period (ERP) Coverage. Healthcare professionals are insured one at a time under the slot position rather than adding each new healthcare professional as a Named Insured and canceling each deleted healthcare professional with the option to purchase ERP Coverage. Since the slot is continuous, the ERP Coverage for any deleted healthcare professionals is "built-in". The slot matures based on the effective date of coverage of the first healthcare professional in the position. A slot will be active and billed premium even when not occupied by a healthcare professional. Only one active healthcare professional at a time can occupy a slot. Slot occupants share the Limits of Liability of the slot.

Slots when unoccupied are designated as "open slots". When the group cancels a slot, payment of the ERP Coverage premium provides ERP coverage for all the occupants of that slot position. The ERP Coverage premium for a canceled slot position is calculated in the same manner as any canceled coverage.

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D. Auxiliary Healthcare Professional Coverage

Auxiliary Healthcare Professional Coverage is available for certain types of risks and is rated on an hourly basis. This coverage is subject to a minimum premium of \$750 per quarter.

Hourly Rate: 0.0625% of the rate based on the medical specialty of the Auxiliary healthcare professional. See State Rate Pages for applicable manual base rates.

E. MediGuard Coverage

Basic Limits Coverage – Included as part of the 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:

\$50,000/\$50,000 Excess:	\$300 per person
\$75,000/\$75,000 Excess:	\$550 per person
\$100,000/\$100,000 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 Medicare/Medicaid only – This applies to groups only. Depending on the group size (number of Named Insureds) 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 Medicare/Medicaid only:

<u>Group Size</u>	<u>Selected Limits</u>	<u>Maximum Group Aggregate Limit for All Medicare/Medicaid Proceedings</u>
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
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 Named Insureds with mixed limits of liability such as four 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.

F. Punitive Damages Coverage

A Named Insured may elect to include punitive damages coverage. When a Named Insured makes such an election, a 5% additional charge shall be applied to the Named Insured's premium.

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STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IV. DISCOUNTS/SURCHARGES

A. Claims-Free Discount

A 17.5% or 12.5% claims-free discount shall be applied on the effective date of the policy for each Named Insured meeting all of the following criteria:

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective date of the policy.
2. Cumulative outstanding claims 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 three full years immediately preceding the effective dates of the policy.

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

A 17.5% claims-free discount applies for General Surgery (All Other), General Surgery (Bariatric), Neurosurgery, Obstetrics & Gynecology, Orthopedic Surgery (No Spinal), Orthopedic Surgery (With Spinal), Plastic Surgery, and Thoracic/Cardiovascular Surgery.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistant, Certified Nurse Practitioner, etc.) that share limits with any Named Insured
- healthcare professionals rated on a "per procedure" basis

B. Prep Discount

A "prep" or new to practice discount may be requested by an insured who purchases a claims-made policy and is entering private practice for the first time within two years of completing his/her: internship, residency program, military service, HMO or Veteran Administration employment, volunteer/county/government work, or teaching position. Prep rate may also apply to a physician who decided to change his or her specialty by completing a new residency training program. No additional discounts will apply.

First year	50%
Second year	25%
Third year	0%

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C. Part Time/Quarter Time Discount

A part time discount is available for non-surgical medical specialties based upon hours worked per week or days worked per year subject to underwriting. No additional discounts will apply.

1. Part Time: 50%

20 hours or less per week or who work 26 weeks or less per year. Anesthesiologists must work 20 hours or less per week (15 billable hours and five hours administrative).

2. Quarter Time: 75%

10 hours or less per week and have been in practice for at least three years with loss history of no more than one claim with no severity.

D. Risk Management Discount

1. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.
2. A risk management discount of up to 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.
3. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in any other risk management program approved by the Company.

E. 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-4% premium discount
- b. \$10,000 deductible per claim-7.5% 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/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

F. Defense Within Limits of Liability Discount

A Named Insured may elect coverage that includes payment of defense expenses within the limits of liability. A 4.5% discount shall be applied to the Named Insured's premium.

