

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE
Project Name/Number: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Filing at a Glance

Company: Great Divide Insurance Company
 Product Name: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE
 State: Illinois
 TOI: 11.2 Med Mal-Claims Made Only
 Sub-TOI: 11.2023 Physicians & Surgeons
 Filing Type: Rate/Rule
 Date Submitted: 08/02/2012
 SERFF Tr Num: MRTN-128526807
 SERFF Status: Closed-Filed
 State Tr Num: MRTN-128526807
 State Status:
 Co Tr Num: ADM-PSAHP-10005-R
 Effective Date: On Approval
 Requested (New):
 Effective Date: On Approval
 Requested (Renewal):
 Author(s): Barb Blackowicz, Martin & Company
 Reviewer(s): Gayle Neuman (primary), Neetha Mamoottile, Caryn Carmean
 Disposition Date: 01/31/2013
 Disposition Status: Filed
 Effective Date (New): 09/01/2012
 Effective Date (Renewal): 09/01/2012
 State Filing Description:
 routed 12/4/12

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE
Project Name/Number: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

General Information

Project Name: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE Status of Filing in Domicile:

Project Number: ADM-PSAHP-10005-R

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 01/31/2013

State Status Changed:

Deemer Date:

Created By: Barb Blackowicz

Submitted By: Barb Blackowicz

Corresponding Filing Tracking Number: ADM-PSAHP-10005-F

Filing Description:

Attached for your review is a Filing Authorization Letter authorizing Martin & Company to submit this filing on behalf of Great Divide Insurance Company (hereinafter referred to as the company). Please direct all correspondence regarding this filing to Martin & Company.

In accordance with the regulatory provisions of your state, the company hereby submits its new Physicians, Surgeons And Ancillary Healthcare Providers Professional Liability program. Insureds for this program will be members of the Healthcare Professionals Risk Purchasing Group, domiciled in the State of Delaware and formed under the Risk Retention Act of 1986. The program administrator will be Contemporary Insurance Services, Inc.

Included with this filing are the rates necessary to underwrite this program. The Company rate pages are modeled after The Doctor's Company approved filings. These rates are not excessive, inadequate or unfairly discriminatory.

The corresponding forms have been submitted under company filing number ADM-PSAHP-10005-F.

The company respectfully requests that the filing be applicable to all policies effective on and after September 1, 2012 or upon approval, whichever is earlier.

Company and Contact

Filing Contact Information

Barbara Blackowicz, Compliance Analyst BBlackowicz@martincompanyus.com
 P.O. Box 70 309-444-5212 [Phone]
 Edgemont, PA 19028 309-444-5212 [FAX]

Filing Company Information

(This filing was made by a third party - martinandcompany)

Great Divide Insurance Company	CoCode: 25224	State of Domicile: North
7233 East Butherus Drive	Group Code: 98	Dakota
Scottsdale, AZ 85260	Group Name:	Company Type: P&C
(480) 951-0905 ext. [Phone]	FEIN Number: 45-0397186	State ID Number:

Filing Fees

State: Illinois **Filing Company:** Great Divide Insurance Company
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Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

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

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

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

Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: acknowledged

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

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

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	01/31/2013	01/31/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Neetha Mamoottile	12/14/2012	12/14/2012
Pending Industry Response	Gayle Neuman	11/20/2012	11/20/2012

Response Letters

Responded By	Created On	Date Submitted
Barb Blackowicz	12/18/2012	12/18/2012
Barb Blackowicz	12/04/2012	12/04/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective date	Note To Reviewer	Barb Blackowicz	01/31/2013	01/31/2013
effective date	Note To Filer	Gayle Neuman	01/07/2013	01/07/2013
vicarious liability	Note To Filer	Gayle Neuman	11/27/2012	11/27/2012
Cert Form Test	Reviewer Note	Neetha Mamoottile	12/14/2012	

State: Illinois **Filing Company:** Great Divide Insurance Company
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Disposition

Disposition Date: 01/31/2013

Effective Date (New): 09/01/2012

Effective Date (Renewal): 09/01/2012

Status: Filed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Great Divide Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document (revised)	Certification		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Authorization letter		Yes
Supporting Document	Actuarial Support		No
Rate	Great Divide PSAHP Countrywide Rate Pages		Yes
Rate (revised)	Illinois Exception Pages		Yes
Rate	Illinois Exception Pages		Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/14/2012
Submitted Date	12/14/2012
Respond By Date	12/28/2012

Dear Barbara Blackowicz,

Introduction:

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

Objection 1

- Certification (Supporting Document)

Comments: Mr. Thomas Kuzma, has signed the certification accompanying the subject filing as an authorized officer of the company. However, we have yet to find evidence that Mr. Kuzma is an authorized officer for Great Divide Insurance Company. Upon search of our records, we find no biographical affidavit has been filed with the Department for Mr. Kuzma. This issue needs to be addressed per the instructions outlined below.

According to Section 155.18 of Illinois Insurance Code (215 ILCS 5/155.18), medical malpractice rate filings shall be certified in such filing by an officer of the company and a qualified actuary that the companys rates are based on sound actuarial principles and are not inconsistent with the companys experience.