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G. Waiver of Consent to Settle Discount

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

H. Imposed Surcharges

Surcharges represent an alternative to cancellation/nonrenewal/declination and are accepted as such by an insured. Surcharges are imposed as a percentage of premium. The primary purpose of a surcharge is to address extraordinary claims frequency or claims severity. Only a small percentage of insureds have surcharges at any given time.

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

<u>Modification Factors</u>	<u>Range of Modifications--Credit/Debit</u>
1) Claims Management	40% to 40%
• Internal Review Procedures	
• Commitment to Loss Prevention	
• Incident/Claim Reporting Procedures	
• Other Claims Management Characteristics	
2) Risk Management	40% to 40%
• Credentialing/Peer Review	
• Medical Record/Consent Form Documentation	
• Quality Assurance Procedures	
• Employee Selection, Training and Supervision	
• Participation in Risk Management Programs (other than those approved by the Company)	
• Other Risk Management Characteristics	
3) General Factors	40% to 40%
• Geographic Location	
• Loss Experience/History	
• Hospital Staff Privileges	
• Managed Care Network Participation	
• Practice Profile	
• Other Factors	
Maximum Credit/Debit for all factors:	40% to 40%

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**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

APPENDIX-ILLINOIS GENERAL RULES EXCEPTION PAGES

IV. DISCOUNTS/SURCHARGES

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

Eligibility-New Business

In lieu of declining a risk, the following surcharges may be applied for a risk that does not meet the minimum underwriting guidelines established for the Company.

Eligibility-Renewal Business

In lieu of nonrenewing a risk, the following surcharges may be applied for:

1. a risk whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or
2. a risk for whom 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. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

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

POINTS SCHEDULE

CLAIMS WITHIN THE LAST 10 YEARS FROM DATE OF REPORT

	<u>Points</u>
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

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- 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

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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. | 50 |
| B. Residency completed at two or more facilities. | 50 |
| C. Started, but did not complete, a full residency program. | 50 |
| D. Did not begin a residency. | 50 |
| 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

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- 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

PATIENT SAFETY/RISK MANAGEMENT

- A. Mandatory patient safety/risk management previously recommended and insured did not comply. 100
- B. Mandatory patient safety/risk management previously recommended and insured had initial compliance but no follow through. 75

GAPS IN MEDICAL PRACTICE

- A. Gaps in medical practice of 3-6 months' duration. 50
- B. Gaps in medical practice of 6-8 months' duration. 100
- C. Gaps in medical practice greater than 8 months. 150

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

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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. Reinstatement of nonrenewal due to company election	150
M. Loss Ratio in excess of 500%.	150
N. Loss Ratio less than 100%.	-100
O. Discrepancies between application answers/documents and verification	150

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**STATE OF ILLINOIS
DEPARTMENT OF INSURANCE**

Frequency and Severity Claims Schedule

Insured: _____ Policy #: _____

Effective Date: _____ Review Date: _____

Claims Without Indemnity		
ALAE		Claim Score
From:	To:	
\$ 5,001	\$ 25,000	1
\$ 25,001	\$ 50,000	2
\$ 50,001	\$ 100,000	3
\$ 100,001	& up	4

Claims <u>With</u> Indemnity		
Indemnity + ALAE		Claim Score
From:	To:	
\$ 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:

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SPRINGFIELD, ILLINOIS

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 each Total Claim Score above 15.