Pursuant to Section 155.04(2) of the Illinois Insurance Code (215 ILCS 5/155.04(2)), all companies licensed to transact insurance business in Illinois must notify the Director within 30 days of the appointment or election of any new officers or directors. Section 915.40 of the Illinois Administrative Code (50 Ill. Adm. Code 915.40) further stipulates biographical affidavits of newly elected or appointed officers must be filed within 30 days after the persons election or appointment.

The subject filing is considered incomplete until an authorized officer certifies the rate filing or until proper biographical affidavit documentation is filed for Mr. Kuzma.

We expect to receive a response no later than December 28, 2012.

Conclusion:

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

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

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

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

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

Sincerely,

Neetha Mamoottile

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/20/2012
Submitted Date	11/20/2012
Respond By Date	12/04/2012

Dear Barbara Blackowicz,

Introduction:

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

1. The manual indicates if the insured does return after the period of suspension, the company will cancel. Is the period of suspension a defined period?
2. If the insured returns to the practice after retirement or disability, they are required to pay for the extended reporting period coverage. Therefore, the insured should not be denied a second waiver of the extended reporting period coverage - as they paid as if they were insured during the period.
3. Vicarious liability must be provided. Any forms that contain provisions to the contrary are deemed to contain exceptions and conditions that unreasonably or deceptively affect the risks that are purported to be assumed by the policy, in violation of 215 ILCS 143(2) and will be disapproved accordingly.
4. 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?
5. On page 2 of IL-PHY-RULE-5/12, the page references Rule G. Extended Reporting Period Coverage - and it states "replacing B.5.b." - where is B.5.b.? I don't see it on form GD-PHY-RR-NAT-5/12.

Conclusion:

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

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

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

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

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

Sincerely,

Gayle Neuman

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
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Project Name/Number: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/18/2012
Submitted Date	12/18/2012

Dear Gayle Neuman,

Introduction:

Response 1

Comments:

Please see the attached revised certification form.

Related Objection 1

Applies To:

- Certification (Supporting Document)

Comments: Mr. Thomas Kuzma, has signed the certification accompanying the subject filing as an authorized officer of the company. However, we have yet to find evidence that Mr. Kuzma is an authorized officer for Great Divide Insurance Company. Upon search of our records, we find no biographical affidavit has been filed with the Department for Mr. Kuzma. This issue needs to be addressed per the instructions outlined below.

According to Section 155.18 of Illinois Insurance Code (215 ILCS 5/155.18), medical malpractice rate filings shall be certified in such filing by an officer of the company and a qualified actuary that the companys rates are based on sound actuarial principles and are not inconsistent with the companys experience.

Pursuant to Section 155.04(2) of the Illinois Insurance Code (215 ILCS 5/155.04(2)), all companies licensed to transact insurance business in Illinois must notify the Director within 30 days of the appointment or election of any new officers or directors. Section 915.40 of the Illinois Administrative Code (50 Ill. Adm. Code 915.40) further stipulates biographical affidavits of newly elected or appointed officers must be filed within 30 days after the persons election or appointment.

The subject filing is considered incomplete until an authorized officer certifies the rate filing or until proper biographical affidavit documentation is filed for Mr. Kuzma.

We expect to receive a response no later than December 28, 2012.

Changed Items:

SERFF Tracking #:

MRTN-128526807

State Tracking #:

MRTN-128526807

Company Tracking #:

ADM-PSAHP-10005-R

State:

Illinois

Filing Company:

Great Divide Insurance Company

TOI/Sub-TOI:

11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons

Product Name:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

Project Name/Number:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Supporting Document Schedule Item Changes

Satisfied - Item:

Certification

Comments:

Attachment(s):

IL Cert Med Mal - rev 12-18-12.pdf

Previous Version

Satisfied - Item:

Certification

Comments:

Attachment(s):

MedMalCertificationForm-revised 8-2-12.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,

Barb Blackowicz

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE
Project Name/Number: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/04/2012
Submitted Date	12/04/2012

Dear Gayle Neuman,

Introduction:

Response 1

Comments:

1. The manual indicates if the insured does return after the period of suspension, the company will cancel. Is the period of suspension a defined period?

--The manual says if an insured does not return to practice, the Company will cancel. We define the period of suspension in the Form, PH01100412 Temporary Leave Absence stating "This endorsement will suspend coverage for a minimum of 60 days and a maximum of 180 days."

2. If the insured returns to the practice after retirement or disability, they are required to pay for the extended reporting period coverage. Therefore, the insured should not be denied a second waiver of the extended reporting period coverage - as they paid as if they were insured during the period.

--Please see the revised exception pages.

3. Vicarious liability must be provided. Any forms that contain provisions to the contrary are deemed to contain exceptions and conditions that unreasonably or deceptively affect the risks that are purported to be assumed by the policy, in violation of 215 ILCS 143(2) and will be disapproved accordingly.

--The language in the insuring agreement is for nurses, assistant's staff, etc. Our policy states under the definitions, letter F. that "Covered Employee(s) means an employee of the Insured other than a Physician or Surgeon, but only while acting in his/her occupational capacity for the insured. Covered Employee does not include Licensed Nurse Practitioner(s) and Licensed Physician Assistant(s) unless specifically identified and listed in a written Schedule or Endorsement We issue and make part of this Policy."

The rule allows a charge to add them to the policy. Since we are creating coverage, the physician can buy the vicarious cover for these individuals.

4. 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?

--ISS will be utilized in IL.

5. On page 2 of IL-PHY-RULE-5/12, the page references Rule G. Extended Reporting Period Coverage - and it states "replacing B.5.b." - where is B.5.b.? I don't see it on form GD-PHY-RR-NAT-5/12.

--Please see the revised exception page. The numbering error has been fixed.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking #:

MRTN-128526807

State Tracking #:

MRTN-128526807

Company Tracking #:

ADM-PSAHP-10005-R

State:

Illinois

Filing Company:

Great Divide Insurance Company

TOI/Sub-TOI:

11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons

Product Name:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

Project Name/Number:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Rate/Rule Schedule Item Changes

Item No.	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #	Date Submitted
1	Illinois Exception Pages	1-18	New		12/04/2012 By: Barb Blackowicz
<i>Previous Version</i>					
1	Illinois Exception Pages	1-18	New		08/02/2012 By: Barb Blackowicz

Conclusion:

Sincerely,

Barb Blackowicz

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE
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Note To Reviewer

Created By:

Barb Blackowicz on 01/31/2013 10:32 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/31/2013 11:09 AM

Subject:

Effective date

Comments:

The company maintains the initial requested effective date of September 1, 2012.

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
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Note To Filer

Created By:

Gayle Neuman on 01/07/2013 03:40 PM

Last Edited By:

Gayle Neuman

Submitted On:

01/31/2013 11:09 AM

Subject:

effective date

Comments:

The Department of Insurance completed its review of this filing. Originally, Great Divide requested the filing be effective September 1, 2012 or upon approval. Was the filing put in effect on September 1, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

State: Illinois **Filing Company:** Great Divide Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
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Project Name/Number: PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Note To Filer

Created By:

Gayle Neuman on 11/27/2012 09:29 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/31/2013 11:09 AM

Subject:

vicarious liability

Comments:

Under III. Additional Coverages - Section A - it states "the supervising physician/surgeon may purchase vicarious liability only coverage...". Therefore, if the policy does provide vicarious liability coverage, why would it have to be purchased? I actually gave you the criticism for a form filing instead of a rate filing - however the issue is still the same.

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Reviewer Note

Created By:

Neetha Mamoottile on 12/14/2012 09:18 AM

Last Edited By:

Gayle Neuman

Submitted On:

01/31/2013 11:09 AM

Subject:

Cert Form Test

Comments:

Send out Cert Form Request

SERFF Tracking #:

MRTN-128526807

State Tracking #:

MRTN-128526807

Company Tracking #:

ADM-PSAHP-10005-R

State:

Illinois

Filing Company:

Great Divide Insurance Company

TOI/Sub-TOI:

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Product Name:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

Project Name/Number:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Rate Information

Rate data applies to filing.

Filing Method:

Use & File - 30

Rate Change Type:

%

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

N/A - initial filing

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Great Divide Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

MRTN-128526807

State Tracking #:

MRTN-128526807

Company Tracking #:

ADM-PSAHP-10005-R

State:

Illinois

Filing Company:

Great Divide Insurance Company

TOI/Sub-TOI:

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Product Name:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

Project Name/Number:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Rate/Rule Schedule

Item No.	Schedule Item Status	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing Number	Attachments
1		Great Divide PSAHP Countrywide Rate Pages	1-14	New		Nat RR gas GD final clean 5 14 12.pdf
2		Illinois Exception Pages	1-18	New		IL exception pg rev1112 final.pdf

GREAT DIVIDE INSURANCE COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS
PROFESSIONAL LIABILITY RATES & RULES MANUAL

This document is privileged and confidential property of Great Divide Insurance Company and its affiliated and/or subsidiary companies and may not be distributed without its permission.

I. GENERAL GUIDELINES

A. Application of Manual

This manual provides the rates, rules, classifications and territories for writing Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance for Great Divide Insurance 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.

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.
2. Normal maturation of the policy continues during the period of suspension.
3. If an 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 an 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

GREAT DIVIDE INSURANCE COMPANY
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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 letter 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. 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.

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.

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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 non-renew 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) 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) 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) 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 sixty 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.

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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.

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

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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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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. Full Time Equivalency Rating Rule

Coverage for a multi-physician group is available, at the Company's option, on a full time equivalent (FTE) basis rather than on an individual physician basis. Coverage is provided on an individual limit or shared limit basis. Full time equivalency is based on each physician's number of hours of medical practice per year. The definition of one FTE is based on 2500 hours per year for a group practice. The premium per FTE is the same as the physician rate.

FTE policies may be subject to electronic or on-site audits. Mid term premium adjustments may be applied based upon the audit findings for the audit period.

The following table identifies the applicable premium modification per the number of FTE's in the policy for a shared limit:

<u>FTE*</u> <u>Per Policy</u>	<u>Premium</u> <u>Modification</u>	<u>FTE*</u> <u>Per Policy</u>	<u>Premium</u> <u>Modification</u>
1	+10.0%	11	-14.0%
2	-3.0%	12	-16.0%
3	-4.0%	13	-17.0%
4	-5.0%	14	-18.0%
5	-7.0%	15	-20.0%
6	-8.0%	16	-21.0%
7	-9.0%	17	-22.0%
8	-11.0%	18	-23.0%
9	-12.0%	19	-24.0%
10	-13.0%	20+	-25.0%

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Premium Modification for claim free, new to practice, part time practice or risk management cannot be used in conjunction with the FTE rating rule.