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

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SPRINGFIELD, ILLINOIS

The Doctors Company

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
131 to 170 points-40% surcharge
251 to 280 points-70% surcharge
326 to 350 points-100% surcharge
391 to 410 points-175% surcharge
451 to 470 points-250% surcharge
511 to 530 points-325% surcharge
571 to 590 points-400% surcharge

51 to 90 points-20% surcharge
171 to 210 points-50% surcharge
281 to 300 points-80% surcharge
351 to 370 points-125% surcharge
411 to 430 points-200% surcharge
471 to 490 points-275% surcharge
531 to 550 points-350% surcharge
591 or more points-Nonrenew

91 to 130 points-30% surcharge
211 to 250 points-60% surcharge
301 to 325 points-90% surcharge
371 to 390 points-150% surcharge
431 to 450 points-225% surcharge
491 to 510 points-300% surcharge
551 to 570 points-375% surcharge

Comments: _____

Completed by: _____

Approved by: _____

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**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 2-ILLINOIS GENERAL RULES EXCEPTION PAGES

I. GENERAL GUIDELINES

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph with the following:

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 limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing 1. Premium Calculation and Payment, item d. with the following:

- d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date 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. At the option of the insured, the following three payment plans will be available with no interest or installment charges:

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

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted.

Rule C. Rating Factors is amended by adding the following to 3. Claims-Made Maturity Year:

NOTE: "Incident" Basis Coverage: This form of claims-made coverage provides coverage for a written demand made against the insured, and allows the policy to be triggered by the report to the Company of an incident that the insured believes may later give rise to a claim.

"Demand" Basis Coverage: This form of claims-made coverage is more restrictive than incident basis coverage, because the policy only responds when the insured reports a written demand for damages or a suit to, and provides no coverage for reported incidents.

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DEPARTMENT OF FINANCE

III. ADDITIONAL COVERAGES

Rule B. Entities is deleted and replaced with the following:

B. Entities

Entity coverage is available when a group of two or more physicians have formed a business organization. The entity coverage also covers non-attable employees and shared limit ancillaries of the entity. Shared or separate limits of liability coverage may be provided to the entity:

Separate Limits of Liability Coverage = 15% of each physician's/surgeon's premium

Shared Limits of Liability Coverage = up to 4% of each physician's/surgeon's premium. The shared limits of liability charge is dependent up on the exposure presented by the entity.

Rule C. Slot Positions is deleted.

Rule F. Punitive Damages Coverage is deleted.

IV. DISCOUNTS/SURCHARGES

Rule A. Claims-Free Discount is deleted and replaced with the following:

A. Claims-Free Discount

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

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective date of the policy.
2. Cumulative outstanding claims 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 three full years immediately preceding the effective dates of the policy.

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

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistant, Certified Nurse Practitioner, etc.) that share limits with any Named Insured
- healthcare professionals rated on a "per procedure" basis

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Rule E. Deductible Discount is deleted and replaced with the following:

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- 1.5% premium discount
- b. \$10,000 deductible per claim- 3.0% 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. Once the deductible has been exhausted, all other claims expenses will be paid in addition to the limits of liability. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

Rule F. Defense Within Limits of Liability Discount is deleted.

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

See Appendix-Illinois General Rules Exception Pages

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

<u>Modification Factors</u>	<u>Range of Modifications—Credit/Debit</u>
1) Loss Control/Claims Management	-20% to +20%
2) Accreditation/Credentialing	-5% to +5%
3) Laboratory/Radiological Services	0% to +5%
4) Collection Procedural Services	-5% to +5%
5) Pharmacy/Optical Supply Unit	0% to +5%
6) Unusual Risk Characteristics	-25% to +25%
Maximum Credit/Debit for all factors:	-40% to +40%

Purpose

This schedule rating plan is intended to allow flexibility in computing premiums for upcoming policy periods where there is a solid underwriting justification for deviating from published rates. The

following factors appear in the Company's schedule rating plan and are described briefly to suggest underwriting philosophy and information required for consideration.

1) Loss Control/Claims Management

Has the Named Insured attended a risk management seminar within the previous 12 months?

Is there a risk management/loss control program in place within the practice? Is it operated and monitored by an administrator or a principal of the Named Insured?

Has the Named Insured retained an independent risk management/loss control consultant to perform these functions on a continuing basis?

Does the Named Insured have a risk manager on staff, and is this his/her primary duty?