D. 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, the Company offers the following limits of liability:

0.5M/1.5M, 1M/3M, 2M/5M (see State Rate Pages for other limits offered).

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

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>
Year 1	0.35
Year 2	0.60
Year 3	0.80
Year 4	0.92
Year 5	1.00

E. Minimum Premium – Surgical Centers

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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III. ADDITIONAL COVERAGES

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists, and Perfusionists. 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 Registered Nurse Anesthetist

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 non-ratable 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.

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.

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E. Supplemental Coverage and Information and Network Security Insurance

Basic Limits Coverage – Included as part of medical professional liability premium are the following supplemental coverages.

Supplemental Coverage	Limits
A. License Protection Defense	\$25,000 Each Claim \$25,000 Aggregate
B. Peer Review Committee Defense	\$25,000 Each Claim \$25,000 Aggregate
C. Informational Privacy Wrongful Act	\$10,000 Each Claim \$10,000 Aggregate
D. Medicare/Medicaid Billing Error Defense	\$10,000 Each Claim \$10,000 Aggregate
E. Medical Payments	\$5,000 Per Injured Patient \$10,000 Aggregate
F. Deposition Assistance	\$2,500 Each Deposition \$7,500 Aggregate
G. Damage to Property of Patients	\$500 Each Incident

Optional Higher Limits, Supplemental Coverages A, B and D – 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 Coverages A, B and D 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 limits may also be purchased by an entity at the applicable per person charge provided that the limits for the entity do not exceed the lowest limits purchased by any one person insured under the endorsement.

Group Aggregate Limits for Coverage D Medicare/Medicaid Billing Error Defense 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 higher limits for the lowest total limits amount selected among all of the group members, the following Maximum Aggregate Limit automatically applies with respect to the group as a whole for Coverage D, Medicare/Medicaid Billing Error Defense 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

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	\$ 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.

Optional Information and Network Security Insurance is included by Endorsement with the following supplemental coverage and limits at no additional charge. This endorsement deletes the coverage under Supplemental Coverage letter C and replaces it with the following:

- Information and Network Security \$25,000 Ea Claim / \$25,000 Agg
- Media Liability \$25,000 Ea Claim / \$25,000 Agg
- Regulatory Privacy Proceeding and \$25,000 Ea Claim / \$25,000 Agg Regulatory Fines and Penalties
- Customer Notification and Credit \$10,000 Ea Claim / \$10,000 Agg Monitoring Expense
- Electronic Data Recovery and \$10,000 Ea Claim / \$10,000 Agg Replacement Expenses

F. Punitive Damages Coverage

A Named Insured may elect to include punitive damages coverage. When a Named Insured makes such an election, a 15% additional charge shall be applied to the Named Insured's premium.

G. Additional Insured

1. No charge for short-term event Additional Insureds, such as "Health Fair" events.
2. **20%** of the policy's developed premium for all other Additional Insured Requests: An additional insured, such as a managed care organization, hospital, etc. All other Additional Insureds must be referred to the Company for approval and rating.

H. Vicarious Liability

1. **10%** of the developed premium is the applicable charge for each Physician/Surgeon not insured by the Company who presents a vicarious liability exposure to the Insureds, this includes Groups with a shared limit. In the event a Group carries a separate limit for the entity, and a physician in the Group is insured elsewhere, apply the Corporate charge as noted in B. above in lieu of the 10% vicarious charge noted herein.
2. Refer to S. Individual Risk Premium Modification, Scheduled Modifications, #3 Classification Anomalies, within this section for debit consideration for the vicarious liability exposure presented by Independent Contractors that are not Physicians/Surgeons.

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I. Medical Director Coverage

1. Excluding patient contact, the rate is 10% of the developed premium based on the specialty of the physician. A \$2,500 minimum premium applies.
2. Including patient contact and acting as a Medical Director, apply a surcharge of 10% of the developed premium based on the specialty of the physician (a \$2,500 minimum premium applies) in addition to the final premium for the physician, based on his/her specialty.

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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 dates 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 12.5% claims-free discount applies to all specialties except Gastroenterology, to which a 17.5% claims-free discount applies.

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 three 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%

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%

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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 5% shall be applied for all Named Insured that participate in a risk management program approved by the Company.

2) A risk management discount of 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 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.

G. Consent to Settle Discount and Surcharge

1) A Named Insured may arbitrate his or her right to consent to settle a claim with the Company. A 5% discount shall be applied to the Named Insured's premium.

2) 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 10% discount shall be applied to the Named Insured's premium.

3) A Named Insured may elect to retain his or her sole right to consent to settle a claim. A 5% debit shall be applied to the Named Insured's premium.

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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 <ul style="list-style-type: none">• Internal Review Procedures• Commitment to Loss Prevention• Incident/Claim Reporting Procedures• Other Claims Management Characteristics	40% to 40%
2) Risk Management <ul style="list-style-type: none">• 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	40% to 40%
3) General Factors <ul style="list-style-type: none">• Geographic Location• Loss Experience/History• Hospital Staff Privileges• Managed Care Network Participation• Practice Profile• Other Factors	40% to 40%

Maximum Credit/Debit for all factors: 40% to 40%

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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 with the following:

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) of the 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) of the 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) of the 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 sixty days of the termination date of the cover age.

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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.

Rule G. Extended Reporting Period Coverage, 2. Retirement, is revised by deleting and replacing with the following:

The Company may 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 under a medical professional liability policy for the five years immediately preceding the date of retirement; and
- c. has been continuously insured with the Company or one of its subsidiaries for at least one year immediately preceding the date of retirement.

Rule G. Extended Reporting Period Coverage, 2. Retirement, paragraph 3, is revised by deleting and replacing with the following:

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.

Rule G. Extended Reporting Period Coverage, 3. Death or Disability, paragraph 3, is revised by deleting and replacing with the following:

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.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

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

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must file the rate for this risk with the Illinois Department of Insurance on or before the effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

Rule D. Rating Factors is revised by deleting and replacing 2. Increased Limits Factors with the following:

2. Increased Limits Factors

For all specialties, the Company offers the following limits of liability:
0.1M/0.4M, 0.25M/1.0M, 0.3M/1.2M, 0.5M/2M, 1M/3M, 2M/5M.

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

Rule D. 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.

Rule E. Minimum Premium-Surgicenters is deleted and replaced with the following:

E. Minimum Premium

Healthcare facility policies are subject to a minimum premium of \$2,500, All other policies are subject to a minimum premium of \$500.

III. ADDITIONAL COVERAGES

Rule A. Ancillary Healthcare Professionals is deleted and replaced with the following:

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists 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 Registered Nurse Anesthetist

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 50% less than the separate limits of liability rate.

Rule F. Punitive Damages Coverage is deleted.

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IV. DISCOUNTS/SURCHARGES

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

A. Claims-Free Discount

A 15% 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 "claimsfree" 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, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (Physician Assistants, Surgeon Assistants, Certified Nurse Practitioners, etc.) that share limits of liability
- healthcare facilities

Rule D. Risk Management Discount is deleted and replaced with the following:

D. Risk Management Discount

1. A risk management discount of 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 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 10% shall be applied for all Named Insureds that participate in any other risk management program approved by the Company.

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 deductible options are:

- a. \$5,000 deductible per claim-3% premium discount
- b. \$10,000 deductible per claim-5% premium discount

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- c. \$25,000 deductible per claim-12% premium discount
- d. \$50,000 deductible per claim-19% premium discount
- e. \$100,000 deductible per claim-30% 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) Accreditation/Credentialing	-10% to +10%
2) Laboratory/Radiological Services	0% to +5%
3) Collection Procedural Services	-10% to +10%
4) Pharmacy/Optical Supply Unit	0% to +5%
5) Unusual Risk Characteristics	-25% to +25%
Maximum Credit/Debit for all factors:	-25% to +25%

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) 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?

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

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?

2) 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?

3) 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?

4) 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?

5) 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?

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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 approximately 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.
- "9-Pay Plan"-15% down payment is due on or before the effective date of the policy. Additional equal installment payments are due 2, 3, 4, 5, 6, 7, 8 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.

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.

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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.

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SECTION 3- ILLINOIS RATE PAGES

A. MANUAL BASE RATES

TERRITORIES

Territory A = Cook, Madison and St. Clair Counties
 Territory B = Jackson, Vermilion and Will Counties
 Territory C = Kane, Lake and McHenry Counties
 Territory D = Champaign, Macon and Sangamon Counties
 Territory E = Bureau, Coles, DeKalb, DuPage, Kankakee, La Salle, Ogle, Randolph and Winnebago Counties
 Territory F = Remainder of State
 Territory G = Adams, Knox, Peoria and Rock Island Counties

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

Health Professional Specialty

	<u>Territory</u>						
	A	B	C	D	E	F	G
Anesthesiology	47,108	43,811	38,630	29,208	34,389	23,791	22,141
Diagnostic Radiology (No Surgery)	49,080	45,644	40,245	30,430	35,829	24,785	23,068
Family General Practice(No Surgery)	39,671	36,894	32,530	24,596	28,959	20,033	18,645
Family General Practice (Minor Surgery)	52,964	49,254	43,432	32,838	38,663	26,748	24,893
Gastroenterology (No Surgery)	49,010	45,577	40,188	30,387	35,778	24,749	23,035
Gastroenterology (Minor Surgery)	52,266	48,606	42,857	32,405	38,154	26,393	24,564
Internal Medicine (No Surgery)	46,583	43,321	38,197	28,881	34,005	23,524	21,894
Pathology	32,875	30,575	26,959	20,383	23,999	16,602	15,452

Healthcare Facilities

	<u>Territory</u>						
	A	B	C	D	E	F	G
Surgery Centers (Per procedure)	32.14	29.89	26.35	19.92	23.46	16.23	15.09

LIMITS OF LIABILITY

All Specialties

<u>Per Claim/Aggregate Limits of Liability</u>	<u>Factor</u>
.1M/.3M	Not Available
.1M/.4M	0.482
.2M/.6M	Not Available
.25M/.75M	Not Available
.25M/1M	0.668
.3M/1.2M	0.704
.5M/1.5M	Not Available
.5M/2M	0.794
1M/3M	1.000
2M/5M	1.350

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

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

C. ANCILLARY HEALTHCARE PROFESSIONALS

Ancillary Healthcare Professional	Separate Limits Rate
Physician Assistant	6% of Family/General Practice (No Surgery) rate
Surgeon Assistant	6% of Family/General Practice (No Surgery) rate
Certified Nurse Practitioner	6% of Family/General Practice (No Surgery) rate
Certified Registered Nurse Anesthetist	6% of Anesthesiology rate

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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 premiums. 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
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	100

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medicine safely.