Does the Named Insured have a medical record review/audit committee? How often does it meet?

What loss prevention recommendations have been made to the Named Insured and have they been implemented?

What level of supervision is utilized for employees of the Named Insured?

What are the type, condition and care of the premises?

Does management cooperate with the Company in the handling of losses and implementation of loss control measures?

2) Accreditation/Credentialing

How does the Named Insured select/credential employees?

What is the overall level of training and experience of the Named Insured's employees?

Is the Named Insured a member of a national organization such as MGMA or AGPA?

Is the entity certified or accredited by AAAHC, ARC, CAP, JCAHO or another recognized credentialing body?

Does the Named Insured have an active medical standards committee, peer review and/or claims review committee?

Does the Named Insured have privileges at a reputable hospital?

3) Laboratory/Radiological Services

Does the Named Insured have these exposures?

Is the equipment up-to-date and well maintained?

Are there appropriately trained ancillary personnel to staff these services?

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4) Collection Procedures

Does the Named Insured use a collection service?

Does the service require the signature of the Named Insured before sending a patient to collection?

5) Pharmacy/Optical Supply Unit

Does the Named Insured provide laboratory, radiological, pharmacy, optical services, etc.?

Is the equipment up-to-date and well maintained?

Are there appropriately trained ancillary personnel to staff these services?

6) Unusual Risk Characteristics

Does the Named Insured own, control or staff any medically related enterprise?

Is the paramedical/physician ratio acceptable?

What is the historical attrition rate?

Is the Named Insured subject to any contractual, vicarious or contingent liability exposures?

Is there an arbitration plan in place?

Do any factors exist which minimize direct patient care exposure (e.g. Are all patients seen on a referral basis with other primary care physicians continuing an active involvement?)?

Is there a university affiliation that is likely to benefit the medical knowledge of the Named Insured?

Are the Named Insured and paramedical personnel engaged in continuing medical education?

Note: The Company must maintain complete files of how and why it applied specific Schedule Rating Plan credits/debits and make these files available to the Illinois Department of Insurance upon request. Specific documentation must be included at the inception of new business and upon each anniversary or renewal date of a policy.

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The following additional rules are added:

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 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.

Any additional premium resulting from changes during the policy period must be spread equally over the remaining installment payments. If there are no remaining installment payments, additional premium resulting from changes during the policy period may be billed separately.

Group Size Discount

<u>Group Size</u>	<u>% Discount</u>
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 quarter time Named Insureds.

Experience Rating Plan

Eligibility

A group of physicians/surgeons is eligible for experience rating subject to a review of the exposure characteristics, a pre-designated minimum manual premium requirement and verification of reliable prior carrier loss and exposure data.

Experience Base

The experience modification is determined from the latest available six report years. If the experience for the full six years is not available, then the total available experience is used subject to a minimum requirement of one complete report year.

The experience period used in generating the modification must end with the year prior to the year in which the experience modification calculation is performed. Loss experience from other companies or self-insurance experience may be used if it is reliable.

Experience Modification Factor

The Experience Modification Factor is calculated in two steps. First, the Expected Loss Based on Experience is credibility-weighted with the Expected Loss Based on Manual Premium to arrive at the

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Credibility-Weighted Expected Loss. Then the Credibility-Weighted Expected Loss is divided by the Expected Loss Based on Manual Premium to arrive at the Experience Modification Factor.

The Expected Loss Based on Experience is a loss forecast based on the account's own experience. It is calculated by first limiting individual claim indemnities to the basic limit and ALAE on a pro-rata basis, and then trending and developing them to a n ultimate, current cost level basis. The total experience pe riod basic limit loss is then divided by the number of Experience Period Exposure Units (base class equivalent) to arrive at a Pure Premium estimate:

Pure Premium = Ultimate Trended Basic Limit Loss / Experience Period Exposure Units.