GOVERNMENT AGENCY ACTIONS

A. Medical license in any state has been revoked.	150
B. Medical license in any state has been suspended.	100
C. Medical license has been placed on probation with restrictions on the type of services he or she can provide.	75
D. Medical license has been placed on probation for more than 5 years.	75
E. Medical license has been placed on probation for 1 to 5 years.	50
F. Medical license is under investigation.	40
G. Public letter of reprimand, fine, citation, etc.	50
H. Failure to report license investigation as required by affirmative duty language in policy	50
 Note: Items A, B, C, D, E, F, G and H – only applies per occurrence – i.e., highest point value.	
I. During the preceding 5 years, DEA license has been revoked suspended, or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician.	100
J. Has been convicted or indicted of a criminal act, or has been found to be in violation of a civil statute, per occurrence.	
Medically related:	
Within 5 years	100
More than 5 years	50
Not medically related:	
Within 5 years	50
More than 5 years	25
K. Medicare/MediCal/Medicaid investigation	40
L. Loss of Medicare/MediCal/Medicaid privileges	50
M. Loss of any health insurance provider privileges	50

INAPPROPRIATE PATIENT CONTACT

A. Proven with a single patient.	75
B. Proven with more than one patient.	150
C. Alleged with one or more patients.	50

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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

- | | |
|--------------------------------------|-----|
| 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 |

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- 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
- 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 nonrenewal). 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

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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	-150
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 in practice characteristics.	150

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Insured: _____ **Policy #:** _____

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

Claims Without Indemnity		
ALAE		Claim
From:	To:	Score
\$ 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
From:	To:	Score
\$ 1	\$ 25,000	4
\$ 25,001	\$ 50,000	5
\$ 50,001	\$ 100,000	6
\$ 100,001	\$ 250,000	7
\$ 250,001	\$ 500,000	8
\$ 500,001	\$750,000	9
\$ 750,001	\$1,000,000	11
\$1,000,001	& up	13

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

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Frequency and Severity Claims Schedule (Continued)

Total Claim Score	No. of Years w/Great Divide (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

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Points Evaluation Worksheet

Insured: _____ **Policy #** _____

Renewal Date: _____ **Evaluation Date:** _____

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

Ranges & Surcharges

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

Comments: _____

Completed by: _____ Approved by: _____

SERFF Tracking #:

MRTN-128526807

State Tracking #:

MRTN-128526807

Company Tracking #:

ADM-PSAHP-10005-R

State:

Illinois

Filing Company:

Great Divide Insurance Company

TOI/Sub-TOI:

11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons

Product Name:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

Project Name/Number:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Explanatory Memorandum		
Comments:			
Attachment(s):			
Memorandum - PSAHP - Rates.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Form RF3 - (Summary Sheet)		
Bypass Reason:	N/A - Initial Filing		
		Item Status:	Status Date:
Satisfied - Item:	Certification		
Comments:			
Attachment(s):			
IL Cert Med Mal - rev 12-18-12.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Manual		
Comments:	The complete manual is attached to the rate/rule schedule tab.		
		Item Status:	Status Date:
Satisfied - Item:	Authorization letter		
Comments:			
Attachment(s):			
Authorization letter 5-17-12-rev.pdf			



Great Divide Insurance Company
NAIC #: 98-25224 FEIN #: 45-0397186
Initial Physicians, Surgeons and Ancillary Healthcare Providers
Professional Liability Filing

Memorandum

Attached for your review is a Filing Authorization Letter authorizing Martin & Company to submit this filing on behalf of Great Divide Insurance Company (hereinafter referred to as the company). Please direct all correspondence regarding this filing to Martin & Company.

In accordance with the regulatory provisions of your state, the company hereby submits its new Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability program. Insureds for this program will be members of the Healthcare Professionals Risk Purchasing Group, domiciled in the State of Delaware and formed under the Risk Retention Act of 1986. The program administrator will be Contemporary Insurance Services, Inc.

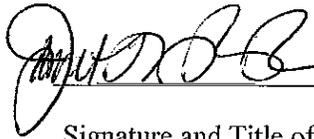
Included with this filing are the rates necessary to underwrite this program. The Company rate pages are modeled after The Doctor's Company approved filings. These rates are not excessive, inadequate or unfairly discriminatory.

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Janet L. Shemanske, a duly authorized officer of Great Divide Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Dean Westpfahl, FCAS, a duly authorized actuary of Martin & Company am authorized to certify on behalf of Great Divide Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.



Janet L. Shemanske, Vice President & Secretary

12/18/2012

Signature and Title of Authorized Insurance Company Officer

Date



Dean Westpfahl, Director of Actuarial Services

12/18/2012

Signature and Title of Authorized Actuary

Date

Insurance Company FEIN 45 - 0397186 Filing Number ADM-PSAHP-10005-R

Insurer's Address 7233 East Butherus Drive

City Scottsdale State AZ Zip Code 85260

Contact Person's:

-Name and E-mail Barbara Blackowicz bblackowicz@martincompanyus.com

-Direct Telephone and Fax Number (309) 444-5212 (phone) (309) 444-5212 (fax)



GREAT DIVIDE INSURANCE COMPANYSM

May 17, 2012

Re: Filing Authorization Letter
Great Divide Insurance Company and Nautilus Insurance Company
TOI: Medical Malpractice-Claims Made Only / Sub-TOI: Physicians, Surgeons and
Ancillary Healthcare Professionals
Rate, Rule, and Form Filings

To Whom It May Concern:

Please accept this filing authorization letter as certification that we hereby authorize Martin & Company to submit rate, rule, and form filings on behalf of: Great Divide Insurance Company (NAIC # 25224) and Nautilus Insurance Company (NAIC # 17370).

With respect to these filings, this authorization includes responding to interrogatories and supplying additional information on our behalf as required. This authorization will remain in force and effect until withdrawn in writing.

All correspondence and inquiries related to filings under this authorization should be directed to the following:

Martin & Company
ATTN: Compliance Division
P.O. Box 70
Edgemont, PA 19028-0070
Phone: (800) 896-8000
Fax: (610) 325-4405

Should you have any questions or require additional information regarding this authorization, please feel free to contact me.

Sincerely,

Richard F. Breitweiser, Esq.
Admiral Professional Program Division for:
Great Divide Insurance Company
Nautilus Insurance Company

Direct Dial: 212-406-2462
rbreitweiser@admiralins.com

Direct Fax: 212-566-5444

SERFF Tracking #:

MRTN-128526807

State Tracking #:

MRTN-128526807

Company Tracking #:

ADM-PSAHP-10005-R

State:

Illinois

Filing Company:

Great Divide Insurance Company

TOI/Sub-TOI:

11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons

Product Name:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

Project Name/Number:

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE/ADM-PSAHP-10005-R

Superseded Schedule Items

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

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/28/2012		Rate	Illinois Exception Pages	11/27/2012	IL 5 8 12 final clean RR.pdf (Superseded)
06/28/2012		Supporting Document	Certification	12/18/2012	MedMalCertificationForm-revised 8-2-12.pdf (Superseded)

GREAT DIVIDE INSURANCE COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS
PROFESSIONAL LIABILITY RATES & RULES MANUAL

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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 with the following:

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) of the 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) of the 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) of the 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 sixty days of the termination date of the cover age.

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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.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing B. 5 b. with the following:

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

1. has permanently and completely retired from the practice of medicine; and
2. has been continuously insured under a medical professional liability policy for the five years immediately preceding the date of retirement; and
3. has been continuously insured with the Company or one of its subsidiaries for at least one year immediately preceding the date of retirement.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

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 file the rate for this risk with the Illinois Department of Insurance on or before the effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

Rule D. Rating Factors is revised by deleting and replacing 2. Increased Limits Factors with the following:

2. Increased Limits Factors

For all specialties, the Company offers the following limits of liability:
0.1M/0.4M, 0.25M/1.0M, 0.3M/1.2M, 0.5M/2M, 1M/3M, 2M/5M.

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

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

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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.

Rule E. Minimum Premium-Surgicenters is deleted and replaced with the following:

E. Minimum Premium

Healthcare facility policies are subject to a minimum premium of \$2,500, All other policies are subject to a minimum premium of \$500.

III. ADDITIONAL COVERAGES

Rule A. Ancillary Healthcare Professionals is deleted and replaced with the following:

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists 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 Registered Nurse Anesthetist

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 50% less than the separate limits of liability rate.

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 15% 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

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\$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 "claimsfree" 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, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (Physician Assistants, Surgeon Assistants, Certified Nurse Practitioners, etc.) that share limits of liability
- healthcare facilities

Rule D. Risk Management Discount is deleted and replaced with the following:

D. Risk Management Discount

1. A risk management discount of 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 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 10% shall be applied for all Named Insureds that participate in any other risk management program approved by the Company.

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 deductible options are:

- a. \$5,000 deductible per claim-3% premium discount
- b. \$10,000 deductible per claim-5% premium discount
- c. \$25,000 deductible per claim-12% premium discount
- d. \$50,000 deductible per claim-19% premium discount
- e. \$100,000 deductible per claim-30% 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

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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) Accreditation/Credentialing	-10% to +10%
2) Laboratory/Radiological Services	0% to +5%
3) Collection Procedural Services	-10% to +10%
4) Pharmacy/Optical Supply Unit	0% to +5%
5) Unusual Risk Characteristics	-25% to +25%
Maximum Credit/Debit for all factors:	-25% to +25%

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) 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 AGA?

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?

2) 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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3) 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?

4) 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?

5) 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 approximately 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.

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- "9-Pay Plan"-15% down payment is due on or before the effective date of the policy. Additional equal installment payments are due 2, 3, 4, 5, 6, 7, 8 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.

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)].