Losses are trended to six months beyond the policy effective date. The Expected Loss Based on Experience is then found by multiplying the Pure Premium estimate by the Current Exposure Units and an increased limit factor:

Expected Loss Based on Experience = Pure Premium x Current Exposure Units x Increased Limit Factor.

The Expected Loss Based on Manual Premium is determined by calculating the account's manual premium and then multiplying by the Permissible Loss Ratio. The Permissible Loss Ratio is the loss ratio underlying our manual rates. The Credibility-Weighted Expected Loss is then calculated using the following formula:

Credibility-Weighted Expected Loss = [Expected Loss Based on Experience x Credibility Factor] + [Expected Loss Based on Manual Premium x (100% - Credibility Factor)].

Finally, the Experience Modification Factor is calculated using the following formula:

Experience Modification Factor = Credibility-Weighted Expected Loss / Expected Loss Based on Manual Premium -1.00.

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**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 3- ILLINOIS RATE PAGES

A. MANUAL BASE RATES

TERRITORIES

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

\$1M/\$3M LIMITS OF LIABILITY MATURE CLAIMS-MADE COVERAGE

<u>Physicians/Surgeons Specialties</u>	<u>Territory</u>			
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
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
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 (All Other)	197,497	157,997	138,247	177,746
General Surgery (Bariatric)	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 (see Note A)	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 (No Spinal)	150,401	120,321	105,280	135,361
Orthopedic Surgery (With Spinal)	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

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

WITHDRAWN

<u>Physicians/Surgeons Specialties (Continued)</u>	<u>Territory</u>			
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
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
Plastic Surgery	117,485	93,988	82,239	105,736
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
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Other Healthcare Professionals

Chiropractic	7,596	6,077	5,317	6,836
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
Podiatry	34,637	27,711	24,247	31,175

B. LIMITS OF LIABILITY

All Specialties Except Chiropractic

Chiropractic

<u>Per Claim/Aggregate Limits of Liability</u>	<u>Factor</u>	<u>Per Claim/Aggregate Limits of Liability</u>	<u>Factor</u>
.1M/.3M	Not Available	.1M/.3M	0.526
.2M/.6M	Not Available	.2M/.6M	0.684
.25M/.75M	Not Available	.25M/.75M	0.737
.5M/1.5M	0.810	.5M/1.5M	0.842
1M/3M	1.000	1M/3M	1.000
2M/5M	1.350	2M/5M	1.350
3M/6M	1.554	3M/6M	1.554
4M/7M	1.673	4M/7M	1.673
5M/8M	1.742	5M/8M	1.742
6M/9M	1.798	6M/9M	1.798
7M/10M	1.843	7M/10M	1.843
8M/11M	1.884	8M/11M	1.884
9M/12M	1.916	9M/12M	1.916
10M/13M	1.946	10M/13M	1.946
11M/14M	1.976	11M/14M	1.976

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.

WITHDRAWN

JUN 02 2010

C. ANCILLARY HEALTHCARE PROFESSIONALS

<u>Ancillary Healthcare Professional</u>	<u>Separate Limits Rate</u>
Physician Assistant	25% of Family/General Practice (No Surgery-Hospital Care) rate or otherwise applicable physician/surgeon rate
Surgeon Assistant	25% of Family/General Practice (No Surgery-Hospital Care) rate or otherwise applicable physician/surgeon rate
Certified Nurse Practitioner	25% of Family/General Practice (No Surgery-Hospital Care) rate or otherwise applicable physician/surgeon rate
Certified Nurse Midwife (Direct Supervision)	15% of Obstetrics & Gynecology rate
Certified Nurse Midwife (Indirect Supervision)	15% of Obstetrics & Gynecology rate
Certified Registered Nurse Anesthetist (Supervised by Anesthesiologist)	25% of Anesthesiology rate
Certified Registered Nurse Anesthetist (Supervised by Surgeon)	45% of Anesthesiology rate
Optometrist	16% of Internal Medicine rate

WITHDRAWN

JUN 02 2010