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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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PROFESSIONAL LIABILITY RATES & RULES MANUAL**

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SECTION 3- ILLINOIS RATE PAGES

A. MANUAL BASE RATES

TERRITORIES

Territory A = Cook, Madison and St. Clair Counties
 Territory B = Jackson, Vermilion and Will Counties
 Territory C = Kane, Lake and McHenry Counties
 Territory D = Champaign, Macon and Sangamon Counties
 Territory E = Bureau, Coles, DeKalb, DuPage, Kankakee, La Salle, Ogle, Randolph and Winnebago Counties
 Territory F = Remainder of State
 Territory G = Adams, Knox, Peoria and Rock Island Counties

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

Health Professional Specialty

	<u>Territory</u>						
	A	B	C	D	E	F	G
Anesthesiology	47,108	43,811	38,630	29,208	34,389	23,791	22,141
Diagnostic Radiology (No Surgery)	49,080	45,644	40,245	30,430	35,829	24,785	23,068
Family General Practice(No Surgery)	39,671	36,894	32,530	24,596	28,959	20,033	18,645
Family General Practice (Minor Surgery)	52,964	49,254	43,432	32,838	38,663	26,748	24,893
Gastroenterology (No Surgery)	49,010	45,577	40,188	30,387	35,778	24,749	23,035
Gastroenterology (Minor Surgery)	52,266	48,606	42,857	32,405	38,154	26,393	24,564
Internal Medicine (No Surgery)	46,583	43,321	38,197	28,881	34,005	23,524	21,894
Pathology	32,875	30,575	26,959	20,383	23,999	16,602	15,452

Healthcare Facilities

	<u>Territory</u>						
	A	B	C	D	E	F	G
Surgery Centers (Per procedure)	32.14	29.89	26.35	19.92	23.46	16.23	15.09

LIMITS OF LIABILITY

All Specialties

<u>Per Claim/Aggregate Limits of Liability</u>	<u>Factor</u>
.1M/.3M	Not Available
.1M/.4M	0.482
.2M/.6M	Not Available
.25M/.75M	Not Available
.25M/1M	0.668
.3M/1.2M	0.704
.5M/1.5M	Not Available
.5M/2M	0.794
1M/3M	1.000
2M/5M	1.350

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

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

C. ANCILLARY HEALTHCARE PROFESSIONALS

Ancillary Healthcare Professional	Separate Limits Rate
Physician Assistant	6% of Family/General Practice (No Surgery) rate
Surgeon Assistant	6% of Family/General Practice (No Surgery) rate
Certified Nurse Practitioner	6% of Family/General Practice (No Surgery) rate
Certified Registered Nurse Anesthetist	6% of Anesthesiology rate

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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 premiums. 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
C. Currently in treatment for unresolved substance abuse.	150
D. Any relapse within the past 5 years.	150

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E. Physical or mental impairment that impacted physician's ability to practice medicine safely. 100

GOVERNMENT AGENCY ACTIONS

A. Medical license in any state has been revoked. 150

B. Medical license in any state has been suspended. 100

C. Medical license has been placed on probation with restrictions on the type of services he or she can provide. 75

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

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

F. Medical license is under investigation. 40

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

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

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

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

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

 Medically related:

 Within 5 years 100
 More than 5 years 50

 Not medically related:

 Within 5 years 50
 More than 5 years 25

K. Medicare/MediCal/Medicaid investigation 40

L. Loss of Medicare/MediCal/Medicaid privileges 50

M. Loss of any health insurance provider privileges 50

INAPPROPRIATE PATIENT CONTACT

A. Proven with a single patient. 75

B. Proven with more than one patient. 150

C. Alleged with one or more patients. 50

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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

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
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- 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
- 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 nonrenewal). 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

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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	-150
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 in practice characteristics.	150

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Frequency and Severity Claims Schedule

Insured: _____ **Policy #:** _____

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

Claims Without Indemnity		
ALAE		
From:	To:	Claim Score
\$ 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		
From:	To:	Claim Score
\$ 1	\$ 25,000	4
\$ 25,001	\$ 50,000	5
\$ 50,001	\$ 100,000	6
\$ 100,001	\$ 250,000	7
\$ 250,001	\$ 500,000	8
\$ 500,001	\$750,000	9
\$ 750,001	\$1,000,000	11
\$1,000,001	& up	13

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

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Frequency and Severity Claims Schedule (Continued)

Total Claim Score	No. of Years w/Great Divide (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

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Points Evaluation Worksheet

Insured: _____ **Policy #** _____

Renewal Date: _____ **Evaluation Date:** _____

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

Ranges & Surcharges

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

Comments: _____

Completed by: _____ Approved by: _____

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Thomas M Kuzma, a duly authorized officer of Great Divide Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Dean Westpfahl, FCAS, a duly authorized actuary of Martin & Company am authorized to certify on behalf of Great Divide Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.



Thomas M. Kuzma, President and CEO

08/02/2012

Signature and Title of Authorized Insurance Company Officer

Date



Dean Westpfahl, Director of Actuarial Services

08/02/2012

Signature and Title of Authorized Actuary

Date

Insurance Company FEIN 45 - 0397186 Filing Number ADM-PSAHP-10005-R

Insurer's Address 7233 East Butherus Drive

City Scottsdale State AZ Zip Code 85260

Contact Person's:

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